Community-Centred Care: Exploring the Integration of Community Context in Healthcare

BY

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BSN, from University of British Columbia Okanagan, 2017

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We acknowledge and respect the Lək̓ʷəŋən (Songhees and Esquimalt) Peoples on whose territory the university stands, and the Lək̓ʷəŋən and W̱SÁNEĆ Peoples whose historical relationships with the land continue to this day.

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Territory Acknowledgement

We also acknowledge that this research was conducted on the unceded, ancestral territories of the xʷməθkʷəy̓əm (Musqueam), Sḵwx̱wú7mesh (Squamish), səlilwətaɬ (Tsleil-Waututh), Shíshálh (Sechelt), Tla'amin, Lil'wat, Heiltsuk, and Nuxálk Nations Peoples whose historical relationships with the land continue to this day.

Abstract

Rural healthcare is nuanced, contextual, and embodies principles that intertwine patient-centred care, collaboration, health equity and health promotion, yet is primarily regarded in relation to its perpetual complexities. The purpose of this study is to explore how healthcare workers (HCWs) understand the context of *Community-centred care* in British Columbia (BC) rural communities. Through semi-structured interviews I explore what HCWs know about the communities they live and work, while also delving into their perceptions of how this knowledge impacts healthcare delivery. For this study, I used Thorne's Interpretive Description methodology to delve into the complexities of Community-centred care to understand the human experience of providing healthcare in rural communities. This methodology allowed for the translation of research findings into practical outcomes that are relevant to the current state of Canadian healthcare. The findings revealed three main themes: Prioritizing relationships and connections; Demonstrating innovation in overcoming challenges; and Integrating knowledge, which were central to Community-centred care and instrumental in rural healthcare delivery. These findings were discussed in relation to the literature and identified areas for future research opportunities. Additionally, we revealed how this research expands this area of scholarship by exploring Building Capacity, Agency Nurses, and Deficit Discourse in rural settings. This study emphasizes the potential of Collaborative Approaches and calls to action to empower rural HCWs to utilize their understanding of their communities to reduce barriers to healthcare.

Table of Contents

Supervisory Committee ..... **ii**

Abstract ..... **iv**

Table of Contents ..... **v**

List of Tables ..... **ix**

Dedication ..... **x**

Chapter 1: Introduction **1**

Background 2

Thesis Structure 3

Researcher Positionality 4

Chapter 2: Literature Review **6**

Rural Healthcare in Canada 6

Defining the Undefinable: Rural 6

Rural Nursing 9

Structural Inequities in Rural Communities 10

Community-Centred Care 12

The Deficit Discourse in Rural Healthcare 14

Gaps in literature 16

Summary 16

Chapter 3: Methods **18**

Theoretical Framework 18

Setting 19

Study Design 20

Sample and Recruitment 21

Sample 21

Recruitment 21

Inclusion Criteria 22

Data Collection 23

Interviews 23

Data Analysis 24

Ethical Considerations 26

Consent 26

Confidentiality and Data Security 27

Reflexivity and Rigour 28

Research Journal 28

Chapter 4: Findings 30

Prioritizing Relationships, Personhood, and Connection 31

Understanding the Community 32

Accountability and Advocacy 35

Patient-Centred Care 39

Demonstrating Innovation to Overcome Status Quo Challenges 40

Autonomy in Healthcare Initiatives and Care Delivery 44

Resourcefulness 46

Knowledge Integration 48

Leveraging Expertise and Resources 48

Equitable Education Opportunities 49

Impact of Education 50

Summary 52

Chapter 5: Discussion Working Document 53

Building Capacity – A Seat at the Urban Table 54

Agency Nurses 59

Agency Staff and Providing Trauma-Informed Care 62

Deficit Discourse 63

Implications and Recommendations 66

Limitations 68

Conclusion 69

References 71

Appendices 79

Appendix A 79

Appendix B 80

Appendix C 81

Appendix D 82

Appendix E 86

List of Tables

Table 1..24

Dedication

I dedicate this work to the incredible support system that has carried me through this journey — to my family, friends, and mentors, whose unwavering encouragement, patience, and belief in me made every step possible.

To my colleagues, whose collaboration, insight, and camaraderie turned challenges into opportunities for growth — thank you for inspiring me to push beyond what I thought possible.

To the breathtaking rural landscapes of British Columbia, whose beauty, solitude, and spirit offered a constant source of peace and perspective, your mountains, rivers, and open skies were silent partners in this endeavour, always reminding me of the bigger picture.

And finally, to all the rural healthcare workers who continue to exemplify strength, connection, and empathy. You showed me what it means to be part of a community and truly inspired this project.

This thesis is as much yours as it is mine.

Chapter 1: Introduction

As a Vancouver Coastal Health (VCH) leadership team member in the Coastal Community of Care (CoC)[1], I routinely witness the consistent disparity between urbanized and rural healthcare sites. The nature of this disparity includes inequitable resource allocation, access to education, and a lack of leadership awareness of rural healthcare. This research will examine the *Community-centred care* construct and its potential impacts on healthcare relationships and functionality in VCH's rural healthcare sites. In this research, I define *Community-centred care* as care that integrates the understanding of a community's context, culture, history, traumas, challenges, and distinct characteristics to inform the approach to healthcare (Afifi et al., 2022; Canadian Association for Rural and Remote Nursing [CARRN], 2020; MacLeod et al., 2004; Malatzky & Bourke, 2016; Malatzky & Couch, 2023). While both urban and rural healthcare sites are held to provincially mandated safety and quality standards of care, lack of access, geographic challenges, limited primary healthcare resources, workforce maldistribution struggles and social determinants of health impacting the overall healthcare of rural communities make delivering equitable, standardized healthcare a difficult feat (Malatzky & Bourke, 2016). Rural healthcare has adapted to overcome the perpetual disparities caused by this disproportionate climate. For instance, in some communities, rural healthcare workers have leveraged their knowledge of cultural and societal contexts to provide care that addresses their community's needs (Malatzky & Bourke, 2016). Culture, as used here, is defined as shared basic assumptions, values, perspectives, experiences, and historical influences characteristic of an observable group in a particular social context (Harhash et al., 2020; Polit & Beck, 2019b; White et al., 2004). This study aims to further explore the idea that understanding concrete contextual characteristics underpinning a community

[1] Coastal Community of Care (CoC) is one of Vancouver Coastal Health's four regions and includes VCH's rural and remote sites.

facilitates rural healthcare workers (HCWs)[2] to create a holistic healthcare[3] environment amidst unending challenges in resource allocation, healthcare equity, and external barriers (MacLeod et al., 2004). The purpose of this study is to explore how HCWs understand the context of *Community-centred care* in British Columbia (BC) rural communities.

Background

While there has been growing recognition of the cracks in support for rural healthcare (Seaton et al., 2022), significant changes have yet to address the perpetual discrepancies. Understanding the intricacies and uniqueness of rural healthcare is not a new phenomenon. Yet, an understanding of how the context of a community informs healthcare in rural communities remains limited. There are, however, some studies that have suggested that a community's culture impacts the health outcomes of those living in rural communities (Afifi et al., 2022; MacLeod et al., 1998, 2004, 2017a; Seaton et al.,42022; Young & Chatwood, 2017). A community can take on many different meanings, but for the purpose of this study, 'community' refers to a place where people live that has many different contextual and cultural factors that shape the overall impression, feelings, priorities, attitudes, interests and goals of the community as a whole (MacQueen et al., 2001). The complex nature of rural healthcare has led to differing definitions across the literature. To capture the nuance and consider existing definitions, rural healthcare for the context of this study is outlined in Chapter Two. To understand *Community-centred care*, I explored the experience of HCWs providing care in rural communities in BC. Interviewing HCWs working in rural healthcare sites in British Columbia aims to inform how approaching healthcare with a community-centred lens impacts care in rural communities facing status quo challenges characteristic of rural healthcare.

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[2] In this study healthcare workers refers to nurses (Licensed Practical Nurses [LPNs], Registered Nurses [RN], and Nurse Practitioners [NPs]), providers, or allied health practitioners.

[3] Holistic healthcare refers to a care approach that considers the person as a whole, rooted in the understanding that physical, psychological, spiritual, emotional, environmental and social factors are all determinants of health (Frisch & Rabinowitsch, 2019).

Additionally, a key facet of this research was to provide an opportunity for rural healthcare partners to share how they are supporting their communities and their perspectives on how to address the disparities of rural healthcare. Lack of resources, accessibility, and feasibility, as well as deficiencies in infrastructure, are among many healthcare challenges surfacing in rural communities, subjecting populations living in rural areas to preventable health disparities. Despite the complexity and challenges inherent to rural healthcare, there are passionate and dedicated healthcare clinicians residing in areas with sparse healthcare resources. As a commitment to the health of their community, they often prioritize providing care over work-life balance (MacLeod et al., 2004). This thesis aims to acknowledge the disproportionate structures within Canadian healthcare, while also drawing on the rural HCW perspective of community and its impact on healthcare delivery to promote opportunities to optimize existing rural structures to address inequity within health authorities.

Thesis Structure

In this section, I outline the thesis structure, providing an overview of how each chapter contributes to the exploration of the research question and objectives. In Chapter 2, I explore pertinent background data intersecting rural healthcare, rural nursing, *Community-centred care*, structural inequities, culture, and discourses of rurality to provide essential context to rural healthcare. Additionally, this chapter delves into key themes such as the nuance of community, the power dynamics in healthcare, the impact of structural inequities, relational aspects of care, and the opportunity for community-centred approaches in rural healthcare settings. Here, I further identify gaps in the current literature, establishing the need for this study to explore how these elements intersect and influence the provision of care in rural communities. In Chapter 3, through the Theory of Culture Care Diversity and Universality lens, I detail the methodology guiding this research and outline the study design, data collection, and data analysis approaches undertaken. Here, I describe how Thorne's (2016) interpretive description was chosen to delve into the complexities of *Community-centred care* and rurality to yield

practical recommendations on this topic. In Chapter 4, I present the findings via three themes generated using Braun and Clarke's (2019) thematic analysis: Prioritizing relationships, personhood, and connection; demonstrating innovation to overcome status quo challenges; and knowledge Integration. Finally, in Chapter 5, I discuss these findings in relation to the literature presented in Chapter 2 and present how the findings broaden the existing literature. Additionally, in Chapter 5, the implications of these findings are discussed, drawing connections between the results and existing theories on rural healthcare. This final chapter explores how the study contributes to understanding *Community-centred care* in rural communities and their healthcare settings, acknowledges any research limitations, and proposes future directions for research in this area, particularly how rural healthcare can be further improved through relational and community-based approaches.

Researcher Positionality

As the researcher, my background in nursing professional practice and extensive experience working in collaboration in rural healthcare settings have considerably shaped my approach to this study. My work with rural healthcare teams in Vancouver Coastal Health has given me a deep understanding of the specific challenges and dynamics within these environments. This experience has allowed me to critically reflect on the interview data and position myself within the context of the findings, recognizing how my perspectives may influence their interpretation. This research was inspired by one particular small community where they undoubtedly face many structural inequities. However, the healthcare workers who have lived and worked there for many years demonstrated unwavering commitment and contextual understanding of the needs of their community, overcoming the adversity of the challenges to bring their community meaningful, holistic healthcare. Furthermore, my professional background has strengthened my advocacy for rural healthcare, particularly considering the disproportionate allocation of resources and the frequent misunderstandings of rural healthcare needs. I have witnessed firsthand the individuality of rural communities and the systemic challenges they face,

as well as the prevalence of interim solutions that fail to address the root causes of these systemic issues. While my professional experience offers valuable insight, I remain mindful of the potential biases this background may introduce. To address this, I have adopted a reflexive approach throughout the research process, carefully examining my assumptions and ensuring a rigorous, objective approach to data collection, analysis, and interpretation. By acknowledging my positionality, I aim to provide transparency and rigour in the research process while recognizing that my experiences contribute to a deeper understanding of rural healthcare.

Chapter 2: Literature Review

This literature review examines the existing research on rural healthcare and *Community-centred care*, focusing on key trends such as the contextual landscape of rural healthcare in Canada, the role of *Community-centered care*, and the impact of structural inequities in rural communities. The review aims to synthesize findings from various studies to provide a comprehensive understanding of how healthcare is delivered in rural communities and the unique factors that influence care provision. Additionally, it explores the significance of relational dynamics between healthcare workers and rural communities, as well as the dominant discourse surrounding rural healthcare. The review is structured in five sections: rural healthcare in Canada, rural nursing, structural inequities, *Community-centred care*, and discourse of rurality. I then identify gaps in the literature and set the stage for the study's objectives. By critically engaging with these topics, this review will lay the foundation for understanding how the context of rural healthcare shapes the delivery of care using a *Community-centred care* lens.

Rural Healthcare in Canada

Defining the Undefinable: Rural

Due to the complexity and diversity across rural communities, the definition of rural has been deliberated by subject matter experts across Canadian research literature. Binary definitions of rural and urban oversimplify rural life, overlook its strengths, and ignore the diverse demographic, social, economic, and health factors that define rural areas. Recent research, therefore, advocates for creating definitions that reflect the contextual factors influencing health (Afifi et al., 2022). Recognizing that rurality and rural healthcare appear to be defined anecdotally rather than quantitatively, I have defined rural communities based on the definition outlined by the Canadian Association for Rural and Remote Nursing (CARRN, 2020). Therefore, for the purposes of this research, 'rural' is defined as areas characterized by limited access to specialized healthcare services and constrained resources, including technology, staff, and healthcare facilities.

Furthermore, rural communities are typically impacted by unpredictable weather conditions and travel challenges and face a higher prevalence of mental health and substance misuse disorders. In these settings, nurses often work within an optimized scope of practice to effectively address the healthcare demands of the population (Canadian Association for Rural and Remote Nursing [CARRN], 2020). Rather than relying solely on population size and commuting time to define rural meaning, I have considered community characteristics such as available amenities, geographic location, limited health resources, technological and equipment availability, and nursing praxis to ensure a more contextual definition.

Even though Statistics Canada has confirmed that 17.8% of Canada's population lives in rural areas, Canada's healthcare resource distribution is inadequate to support the proportion of people living in rural communities (Statistics Canada, 2022). Despite the vast population occupying rural communities in Canada, they often have limited community and health infrastructures. For example, rural healthcare sites have limited baseline healthcare resources, dated technologies, and minimal community resources. Due to the limited health resources, interhospital transfer or personal travel may be required to utilize specialized, innovative, or intensive care strategies to meet the patient's healthcare needs in a timely manner. Additionally, people in rural areas often have limited access to healthcare specialists and allied health coverage because of multifactorial systemic barriers. Interhospital transfers are commonly facilitated in urgent health situations where a higher level of care is beyond the scope of the local infrastructure (Jahner et al., 2020). In rural communities without access to specialized healthcare structures and resources, nurses often have extended responsibilities, autonomy, and scope of practice to mitigate emergent healthcare situations (CARRN, 2020). This ensures that patients receive timely care, increasing their chances of recovery through optimal treatment intervention. Occasionally, it also allows patients to stay within their home community if they prefer. Characteristically, rural communities are affected by geographical constraints, including weather and transportation limitations (CARRN,

2020; MacLeod et al., 2004, 2017a; Malatzky & Bourke, 2016). Provider coverage is not consistent among rural facilities, resulting in a variety of provider structures to meet the needs of the community. To compensate for this gap, nurses must optimize their scope of practice and intervene autonomously to meet the client's needs in both emergent and non-urgent circumstances (CARRN, 2020; MacLeod et al., 2017a).

The health disparities associated with residing in rural locales in Canada were consistent across the literature. Disparities include staff shortages, restricted accessibility, geographic and environmental complexities, limited specialty support, lack of capacity to support intensive care needs and the use of outdated equipment for healthcare interventions (CARRN, 2020; MacLeod et al., 2017a; Stewart et al., 2011). Additionally, educational structures specific to supporting HCWs working in rural communities are limited (MacLeod et al., 2004). For instance, according to MacLeod et al. (2004), 40.3% of British Columbia's registered nurses in rural communities received nursing education in other Canadian provinces. Because health authority leadership is often out of touch with rural challenges, contexts and needs, urban health policies often do not reflect the rural perspective. In most cases, rural HCWs and leadership are stretched thin, with limited capacity to inform or create policies specific to rural healthcare settings (Jahner et al., 2020; Stewart et al., 2011). Therefore, the use of urban-centric guidelines exacerbates the already existing disparities in healthcare outcomes for rural healthcare sites (MacLeod et al., 2004, 2017a; Malatzky & Bourke, 2016). While some rural healthcare disparities are community-specific, most arise from systemic issues that disproportionately impact the most vulnerable: rural and remote regions.

These systemic disparities have a profound impact on the health of people living in rural communities. People living in rural communities have a higher mortality rate than their urban counterparts, a phenomenon referred to as the 'rural mortality penalty' (Afifi et al., 2022). According to Thompson et al. (2024), rural patients come into the hospital in much worse condition than

metropolitan patients due to the underlying socioeconomic factors and systemic barriers impacting health. In a survey by the Centre for Rural Health Research (2019), people living in rural Canada emphasized the lack of local services available, obligating them to travel outside of their communities to receive care. Survey participants recounted the financial strain of this reality while also recognizing that these barriers contribute to delays in care and contribute to a decrease in preventative or health promotion measures (Centre for Rural Health Research, 2019). Additionally, restricted local services, including long-term care and assisted living, prenatal care, and specialized treatment, result in patients needing to leave their homes and support systems to receive treatment and utilize services (Centre for Rural Health Research, 2019; Young & Chatwood, 2017)

Rural Nursing

To gain a comprehensive understanding of rural healthcare, it is crucial to acknowledge the pivotal role of nursing in the rural healthcare landscape. Scharff (2013) describes rural nursing as "distinctive" (p. 241), speaking to the marked differences in staffing models, the scope of practice, and the nature of the role. For instance, in rural and remote healthcare settings, nurses sometimes work independently (MacLeod et al., 2004, 2017a), utilizing a broadened scope of practice to meet the care needs of a diverse patient population (Scharff, 2013). In cases where care cannot be managed by the nurse independently, providers can be called in or consulted by distance using communication technology (MacLeod et al., 2004). Afifi et al. (2022), CAARN (2020) and the Centre of Rural Health Research (2019) recommend utilizing the available telehealth services across Canada; however, they recognize the challenges in internet reliability and expect this solution to require an overhaul of internet connectivity improvements. To circumvent such challenges, nurses in some rural sites residing in VCH have access to a nurse-to-nurse call line where rural nurses can access valuable telephone advice on nurse-specific tasks, including administering medications, setting up equipment, and locating health

authority-related resources to address gaps in after-hours on-site resources (Coastal Professional Practice, 2023).

In nursing, the quality of relationships between nurses and patients plays a crucial role in promoting ontological practices, such as patient- and family-centred care, holistic care, and the enhancement of health outcomes (Doane & Varcoe, 2020). Nursing encompasses a relational inquiry that explores the interconnection between intrapersonal, interpersonal, and contextual factors to gain a comprehensive understanding of individuals' experiences and behaviours in healthcare settings (Doane & Varcoe, 2020). This is particularly significant in rural nursing, where relationships and care are central to healthcare delivery, shaped by the close intersection of professional and personal life (Jahner et al., 2020; Scharff, 2013). Working in small community environments, nurses are intertwined personally with their care (MacLeod et al., 2004). This further underscores the importance of integrating relational considerations and aesthetic knowing in nursing, which refers to understanding the unique meaning of each circumstance (Chinn et al., 2022). In essence, the literature reflected the significance of a relational understanding of rurality and the interplay of the role of relational perspectives and healthcare delivery (Bourke et al., 2013; 2020; MacLeod et al., 2004, 2017a). In essence, the literature highlights rural nursing's relational qualities, including practicing nursing concepts such as aesthetically knowing to observe complex, interconnected situations. Understanding the existing research on this topic is integral to understanding how community-centred healthcare shapes care delivery in rural communities and fosters a deep connection between healthcare workers and the communities they serve.

Structural Inequities in Rural Communities

Among Canadian rural communities, structural inequities[4] create barriers for varying populations to optimize health. Research suggests the intersection of community and healthcare in rural

[4] Structural inequities refer to systematic disadvantages experienced by populations ingrained in societal norms (National Academies of Sciences et al., 2017).

areas, and researchers concur that rural communities experience distinct structural inequities compared to their urban counterparts (Jahner et al., 2020; MacLeod et al., 2004, 2017a; Malatzky & Bourke, 2016; Stefanon et al., 2023; Stewart et al., 2011). Staffing recruitment and retention challenges, lack of healthcare resources, accessibility concerns, the feasibility of change and deficiencies in infrastructure are among many healthcare injustices surfacing in the existing research. These systemic issues have the most significant effect on marginalized populations, including Indigenous peoples, leading to preventable health disparities (Nguyen et al., 2020). Many health disparities could be prevented or resolved with the proper allocation of resources and practical implementation strategies (MacLeod et al., 2004, 2017a; Stefanon et al., 2023; Stewart et al., 2011). However, despite recognition in the literature of the need to redistribute healthcare resources and address the structural inequities in rural communities, there is no evidence to support the implementation of interventions to acknowledge the consistent healthcare inequities. Despite consistent challenges across rural communities and the lack of intent to address these problems, researchers also emphasize the relationship between rural nursing and a sense of community, accentuating how understanding the nuances of community-building capacity is essential in the role of the rural nurse (MacLeod et al., 2004, 2017a).

The Canadian Health Act (2023) delineates the country's health insurance legislation and outlines the ethical principles underpinning Canadian healthcare equity and inclusivity. As an integral part of Canada's national identity and its commitment to principles of equity, justice, and unity, the Act is proposed to ensure continued access to quality healthcare without barriers to maintain and improve the health of all Canadians (Ministry of Health, 2023). However, despite outlining fundamental principles, Canadian healthcare delivery often fails to address social and geographical constructs, leading to health disparities among specific vulnerable populations (Nguyen et al., 2020). VCH's rural populations are a case in point, prone to systemic disadvantages due to intersecting factors, including colonization, racism, socioeconomic status, geographic location and accessibility (Nguyen et al., 2020;

Seaton et al., 2022). The unjust distribution of resources, wealth, and power further exacerbates pre-existing disparities (Seaton et al., 2022). For this research study, people living in the VCH rural healthcare sites are anticipated to face structural inequities in healthcare because these sites share challenges consistent with the rural communities reflected in the literature. To facilitate health promotion throughout Canada and mitigate care falling below the established standards, I propose that the diversity of the rural context should be understood to deliver strength-based solutions to exhaustive challenges in Canadian healthcare (Seaton et al., 2022).

Community-Centred Care

As defined in Chapter 1, for the purpose of this research, I describe *Community-centred care* as a dynamic approach that weaves together the unique context, culture, history, traumas, and challenges of a community to shape effective healthcare strategies (Afifi et al., 2022; Canadian Association for Rural and Remote Nursing [CARRN], 2020; MacLeod et al., 2004; Malatzky & Bourke, 2016; Malatzky & Couch, 2023). Leveraging *Community-centred care* in rural healthcare may offer grassroots solutions that promote culturally competent, trauma-informed, and person-centred care while addressing the existing gaps in rural healthcare. This concept has been described throughout the literature; however, it was not given the same overarching term: *Community-centred care*. Instead, the term 'place' is often used to describe the contextual social and political factors that create equity and inequity in the surroundings where someone resides (Afifi et al., 2022; CARRN, 2020). These concepts are fundamentally interconnected, providing a comprehensive understanding of how the environment impacts healthcare and health outcomes. While not naming this concept, MacLeod et al. (2004) discuss the interwoven personal and professional roles of nurses in small communities. For example, seeing your clients at the grocery store or the community recreation centre.

Additionally, they emphasize that rural nursing practice is influenced by the communities in which they work and live (MacLeod et al., 2004). Because there are fewer healthcare resources,

Malatzky and Bourke (2016) state that providing healthcare in rural environments can present ample opportunities for professional growth and continuity of care. Additionally, rural healthcare can instill interprofessional collaboration and integrated and holistic care due to the complexities of clients (Malatzky & Bourke, 2016). Embracing *Community-centred care* incorporates these research perspectives while also integrating a profound understanding of the community's complexities to implement health provision strategies effectively.

As previously suggested, Afifi et al.'s (2022) research dissects rural narratives to reframe rural connotations to include the nuance of a given 'place.' This literature advocates that the nuance of place has a purpose, suggesting that it is this nuance that vicariously implicates equity and disparity. Similarly, Cummings and colleagues (2007) discuss the power and privilege central to complex political and social processes and the allocation of resources and infrastructure directed by varying partners at macro and meso levels of healthcare. In the context of rural communities, its definition is crafted from metro-normative urban-centric viewpoints, which drastically underestimates its potential and further solidifies assumptions and stereotypes (Afifi et al., 2022). Throughout the extant literature on *Community-centred care*, the trend surfaced that power dynamics prevent diverse perspectives of rural communities from gaining traction (Bourke et al., 2010). Higher governing structures and urban leadership approach rural community policy, reform, and intervention with a murky understanding of the rural contexts that impact healthcare. Ongoing comparisons between urban and rural contexts further marginalize rural populations as they are labelled as a deficit and may be left feeling misunderstood in their context (Malatzky & Bourke, 2016).

While most research on rural healthcare settings commonly focuses on the challenges in this area of healthcare to spread awareness of the structural inequities, several sources suggest an alternative perspective in rural healthcare settings. The complexity and diversity in workload reveal that nurses in rural communities have passion and dedication to these dynamic healthcare settings (Gregory,

2009; MacLeod et al., 2004; Malatzky & Bourke, 2016). Furthermore, having constant challenges to provide patients with comprehensive care, the researchers suggest that care is more collaborative, cohesive, innovative and holistic than their urban counterparts, further engaging HCWs in their communities (Gregory, 2009; Malatzky & Bourke, 2016). Approaching rural health initiatives by understanding a specific area's background and highlighting strengths and innovations could improve health outcomes and healthier communities. Additionally, it gives more meaning to creating rural health policies underpinned by values, strengths, individuality and environment (Bourke et al., 2010, 2013; Wakerman & Humphreys, 2011; White et al., 2004). This research focuses on the strengths of rural healthcare, acknowledges its attributes, and discusses a community-centred, strength-based approach to healthcare inequity (Malatzky & Bourke, 2016). Ultimately, understanding *Community-centred care* and the concept of 'place' within the context of rural healthcare is crucial for framing the research findings and subsequent discussion.

The Deficit Discourse in Rural Healthcare

To contextualize the interpretations of this study, it is essential to first examine the complex interplay between rural and urban healthcare and recognize the dominant discourses surrounding rural healthcare. As stated earlier in this chapter, many cultural, political, and contextual factors influence the relationships interweaving rural and urban healthcare, which contribute to power dynamics and the allocation of resources. Depicting these ideas, as informed by existing research, ultimately shapes how rural healthcare settings are positioned within the broader healthcare system framework. Bourke et al. (2013) introduce the concept of the deficit discourse in rural healthcare, which has been instrumental in informing the assumptions about rural health and has evidently led to downstream effects for individuals living and working in rural communities. Recent research has further analyzed this perception, determining that rural is often assumed as an area of scarcity (Afifi et al., 2022; Malatzky & Bourke, 2018a; Malatzky & Couch, 2023). Researchers clarify that the intent in acknowledging the deficit

discourse phenomenon is not to reduce the inequities challenging rural populations but to emphasize the prevailing role of power in the preventable health disparities observed between rural and urban communities (Malatzky & Bourke, 2018a). The literature consistently argues that the deficit discourse shapes our social understanding and perception of rural communities, focusing on their shortcomings relative to urban counterparts rather than recognizing their potential within their own context (Afifi et al., 2022; Malatzky et al., 2020; Malatzky & Bourke, 2016, 2017, 2018a; Malatzky & Couch, 2023).

So why is a deficit discourse so detrimental if framing deficits has drawn political attention and fiscal support to the field? According to Malatzky and Bourke (2018), the dominant discourse emphasizes rural insufficiencies rather than observing the system in its entirety or taking a strength-based approach in viewing the problem for opportune solutions. Furthermore, the literature warns that the dominant messaging about resource and staff insufficiencies in rural communities casts a message on students, novice practitioners and clinicians. These stereotypes impact those entering the workforce, further perpetuating systemic complexities, such as workforce inequitable distributions (Malatzky et al., 2020; Malatzky & Bourke, 2017, 2018a; Malatzky & Couch, 2023). It was only upon analyzing this research that I recognized the complexities of rural communities as stemming from broader systemic challenges. The issues faced in rural contexts cannot be reduced to merely 'rural' challenges but are, instead, a consequence of systemic failures that disproportionately impact the most vulnerable sectors.

Malatsky and Bourke (2017, 2018a), experts in this field and influential in this concept, emphasize that the deficit discourse that drives power relationships needs to shift. Therefore, rural and urban healthcare workers should be encouraged to consider how rural care is framed and discussed. Additionally, Malatsky and Bourke (2017, 2018a) suggest that healthcare educators should highlight rural communities using strength-based approaches rather than perpetuating deficit discourses. Afifi et al. (2022) expanded on these recommendations by advocating for the integration of community-engaged research and processes as a strategy to shift this paradigm, suggesting that these approaches

will empower communities and deconstruct power hierarchies. Reimagining rural discourses requires further research that balances the strengths and opportunities within rural contexts, amongst the perpetual challenges. While the disproportionate inequities faced by rural communities must be acknowledged, reframing how rural is defined as more than their challenges may shift deficit paradigms. Furthermore, there is a gap in the literature regarding the barriers that drive the lack of political will to implement systemic changes addressing the complexities disproportionately impacting marginalized communities.

Gaps in the Literature

While existing research on the contextual intricacies underpinning rural communities is recognized within current literature, there is limited material situated within Canada. Acknowledging the complexities of rural communities and honouring the individuality of environmental and social impacts on health determinants highlights the necessity for more studies exploring the perspectives of healthcare workers in Canada, particularly in rural settings. Furthermore, current research often overlooks the experiences of permanent, established healthcare staff working in familiar communities, presenting a gap that could provide valuable insights into staffing challenges within Canadian healthcare. Rural communities, with their diverse and complex landscapes, intersect with vulnerable populations facing systemic barriers that significantly affect both care delivery and health outcomes. Despite the profound impact of these challenges on vulnerable communities in Canada, they remain underexplored in the existing literature. This study aims to fill this gap by examining how these unique aspects of Canadian rural healthcare dynamics shape *Community-centred care*.

Summary

This chapter presents a comprehensive review of several topics intersecting with this research study, including rural healthcare in Canada, rural nursing, structural inequities, *Community-centred care* and deficit discourse. In order to further research within the rural healthcare field and understand how

Community-centred care shapes how care is provided, it is important to understand the scholarly perspectives on these topics. The existing literature recognizes that the power within healthcare lies with urban metropolitan sites, casting perceptions of rural healthcare sites and communities at large as riddled with challenges. This research spans several decades, but these views remain prevalent. I am, however, advocating for a shift in perspective, urging urban partners to recognize that rural communities are not solely defined by their challenges. Rather, rural is a multilayered entity shaped by the interconnections of history, trauma, environment, geography, and relational dynamics. The challenges in rural communities are not rural challenges; they are systemic challenges that affect the most vulnerable. While BC health authorities are beginning to recognize the importance of addressing the gaps in rural healthcare to create psychologically safe, inclusive, and respectful environments for Indigenous, vulnerable, and marginalized populations, there needs to be further upstream system-wide and structural changes that span across all healthcare environments in Canada (Stefanon et al., 2023). In the following chapters, this study will build on the discussions presented throughout this literature review, aiming to explore how the context of *Community-centred care* influences the way care is provided in rural communities.

Chapter 3: Methods

Theoretical Framework

Madeline Leininger pioneered the Theory of Culture Care Diversity and Universality, which was used to guide this project (Leinginger, 1997). This framework, as seen in Appendix A, underpins the research, as understanding the cultural factors contributing to community nuance facilitates providing inclusive, psychologically safe, and conversant care (Leinginger, 1997, 2002). Ultimately, considering the dynamics and concepts influencing values, beliefs, well-being, and health in rural BC communities could improve the quality of care delivered to those subject to health inequities. This theory suggests that understanding the intersection between culture, society, healthcare delivery, and cultural competence strengthens the relationship between nurses and their clients. Research that supports this construct may provide leverage to attain fiscal support to fund instrumental resources, such as program development, policy, and mandatory education, to understand specific community needs. Individualized community-driven programs could begin to address the healthcare deficiencies in rural communities (Leinginger, 1997, 2002).

The Theory of Culture Care Diversity and Universality integrates ethnonursing[5] and anthropological views, proposing the construct that understanding an individual's culture inspires an insightful nurse-to-patient relationship where differences are recognized, appreciated and respected (Lancellotti, 2008). Leininger (1997, 2002) recognized the need for nurses to draw on context when delivering individualized care that feels safe to each client. While normalizing the acknowledgement of culture, this framework addresses the philosophical underpinnings dividing our population and further marginalizing those with cultural views differing from dominant Westernized perspectives (Leinginger, 1997, 2002). Still, this transcultural framework proclaims meaning, expression, patterns, processes, and

[5] Ethnonursing is a term used to describe the nursing practice of integrating diverse contexts to promote culturally safe care that is meaningful to the patient or a group of people (Molloy et al., 2015).

experience as the basis of holistic caring. The theory supports that creating solutions based on a community's strengths and understanding is meaningful to delivering patient-centred care. While standardizing healthcare across urban and rural healthcare sites has hypothetical value, using the Theory of Culture Care Diversity to support relationship-building in healthcare policy and promote individualized care proves more beneficial to rural healthcare sites. The Culture Care Diversity theory reinforces that care involves more than just a one-size-fits-all policy. Instead, addressing divergences in our healthcare system requires understanding the inequities that affect how conventional care is interpreted (Leinginger, 1997, 2002).

The Theory of Culture Care Diversity and Universality supports this research due to the complexity of *Community-centred care* and its inherent integration of culture, relational, and diversity at its core. While understanding the experience of HCWs providing care to communities in which they are embedded, the study examines the role this plays in overall health to analyze and demonstrate the relationship between individualism and the environment in which we live. Understanding HCW perspectives of staff living and working in rural VCH communities aims to influence informed decision-making and the implementation of interventions. Therefore, solutions are tailored to the specific contexts of a community and address disparities in a meaningful way, underpinned by relationships and the community's values, strengths, and customs.

Setting

To ensure the research is applicable to other rural communities facing challenges in maintaining healthcare standards, I chose to consider HCW perspectives across VCH rural healthcare sites. While each of these communities faces unique challenges, they are also connected by the need to adapt to the current terrain of healthcare and urban priorities. Additionally, awareness of a community's history gives context to the healthcare relationships between community members and governing leadership, informing policy. This leaves me to wonder, does understanding the community's traumas, resilience,

and relationships contribute to providing more culturally competent, trauma-informed, and empathetic healthcare? Does understanding the community's historical genocide offer reasoning for the resentment and silent apprehension to accept care and leadership?

Study Design

For the sake of generating practical outcomes, this qualitative study utilized an interpretive description (ID) approach to consider the HCW perspective on *Community-centred care* in rural healthcare settings (Thorne, 2016). ID allowed for the acknowledgement of the intangible, contextual intricacies of rural healthcare, which make it so dynamic yet delicate. Thorne (2016) characterizes ID as an "applied" (Thorne, 2016, p. 279) qualitative methodology designed to produce practical guidance that intersects real-world challenges, foundational knowledge, and, above all, an appreciation for the inherent complexities of the subject matter. This methodology offers a flexible structure that enables researchers to adapt their strategies to the "messiness" (Thorne, 2016, p. 35) of their field. It adds depth and guides decisions through circumstantial insights and interpretations of the human health experience, making this the ideal methodology for this study (Thorne, 2016). This approach provided me with the opportunity to explore the nuances of the research question while framing the description to examine what we know and what we do not know, allowing space to delve beneath the surface to yield realistic, feasible outcomes that extend beyond clinical and epistemological understanding (Thompson Burdine et al., 2021; Thorne, 2016). Ultimately, these outcomes prove relevant in supporting implications that can inform resource development, knowledge translation, and systematic transformation.

Through semi-structured interviews with VCH rural HCWs, the construct of *Community-centred care* and the concept of place in delivering care in rural communities were researched. Through clinical practice, I have witnessed the challenges, deficiencies, and multifaceted terrain of rural healthcare. I needed a methodology that would integrate the contextual nature of rural communities while creating

meaningful implications to advance this field. Given that rural healthcare sites are diverse and require individualized considerations, an ID approach supported the rigorous development of tenuous inferences (Thompson Burdine et al., 2021). Furthermore, practical applications on providing rural-centric solutions to common challenges were derived from the shared experiences and patterns recognized in HCW experiences (Thompson Burdine et al., 2021).

Sample and Recruitment

Sample

A self-selected sampling approach was used to recruit HCW participants in rural communities within the VCH authority. Self-selected sampling occurs when research participants volunteer to take part in response to a research poster or another recruitment strategy (Polit & Beck, 2019b). HCWs of any profession could participate to ensure the inclusion of perspectives beyond nurses if the opportunity arose. Additionally, the sample was expanded to include other HCWs because nurses closely collaborate with interdisciplinary team members in rural areas, often overlapping responsibilities and sharing similar experiences in providing care. To support the depth of analysis of each interview, which is fundamental in this type of research, there is no number of participants that is typical to distinguish themes meaningful to the research question (Thompson Burdine et al., 2021). Therefore, the target sample of 10 HCWs was recruited to obtain various interview data. Given that ID methodology was used to guide the research project, data saturation was relative to the subject (Thorne, 2016), recognizing that the findings have nuanced applicability to the rural context.

Recruitment

Through my Professional Practice position at VCH, I identified several contacts to request assistance in distributing recruitment materials (as per Appendix B). I emailed the leadership contacts to request assistance with circulating recruitment posters to VCH HCWs. The recruitment posters were made available in staff-facing areas and were distributed via email, requesting participation in a semi-

structured interview. HCWs were made aware that they have no obligation to participate in the proposed research, and it was merely an opportunity to share perspectives on *Community-centred care* and rural healthcare. Additionally, it was communicated that participation did not impact their job or role within VCH. Snowball sampling was also utilized to ensure that the target of 10 participants was met. At the end of the interviews with already-recruited participants through the method previously explained, the researcher requested that the participant disseminate the researcher's contact information to any contacts interested in participating in the research. It was made clear to the participants that this is entirely voluntary and should only be done if they are comfortable doing so. Given the sampling approach, it was understood that this sampling method would not guarantee that there would be an equal distribution of professional and demographic diversity representation in this sample. However, given the delegate dynamics of healthcare in rural communities, allowing all HCWs to volunteer to share experiences and perspectives on their community and healthcare would likely ensure meaningful results.

Inclusion Criteria

Given that the ID methodology was utilized to develop a better understanding of the subjective reality of HCWs' perceptions and utilization of *Community-centred care*, inclusion criteria were carefully defined to yield sufficient data to answer the research question (Thorne, 2016). Firstly, the HCW participants needed to speak English and be at least 19 years old. Furthermore, to capture the nuanced interrelation of community understanding and 'place' the participants needed to have worked in one or more of the VCH 8 rural healthcare sites for at least two (2) months in total **AND** have lived in the community in which the healthcare site resides for at least six (6) months. However, all the participants had lived in the community for at least 15 months. While this study focuses on nursing, I believe it would be beneficial to also open the opportunity to providers and allied health professionals, given the

collaborative interdisciplinary relationships and overlapping roles and responsibilities in rural areas. Therefore, HCWs (providers, nurses, or allied health clinicians) were able to participate in the study.

Data Collection

Interviews

To understand the context of *Community-centred care* and delineate the impact of 'place' in delivering care in British Columbia (BC) rural communities, data was collected using semi-structured interviews with each HCW. Interviewing was selected to incorporate human connectivity central to nursing practice and this research enabling circumstantial nuance and sociocultural diversities to emerge through conversation (Thorne, 2016). Participants provided consent to engage in a semi-structured 45 to 60-minute interview. A semi-structured interview guide was used to direct the discussions; however, it allowed space for participants to share their perspectives and experiences. These 45 to 60-minute interviews took a strengths-based approach to interpreting the HCW experience in providing care in a rural healthcare site, their perceptions of rural healthcare, their knowledge and engagement with their community, and their perception of *Community-centred care*. Interviews included investigative questions eliciting participants' perspectives on the patterns and particulars of community structure. For example, what cultural practices are part of your daily routine? What is important to you in healthcare? What has been your experience providing care in [insert community area]? Refer to Appendix C for the interview guide.

Due to the widespread geography of participants, interviews were conducted virtually via the University of Victoria (UVIC) licensed Zoom. Interviews were audio recorded and transcribed verbatim using the third-party transcription software, Otter AI. After Otter AI generated the transcriptions, they were manually verified against the audio recording to ensure accuracy. The transcriptions were saved as hardcopy files, and both the audio and transcription files were permanently deleted from the Otter AI database. To ensure anonymity, participants were assigned unique identifiers. Demographic information

was collected at the beginning of the interviews before the participant was recorded, including the participant's gender identity, role, site they work at, and amount of time they have lived in the community in which they work (see Table 1).

Table 1
Demographic characteristics of study participants (n=10)

Characteristic	n (%)
Gender Identity	
Female	9 (90%)
Male	1 (10%)
Role	
Registered Nurse	9 (90%)
Social Worker	1 (10%)
Sites Employed At	
Site A	2 (20%)
Site B	3 (30%)
Site C	4 (40%)
Site D	1 (10%)
Time Living in Current Rural Area	
1-5 years	4 (40%)
6-9 years	1 (10%)
10-15 years	1 (10%)
16-20 years	1 (10%)
21 + years	3 (30%)

Data Analysis

Using Braun and Clarke's (2019) reflexive thematic analytic approach, interview data was analyzed to develop themes to address the research purpose: to explore how healthcare workers (HCWs) understand the context of *Community-centred care* in British Columbia (BC) rural communities. This approach allowed for themes to be derived from the data while providing relevance to the practical outcomes to inform rural healthcare. Additionally, utilizing the principles of ID, I was able to situate myself within the interview data prior to coding and organizing to gain insights into the participants' experiences (Thompson Burdine et al., 2021). According to Braun and Clarke (2006), reflexive thematic analysis is a flexible approach used to recognize existing similarities to extract themes to provide

meaning to the findings (Braun & Clarke, 2006; Clarke & Braun, 2018). While formulating shared concepts embedded within the research, creating categories representative of the question categories is crucial (Braun & Clarke, 2019). The analysis of the interview data was conducted concurrently with data collection, allowing for immersion in the data as it was gathered (Thompson Burdine et al., 2021; Thorne, 2016). However, arguably, immersion in this content began much earlier, as I have developed perspectives on the rural healthcare experience through my practice in healthcare leadership. As I engaged in data analysis, I critically reflected on my positionality to explore how my values and beliefs may influence my perspectives on the data.

Reflection was a crucial step in the data analysis process. To delve deeper into the data and uncover a deeper meaning to rural healthcare, I prioritized listening to the participants' experiences shared in the interviews. Additionally, I read interview transcriptions and summaries to inform reflection, gained understanding, and ultimately, considered the findings in relation to future participant interviews. These reflections were recorded in a personal research journal. The interview guide was evaluated and modified accordingly to capture preliminary thematic assumptions within the ongoing data collection.

Furthermore, having an intimate relationship with the dataset allowed me to recall preliminary themes in previous interviews, probing the participants for further explanation in areas resembling the experiences previously shared by other participants. Augmenting the interview transcriptions, notes detailing the themes, ideas, insights, and reactions were stored in a research journal throughout the data engagement process (Thompson Burdine et al., 2021; Thorne, 2016). UVIC-licensed NVIVO 14 software was utilized to arrange, record, and code themes. Once the interview data was analyzed for themes and patterns, the data, including transcripts, notes and reflexivity journal entries, were considered in their entirety to ruminate themes in relation to the research purpose and underlying

questions. This was intended to ensure themes were captured, which deepened the understanding of the construct of *Community-centred care* and built upon the existing research.

Ethical Considerations

Harmonized ethics approval for this study was obtained through both the UVIC Human Research Ethics Board (REB), #BC240016, as well as the UBC Behavioural Research Ethics Board (BREB), # H23-03851. All members of the research team have completed the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans- Course of Research Ethics (TCPS2:CORE) (Government of Canada, 2022). In this section, I reflect on the ethical considerations within this study, including consent, confidentiality, and researcher reflexivity.

Consent

To uphold the Government of Canada's (2022) research standards, informed consent from all participants was vital. This process included presenting information about the study, its benefits and risks, and allowing time for the participants to ask questions in advance of data collection. Before commencing all participant interviews, verbal consent was obtained from the individual. The verbal consent process was chosen in this study to mitigate the complexities of remote data collection (i.e., participants' inability to access a scanner technology). Additionally, not requiring written signatures on the consent form offers an extra layer of confidentiality and privacy for participants who may be uncomfortable having their signatures and names recorded on paper. Appendix D includes the consent form that was provided to all potential participants at least 48 hours in advance of their agreement to participate in a semi-structured Zoom interview. Before obtaining verbal consent, I presented the purpose of the study, the steps I was taking to ensure confidentiality and privacy, and the potential risks and benefits of participation. It was emphasized that participation was voluntary and would not impact individuals' employment status. Verbal consent and demographic information was obtained before beginning the audio recording of the interviews.

Confidentiality and Data Security

In addition to obtaining informed consent, ensuring confidentiality is an important ethical consideration in preparing to undertake this research. Multiple safeguards were established to ensure confidentiality. Interviews were conducted over UVic-licensed Zoom, which ensures secure and encrypted confidentiality in accordance with TCPS2:CORE and the University of Victoria Information Security Policy. As noted above, informed consent was obtained, and participants were assured that any personally identifiable information, such as names, personal features and names of colleagues, would be removed from the data sets. Audio was recorded only and was then uploaded to Otter.ai, a transcription service with servers located in the United States, as outlined in the consent form. Otter.ai's privacy policies ensure that once the transcription files are deleted, they are permanently removed from all servers. To maintain anonymity, pseudonyms were assigned to each participant, and names and other demographics were not captured in the audio recordings. Data was securely stored on password-protected computers and encrypted servers, with access restricted to the graduate student and committee members. I was the only member of the research committee who had access to the electronic copies of the transcriptions and raw data. Hard copies of notes and transcriptions were kept in a locked cabinet, and any electronic files were transferred securely using UVic-licensed email. After data collection, the transcripts were reviewed to remove identifiable information that was deemed irrelevant to the dataset prior to analysis. All data will be destroyed after 5 years in compliance with ethical guidelines.

Health authority policies were reviewed as a commitment to participant safety, trauma-informed care, cultural competence, and psychological safety. In adherence to ethical principles, participants could end discussions at any time. Interviews were conducted with dignity and in private spaces where participants could best be supported to share openly. The interview intentions were to focus on positive community and healthcare experiences. However, after the interview, the participants

were provided with BC and VCH Mental Health resources. Overall, these measures were implemented to ensure psychologically safe environments for participation and to assure participant confidentiality and privacy, considered in the research process.

Reflexivity and Rigour

In this qualitative research study, rigour was upheld through several key principles that ensure the credibility and trustworthiness of the findings. Providing sufficient context and detailed descriptions of the research process contributed to the transferability of the research, allowing others to determine the applicability of the findings in different settings or populations through the contextual descriptions. Additionally, dependability was maintained by ensuring consistency in the research process, with clear documentation of all steps, including data collection, analysis, and adherence to the plan laid out in the ethics application. Furthermore, authenticity was prioritized by striving to fairly and accurately represent the diverse perspectives of participants, ensuring that their voices are genuinely reflected in the findings. Finally, confirmability was supported by practices that minimize researcher bias, such as the reflexivity considerations. In this section, I will discuss how I utilized a research journal to uphold rigour throughout the research process.

Research Journal

To exercise reflexivity while immersed in the data and to adhere to key principles of rigour, such as confirmability, dependability, and authenticity, a reflective journal was kept to record and refine the research experience. This reflection ensured my perspectives, values and beliefs were considered during data collection, analysis and interpretation of the findings. The reflective process facilitated a thorough data analysis, which helped uncover significant insights into the human experience (Thorne, 2016). Apart from reflections, personal and analytic notes were also documented throughout the data collection and data analysis process (Polit & Beck, 2019a). Theoretical notes were documented to

capture the thoughts on how to comprehend what is happening during the process of data collection and analysis.

In contrast, personal notes relayed the researcher's feelings. This practice prompted me to consider how my previous experiences, values, opinions, and philosophical beliefs affect the process and outcomes, especially since I am passionate and invested in rural healthcare and the relevance of ‘place’. Ultimately, this strategy allowed me to discern between preconceived notions and emerging themes during data analysis and when contemplating practical implications (Thompson Burdine et al., 2021).

Furthermore, this reflective process encouraged me to contemplate the impact of the lens through which I view rural healthcare and how my perspective shapes data interpretation and analysis. Additionally, during the reflexive process, I considered my role as a VCH leadership member and its influence on data interpretation. The power dynamics are considered, which is important to uphold rigour in the research.

Chapter 4: Findings

This chapter provides an overview of the findings from interviews with HCWs who have worked and lived in rural communities in BC. Refer to Appendix E for a visual representation of the themes. The participants in this study included both men (n=1) and women (n=9). The participant sample mainly consisted of registered nurses (RNs) (n=9), with one social worker (SW) (n=1). The 10 participants in the study resided in four different rural and remote communities within British Columbia, working in diverse areas of healthcare, including Perioperative Services, Mental Health, Emergency Departments (ED), Home Health, Public Health, and Medicine and Surgical areas. Each participant brought a unique narrative of their experience working and living in rural communities. Refer to Table 1 for more information on the demographics of the participants. As previously discussed, the purpose of this study is to understand how the context of *Community-centred care* impacts the care that healthcare workers deliver. As described in Chapter 1, *community-centred care* is defined in this research as care that incorporates consideration of a community's contextual intricacies, culture, history, traumas, challenges, and distinct characteristics to inform the approach to healthcare. In this chapter, drawing on an interpretive descriptive approach, I present findings illustrating the nuances of rural healthcare experiences from the perspectives of healthcare workers in relation to *Community-centred care*.

To discern patterns and relationships in this data, the findings were framed according to themes and were analyzed more explicitly through respective sub-themes. The first theme described is *Prioritizing Relationships, Personhood, and Connection*, which is organized into three sub-themes: *Understanding the Community*; *Accountability and Ad*vocacy; and *Patient-Centred Care*. The second theme presented is *Demonstrating Innovation to Overcome Status Quo Challenges*. This theme was further delineated into several sub-themes to encapsulate its scope, including *Adaptability and Flexibility*; *Autonomy in Healthcare Initiatives and Care Delivery;* and *Resourcefulness*. The last theme presented in this chapter is *Knowledge Integration,* which is categorized into the following sub-themes:

Need for a Depth of Expertise, Experience, and Awareness of Existing Resources; *Equitable Education Opportunities*; and *Impact of Education*. Taken together, the themes illustrate the foundations that rural healthcare workers need to provide care through a community-centred lens, which embraces the complexities of a community's culture, history, and unique challenges to deliver flexible, autonomous, and resourceful healthcare solutions.

Prioritizing Relationships, Personhood, and Connection

> *"When you stay in one place for 30 years, your patients become your friends, and your friends become your patients. And I kind of like that… and eventually you become a patient"* (Mike, participant).

This quote resonated with me from an early interview because it illustrated the interconnectedness of healthcare, community, and relationships in rural communities. Through conducting interviews and undertaking data analysis, I recognized that the data revealed that *Prioritizing Relationships, Personhood, and Connection* was pivotal to the delivery of *Community-centred care* for healthcare workers working in rural communities. To better understand this theme, relationships, personhood, and connection will be described in relation to this study. Within this theme, the relationships represented encompass relations between staff, relationships between healthcare workers and patients, and the relationship that staff and patients have with their community. In the context of *Community-centred care*, personhood emphasizes recognizing and treating individuals as whole persons, considering their unique experiences, values, and perspectives. This principle prioritizes the complexities of a community's cultural, historical, and social context, ensuring that care goes beyond medical conditions to honour the humanity and inherent rights of each individual within the community. Drawn from this theme, connection represents the relation between healthcare workers and the community, which is fundamental to providing effective, compassionate care. Healthcare workers often serve as a bridge between medical expertise and the lived experiences of the community, fostering trust, understanding, and collaboration. Contextual factors that arose from the connection that staff and patients have with their surroundings solidified a shared understanding of external factors impacting the

day-to-day of a community. For instance, as noted in Chapter 2, many rural healthcare sites experience a similar subset of challenges. Participants who lived in the community, especially those who had lived in rural communities for most of their careers, portrayed how they were embedded in their community. They demonstrated knowledge of their community's historical contexts and described themselves as "more of a person in a community" rather than "a worker in a hospital" (Rachel, participant). For instance, one participant recalled how their community copes after they experience shared traumatic healthcare or community events, losses or issues and described it as such:

> We know who each other are, and I think we kind of know each other's strengths, and probably weaknesses to balance that out. And so, I think that when traumas happen, or when big issues happen, we come together and debrief, or we come together just to be supportive of one another. It gives you this whole sense of a tight group, (Roselle, participant).

This quote illustrates the participants' relationships with their co-workers, patients, and community when faced with turmoil. To further portray how relationships, personhood, and connectedness impact the healthcare provided in rural communities and create a more systematic picture of the data, the following subthemes are identified: *Understanding the Community, Accountability and Advocacy*, and *Patient-Centred Care*.

Understanding the Community

The sub-theme, *Understanding the Community,* arose through the analysis of participant narratives and personal accounts, wherein participants situated themselves within their communities and demonstrated an understanding of their community's strengths, weaknesses, and contextual considerations. When analyzing the data, it was evident that participants who were entrenched in the community had an intimate understanding of the resources, environments, social norms, and challenges as they had experienced them firsthand. Cathy, for example, stated, "I'm not separate from this community. This is my life; I feel like this is my community." Likewise, Mike explained a similar stance, "as health care workers living in the same area, as the people that you're caring for, you have a better

understanding of what their reality might be." These personal accounts contributed to the rapport and connection between the patient and healthcare personnel.

Through personal stories, participants highlighted how their *Understanding of the Community* influenced their decision-making and the healthcare they provide. For example, Rachel and Chantel work at the same rural hospital (site A). They described the communities supported by the hospital and demonstrated that the unique contextual elements impacting health are mutually understood. Both participants interpreted the patients' environment and adjusted their admission assessments to determine whether the environment affected the care needed and aligned with discharge considerations. Specifically, both Rachel and Chantel recalled that the focus of their assessment changed when a patient was admitted from a nearby rural island. The island is located a 20-minute ferry ride away from site A, with only one sailing to and from the island each day. Services on the island are limited, including a small convenience store. The healthcare resources consist of a small clinic that offers limited primary care and pharmacy services. Home care, specialty care, and community healthcare services are scarce in this area, and significant accessibility challenges exist in accessing medication, wound care, social work, mental health resources, healthcare education, and individualized care due to proximity to a larger site and geographic considerations in planning for travel. The participants recognized the area's potential impacts on care, prompting them to investigate the patient's housing, environment, and recent access to health services as part of their baseline assessment. Rachel states:

> If I knew they were coming from [specific location], I just probably have a few more questions around when they last saw their health care provider. What are their comorbid factors and how do they live? [Do they live] on a big property at the end of [specific location] and only come to town once a month?

Chantel similarly stated, "So I can picture their living situations… and the challenges they have with that." These questions guide the care provided and the interdisciplinary teams that consult to meet individual client needs. For example, knowing that this area has limited access to outpatient services like wound care, the social worker may be consulted to inquire further about the patient's social support. The social

worker may inquire if a family member can support the wound care needs of the client at home or help organize temporary housing closer to outpatient resources until the patient can manage the wound independently, the wound is healed, or alternative arrangements are secured. In summary, having healthcare workers who *Understand the Community* where their patients reside is essential for delivering comprehensive care. It promotes consideration of external factors that led to the patient's healthcare admission, such as comorbidities that may result in poor healthcare outcomes. Furthermore, utilizing a *Community-centred care* lens encourages early recognition of discharge considerations to mitigate potential barriers that prolong hospital stays.

During my interview with Roselle, she drew on her own experiences with the pharmacies in her community to ensure her clients could access the care they needed. She discussed the challenges with the pharmacies in her community, stating:

> Only some pharmacies have certain products, and the other ones don't. So, they have to borrow from each other. So that's one of the disadvantages, is accessibility to certain meds, and they can only give you meds for a certain amount of time too. We can't refill for three months; I think they only do about a month at a time.

She emphasized the importance of this information and used it in her practice to:

> Educate the home and community care clients to say, okay, yes, you do have medications coming up. You have to be proactive in making you have enough. So, it kind of helps plan or at least helps people put a plan in place for them to get the care that they need.

Roselle's experience accessing pharmaceutical care within her community provides her with insight into a unique challenge in obtaining healthcare resources. Understanding potential barriers through her experience allows healthcare workers like Roselle to partner with patients to navigate solutions proactively – an opportunity that Roselle would not have without living in the community. Preparing patients for possible barriers in accessing community resources, such as pharmacy services, fosters rapport, person-centred care, and proactive healthcare, even when facing ongoing challenges.

These examples highlight how essential it is for healthcare workers to share their personal experiences regarding the available healthcare resources in the area. The findings highlight that by

disseminating knowledge about these resources, healthcare workers can enhance patient compliance and accessibility to necessary care while reducing potential barriers. Furthermore, participants illustrated that a community-centred approach supports relational and therapeutic methods, which provide a sense of personhood and identity, forming a foundation for holistic healthcare. Additionally, considering social determinants of health, such as environments, allows for a more comprehensive understanding of a patient's living situation. Healthcare workers living in the community typically understand these environments better than transient staff who are unfamiliar with the area. *Understanding the Community* is central to the theme because recognizing these distinctions about a patient, without over-explanation or resurfacing trauma, fosters rapport and relationship building, improving healthcare accessibility and the overall healthcare experience.

Accountability and Advocacy

Throughout the interviews, participants conveyed a strong commitment and care for their communities through both verbal and emotional expressions, a sub-theme I have classified as *Accountability and Advocacy*. Accountability emerged from participants expressing a shared commitment to their community, regardless of personal connections. Furthermore, the participants expressed a desire for their neighbours to have access to quality healthcare, reflecting their sense of interconnectedness within the community. They also advocated for better care for themselves, their families, and their neighbours, which exemplified the concept of *Community-centred care*. The participants expressed their responsibility to their community and their neighbours while living and working in a rural community, evident in their unwavering commitment to the patients they cared for.

Additionally, they demonstrated their acute awareness of the community context in which they operated. For example, Julie, Rachel, Phoebe, and Joey recalled that there is a chance they may see their patients outside the healthcare context. Specifically, Rachel described this concept by stating that "it's maybe not at the forefront of your mind, but it's in the back of your mind that you might see this person

at the grocery store later, and so, I think that people treat each other better because they're aware of that." This underscores the close-knit nature of rural life, where healthcare providers and patients often share social spaces, contributing to the connection and personhood of the patients receiving care. Julie suggested that "rural [healthcare workers] really work for themselves. They feel very personally responsible for their units and their teams." Several participants emphasized that their families and they may be accessing healthcare services, thereby rectifying accountability for comprehensive care.

Although there was a thread of accountability among the participants, several interviewees raised concerns about the lack of accountability regarding transient staffing and the influx of agency workers on which rural healthcare systems have become reliant. For example, Julie stated the following:

> The massive amount of agency staff has eroded [the staff culture] as well because you've got this transient staff that are only doing what they *need* to do. Some are great and really fit in and stay a long time. But then we do have these other ones that are just there to do the bare minimum, and it's really hard to extend yourself when you're working with three people who are like… maybe I'll do it, maybe I won't.

The interviews revealed that using agency staff could lead to a disconnect in the quality of care provided. Participants described how permanent staff perceive agency workers' lack of engagement and the short-term nature of their contracts as reasons for substandard work instead of delivering quality patient care based on genuine patient engagement. The quote, "it's hard to be the one who's always really worried about things when other people just aren't [emphasis added]," (Julie, participant) emphasizes how this can impact the morale and effectiveness of local healthcare providers. Monica and Janice discussed how transience threatens clients' trust in healthcare workers because of the impermanence of their relationship. Monica states that due to "the transiency here, people take a while to warm up because they know that this person is going to leave. They are used to that, and so they don't want to get attached." Similarly, Janice described a recurring situation she faces as a mental health support worker. They stated that clients:

> Kind of get invested with a counselor or support worker and then that person moves along. Then they start with somebody else, and that person may have a different method. They still have to

> do their intake process and it's very frustrating to have to start over and over and over. Some just refuse to do it, (Janice, participant).

In both instances, Janice and Monica share their perspectives on working with clients who are also supported by temporary healthcare workers and the strain it puts on the relationships that clients have with the healthcare system. The temporary and disconnected nature of locums and travel staff leads to a lack of accountability for patients and their care. Both participants explained that they find patients need "consistency" and connection for a therapeutic environment. Janice recounts:

> I try to connect people with other resources. So, then they know to come to me… I try to develop the connections we have with existing resources to I try to keep them on [engaged in the healthcare system]. We like continuity here. Which I think is a rural, remote thing to want to see the same doctor and want to see the same therapist. That's very important here.

The interview data suggested that these clients would benefit from someone who can provide consistent continuity and who understands their lifestyle, so "when [they] say this, then [the health care worker] knows what it means," (Janice, participant) and can recommend the existing resources to support them in an environment they recognize.

Through engaging in analysis, it became clear that advocacy stems from the sense of accountability participants communicated. Because rural healthcare workers utilize these healthcare resources for themselves and their families, they advocate for comprehensive, timely, and relational healthcare. The participants emphasized their commitment to providing excellent care for patients and their families based on their collective commitment to community health and the environment they share. Referencing members of the community, one participant noted, "we want to make sure that they're looked after" (Phoebe, participant), an illustration that reflects a shared sense of purpose. Advocacy for the community is based on the belief that local healthcare workers understand the values and needs of their patients better than external healthcare professionals due to their shared understanding of the complexities of the community.

Advocating for healthcare that is underpinned by a *Community-centred care* lens presents some complexities. Some participants noted that healthcare workers might be assumed to “think they know what is best for the patient” (Phoebe, participant) due to the shared lifestyle, environment, and culture embedded in the place they live. This assumption may undermine patient autonomy and person-centred care. For example, Phoebe shares that:

> Everybody wants to do their best. Not always knowing what that is, but wanting to help each other, wanting to help their neighbours, wanting to help their friends because we are a community, and we see each other all the time. We want to do what is right and what is best for somebody else. What that means per person is dependent on their background, I think because some people will want what's best for themselves, not best for their neighbour. You know what I mean? Healthcare is like a very personalized thing, and some healthcare workers will think, ‘Oh, you need this treatment because I know you need it. Rather than doing the actual ethical thing of saying, what do *you* want?’

While the healthcare worker may intend to advocate for thorough care for the patient, making decisions on the patient's behalf may not align with the patient’s goals of care or values.

Despite facing these challenges, the healthcare worker participants consistently expressed their commitment to maintaining high standards of care. One participant stated, "we do have a higher standard. We do care more," (Julie, participant) understood to be rooted in their commitment to their patients, colleagues, and their professions. All of which, indicates that this relational commitment is a fundamental aspect of their identity as community healthcare workers. This sense of pride and responsibility reinforces their advocacy efforts and the commitment to ensuring that care delivery is aligned with community values and needs.

In summary, the sub-theme *Accountability and Advocacy* is intricately linked to the theme of *Prioritizing Relationships, Personhood, and Connection.* It highlights the position of healthcare workers in their communities, as not only public servants but as a member of the community at large. This demonstrates how strong personal connections between healthcare providers and their communities cultivate a profound sense of responsibility and fuel advocacy for optimal patient care. This aligns with

the study's purpose of exploring how *Community-centred healthcare* is shaped by the unique contexts, cultures, and histories of rural populations.

Patient-Centred Care

Patient-Centred Care (PCC) is a foundational healthcare concept that positions the patient's needs, beliefs, and values at the centre of the care being provided (McMillan et al., 2013). The healthcare workers who participated in this study demonstrated their commitment to their patients' needs, sometimes prioritizing the patients' comfort before their own. Cathy recalls a patient she cared for collaboratively with another provider. The patient was not from the town, but both the provider and Cathy took the time to listen to the client's needs, order the appropriate intervention, and ensure that the provider would follow up. An observation attributed to the context of a smaller community setting and the role of *Community-centred care* alongside previous findings, including accountability, relationship building, and PCC. Although the patient was 'unattached' (a term used to describe patients without a family doctor as the most responsible for their care), their needs were identified, and the healthcare team ensured appropriate follow-up. Cathy described the "personalness that comes from being in the community… it's just, we can get to really know the people." Similarly, Joey explained the empathy that healthcare workers who understand the broader concept of community have toward patients. They further highlighted that "knowing that there's a lack of community support for people who are basically stuck," (Pheobe, participant) causes frustration. Lacking the resources to support their goals of care and "knowing that there are no real other options for them, gives healthcare providers a lot more sympathy toward these patients and their situations" (Pheobe, participant).

For some participants working in small rural communities, *Community-centred care* can contribute to challenges with relational boundaries. For example, the overlap of personal and professional relationships can make delivering PCC difficult. Mike described that smaller communities result in less access to healthcare workers when the patient is someone with whom you have a pre-

existing relationship. If a patient you know requires care and feels uncomfortable with you as their clinician, Mike explained how morally distressing that can be. If he is the only healthcare worker available, and an RN is required in the operating room, then there is little choice in the healthcare team. While efforts are made to call in an alternative staff member, depending on the urgency of the situation, providing the patient with what they want is not always possible. Mike stated, “somebody might have to give something up… the patient might have to give up a little bit of privacy and confidentiality… I may have to give up a little bit of my ethics.” As suggested, PCC aligns directly with the overarching theme of *Prioritizing Relationships, Personhood, and Connection* by highlighting how these interpersonal dynamics shape the healthcare experience. In rural communities, healthcare workers often know their patients personally. This familiarity fosters trust and enhances the quality of care. However, it can also lead to morally distressing situations where both the patient and the healthcare worker must compromise their values to deliver interventions and meet healthcare needs.

Demonstrating Innovation to Overcome Status Quo Challenges

Through engaging in data collection and analysis, it was evident that innovation – including critical thinking and resourcefulness – was crucial for providing care in rural healthcare settings due to the unpredictable and ever-changing landscape of rural healthcare clinics and Emergency Departments. Despite working in various rural healthcare sites within the same Health Authority, a consistent pattern was evident: healthcare providers demonstrated the need to adapt to different circumstances, exercise autonomy in decision-making, utilize limited resources, and possess a wide variety of expertise to manage their community's healthcare demands. Therefore, the theme *Demonstrating Innovation to Overcome Status Quo Challenges* was synthesized to represent this emerging pattern in the findings. To portray the patterns within this theme, I divided it into three sub-themes: *Adaptability and Flexibility*, *Autonomy to Make Care Decisions*, and *Resourcefulness*. The next section will present the findings of this theme using quotations and observations collected during data analysis.

Adaptability and Flexibility

As reviewed in Chapter 2, rural healthcare sites face many challenges that make it difficult to integrate and provide care that meets the standards of the health authority, province, and Canadian healthcare, especially when proposed solutions are urban-centric. *Community-centred care* fosters the integration of individuality and the dynamics of the community when implementing solutions. However, this can create tension in situations where rural healthcare sites are pressured to adopt policies and approaches that are typically initiated at urban sites. However, despite ongoing issues and the integration of urban-focused solutions, rural healthcare settings will continue to pose challenges where *Community-centred care* is essential. This sub-theme discusses the Adaptability and Flexibility of healthcare workers in overcoming ongoing systemic challenges and managing the healthcare needs of their clients. During the interview process, participants explained the importance of teamwork, analyzing the situation as it presents itself, and being able to pivot accordingly. This was evident in Julie's words: "we do have such a lack of structure and a lack of formal education opportunities. People really do go figure out their own information." Cathy expressed similar remarks about the need to be flexible when living and working in a rural community, and testified, "I feel like it forces you to become resourceful, adaptable, and very accountable."

Joey introduced the acronym HALO (High-Acuity Low-Occurrence) to describe a high-acuity situation that "rolls in the door maybe once every six months." This term is commonly used in rural healthcare, referring to rare high-acuity situations that healthcare workers must manage but are likely uncomfortable handling due to their infrequency (Hack et al., 2022). While only one participant (Joey) specifically used this term, many others recalled HALO situations during their interviews, as evidenced by their recollections of memorable one-off events that demanded intense medical responses requiring flexible responses by themselves and their colleagues. Participants described their feelings during these circumstances as "nervous" (Joey, participant) and "uncomfortable," (Joey; Phoebe; Rachel, participants)

while one participant stated, "you have to know your shit even if it's not supposed to be your shit" (Rachel, participant). The interviewee indicated that this statement was describing clinical work typically performed by a healthcare worker in a different discipline or specialty, in a more predictable situation. However, given the urgency of the situation, the right person, with a more experienced clinical background, may not be available. In a moment of reflection, Julie considered the effect these acute situations have on healthcare workers. They stated:

> You would never plan for those things. It's not part of the program. So, you deal with situations like that, but in the end, those are the things that either make you more interested in being more resilient…[or] you decide to give it up (Julie, participant).

Among the participants, a common solution for managing these situations is adapting to unique circumstances and trusting each other to exercise their expertise in stabilizing the patient. In order to adapt to HALO situations, Mike explained that "in a small environment, I think I recognize who is the person for what. I think everybody just sort of falls into a natural role." Similarly, Rachel suggested, "the strengths [of rural healthcare are] people are super adaptable. I feel like in rural, they just have to be. It's like okay…well, that's not going to happen. I'll just pivot." When Roselle was asked what rural healthcare meant to her, she expressed the same notion, reporting that "we do the best we can, with the people we have and the sort of the brains that we have, but then also know when it's time for them [the patient] to be flown out." These three instances illustrate that rural healthcare participants understand the limitations of their communities. When faced with situations requiring complex critical thinking, adaptability becomes an essential resource.

Another illustration of the *Adaptability and Flexibility* of the healthcare community in rural areas is explained by Mike. They remark:

> I think about, to go back up north for a second, in order to get like bloodwork out. Right? We'd have to do Tuesdays and Thursdays, like lab workday. We'd collect people's blood labs and stuff. And then it was like, we would spin the blood and we would package it or like separate plasma from it, you know, whatever the test was, and then like, package it up in a cooler, and like hand it off to a taxi driver like a community taxi driver, who would take it to the ferry, who would like

> hand it to the ferry captain who would then get off on the other side and drive it to the hospital for us. That was the process that had to take place in order to get [it] done (Mike, participant).

In this data extraction, Mike described the complex roles of people in the community and their contributions to overcoming challenges. This example clearly shows the nuances of *Community-centred care*, demonstrating how personal experience influences decision-making in smaller contexts where individuals are well-acquainted with their community dynamics, unlike in large inner-city healthcare facilities. Furthermore, Janice and Julie also explained the need for *Adaptability and Flexibility* when faced with challenges in rural healthcare areas. Janice said, “I think it's kind of important that there's some flexibility in smaller places… that we do need to do things like this,” while Julie stated, “we will work around a lot of things that you might not have the flexibility to do in a bigger hospital with more structure. Just because we can do what works for us and what fits us without a lot of oversight.” Other participants shared similar examples, using keywords such as “adaptability,” “resilience,” “pivot,” “flexibility,” “compromise,” and “versatile” to describe HALO, and more familiar healthcare situations.

Lastly, Julie shared a compelling story that truly represents *Adaptability and Flexibility* in the face of HALO. Julie described a staffing shortage during the event, and instead of providing care to 12 patients, she had to support 24. They had five nurses in various areas; however, if they had been fully staffed, they would have had at least 7. This workload is evidently very heavy and does not allow for any variations in standard patient flow to occur without impacting the level of care provided. Julie explained that:

> A lady came in with twins. She had said she was supposed to meet her midwife earlier and that the midwife had told her, ‘Oh, I think she should go get some bloodwork, and she didn't.’ She told us, ‘She didn't want to go get bloodwork.’ She decided she was going to have a nap instead. So, she did. My partner, [who was working on the unit with Julie], started looking after the 36-year-old patient, and I started looking after her assignment. So now I was nursing 24 people. 24 PATIENTS! And then in her [nurse looking after the newly admitted women pregnant with twins] assessment she could not get a heartbeat on either of the twins, all she got was two flatlines. So, they had heartbeats, but they had absolutely no variability, and so they [the team] would have to do an emergency C-section with four nurses when normally you would have two teams.

When Julie recounted the situation, her tone and demeanor clearly exhibited how stretched the healthcare team felt at that time. She was still shocked that she had to care for double the number of patients and was expected to do so safely. Despite being over 20 years ago, the situation stayed with them due to the severity and the teamwork and flexibility required to deliver those babies while ensuring the mother's safety. Further challenges caused further need to pivot:

> They couldn't get a spinal. So, they had to do a general. At the end of that, we delivered both [babies]. We had to make two setups, so two warmers in the OR, [in] two separate spots. We had to have someone take the other baby. The lady was so preeclamptic but atypically. She ended up in VGH ICU because she didn't actually wake up after the surgery. So, we delivered those babies just after midnight in our OR with the equivalent of 4 nurses. One nurse stayed even though she was supposed to go home at 11 and had [to nurse] the whole hospital while two of us were in the OR with these [babies]. I think I had a medical student and someone else. All three patients [Mom and two babies] needed full resuscitations, on antibiotics and everything else, and in the end, one [baby was] okay. And the other one died after they [were transferred]. But I mean, that's the type of response that you have in a small place (Julie, participant).

This story demonstrates the Adaptability and Flexibility of healthcare workers in overcoming adversity in urgent situations, especially when resources are limited.

Autonomy in Healthcare Initiatives and Care Delivery

The next sub-theme within the overall theme is *Autonomy in Healthcare Initiatives and Care Delivery*. Regarding the overall theme, Demonstrating Innovation to Overcome Status Quo Challenges, the participants discussed their perspectives on rural versus urban healthcare sites. They agreed that rural healthcare workers have more control to initiate interventions instead of waiting for provider orders or leadership directives in community programs. Participants explained that healthcare workers often work within diverse hierarchical structures in rural healthcare sites, which may significantly differ from those in urban settings. As one participant noted, they “do feel that we have a bit of autonomy but also a lot of resilience” (Julie, participant). Additionally, participants reported that the lack of a rigid structure in rural healthcare often allows them a more autonomous practice to assess and respond to community needs directly. For example, one interviewee described their experience of being “very

independent" (Monica, participant) while managing patient care, highlighting the necessity of self-sufficiency in meeting healthcare demands. As suggested by the data, this autonomy enabled them to adapt their approaches, advocate for their patients, and address discharge planning needs without heavy reliance on external systems.

Comparatively, contributors discussed how autonomy supports them in doing what is needed for their patients. For instance, Monica works independently in a small community on public health initiatives. Because "nobody is [t]here mentoring or guiding the program," they are autonomously managing the "constant asks from the community" and "how to navigate them" (Monica, participant). On the other hand, Rachel noted that "it's up to…the nurses at the bedside to know how to advocate for their patients." Furthermore, the interviews revealed that the professional autonomy granted to healthcare workers often leads to significant professional growth and skill development. One participant reflected on the importance of "independent learning" (Rachel, participant). During their transition from working in urban to rural healthcare sites they noted, "now I feel like a lot more capable when it comes to kind of like managing situations on my own" (Rachel, participant). The analysis established that evolution is important in rural contexts where resources and mentorship may be limited. Empowering workers to take initiative enhances their competencies and improves patient care outcomes.

In summary, these examples illustrate the autonomy of healthcare workers in rural communities, while also emphasizing that their relationship with the community remains important in these situations. Investigating these practices, such as intervening in acute situations or autonomously launching health promotion projects, requires experience. For example, intervening autonomously in an acute situation involves understanding the dynamics of the hospital, relationships with providers, comfort with personal competence, and awareness of colleagues' competencies. Diversely, initiating a health promotion program for a small rural community involves understanding the community's needs. The autonomy demonstrated in these instances is understood to be rooted in the community's context.

Resourcefulness

Finally, the data highlights the importance of *Resourcefulness* in guiding healthcare delivery, considering the inherent challenges and limited structural, equipment, and staffing resources in rural communities. Participants suggested that a *Community-centred care* approach allows for resource optimization and the integration of creativity in all situations, enabling care delivery based on best practices. For instance, one interviewee describes running code blues at their site. They exclaimed, “Oh shit, who's done this before?” (Mike, participant) searching for someone with the relevant clinical expertise to rely on in an urgent situation. Utilizing their healthcare worker community to offer their clinical expertise enables the delivery of the best possible care in that situation, despite the insufficiencies. Participants expressed comparable experiences in utilizing their rural co-workers as resources. One participant expressed that the “expertise that's been shown is really quite remarkable” (Chantel, participant). Joey further delineated the dynamic, describing that for telemetry (tele) questions, they have “someone who's got a lot of experience with patients on tele. And then if anyone has any renal issues, they always ask me.” As embodied in Julie’s guiding principles, we should “do what a reasonable nurse would do” and “make do with pieces that we have” to tolerate the “lack of resources” (Julie, participant). This idea suggests that autonomy and resourcefulness are intertwined and demonstrates how autonomy is an attribute of resourcefulness. Many participants highlighted the “psychologically safe” (Joey, participant) culture in rural healthcare regarding addressing gaps in personal knowledge by seeking support from colleagues. This fosters a supportive environment conducive to learning and improvement. The participants referred to a culture of recognizing gaps in personal competence and feeling comfortable seeking assistance. In circumstances where healthcare workers feel out of their depth, Joey stated:

> It's really psychologically safe, where we can just go to the desk and just say, ‘I don't know this.’ Blatantly, just say it, and then there will be someone who says, ‘Oh, I know it.’ Then you go, and you do it together.

A defining characteristic of this sub-theme is the culture of vulnerability and collaboration among healthcare workers, which fosters a strong team dynamic. On the contrary, Joey described that healthcare settings in urban contexts do not foster an environment to “say you don't know something” because the response will be “What do you mean you don’t know?” This might be attributed to less emphasis on relationships, varied colleague dynamics, and a limited need to be resourceful when educators and support staff are available to fill gaps in practice. Additionally, it is important to note that integrating *Community-centred care* into urban healthcare settings is less common. While community and environmental factors, along with values, are considered in urban healthcare, there is less tendency for these dynamics to be understood on a personal level. These examples support the idea of *Community-centred care* in rural healthcare as an intersection of relationships with colleagues, accountability to patients, upholding rigorous care standards, and the flexibility and resourcefulness to rely on colleagues. This commitment stems from healthcare workers’ dedication to a healthy community and the people living within it.

Another demonstration of this sub-theme within the data is the use of time as a resource in rural healthcare. In particular, Cathy noted that “there's not long waiting periods usually.” They also eloquently express that “time is a gift, and time is a limited resource; I feel like sometimes, a small community can give you time” (Cathy, participant). Similarly, Cathy reported that both nurses and doctors in her facility often have time to provide thorough care and explanations to the patients during their visits or appointments. Joey also remarked that the facility has less “hustle and bustle” and consistent staff, allowing for relationship building and rapport. This exhibits how relationships with the community are strengthened through trust and timely care. In summary, the sub-theme *Resourcefulness* is a vital component of the theme *Demonstrating Innovation to Overcome Status Quo Challenges* in rural healthcare. It highlights how healthcare workers navigate limited resources creatively by leveraging their

understanding of community context, optimizing interprofessional collaboration, and using overlooked concepts, such as time, as a resource.

Knowledge Integration

The theme *Knowledge Integration* emphasizes the crucial role of knowledge, especially knowledge of community and community dynamics, as it intertwines with the understanding of community contexts and the social determinants of health that affect the population. It encompasses acquiring and translating knowledge while addressing the deficit discourse in education accessibility. As mentioned in previous themes, participants suggest that a depth of knowledge is essential for maintaining care standards, especially in rural healthcare settings where educational resources are limited. Despite the consensus on the importance of knowledge in rural healthcare settings, participants articulated the challenges of accessing education. To illustrate the components of this theme, I have identified three key sub-themes: *Leveraging Expertise and Resources*, *Equitable Education Opportunities*, and the *Impact of Education*.

Leveraging Expertise and Resources

As evident in both the literature review and the data collected in this research, there are frequently limited resources in rural healthcare settings. In rural healthcare, HCWs often face situations that require immediate and informed responses. This emphasizes the need for healthcare professionals to cultivate a robust understanding of local resources and community dynamics, and have both systemic, leadership, and infrastructural support to do so. Participants shared numerous experiences where colleagues leveraged their expertise to support each other in unfamiliar situations. Another healthcare worker insisted that a “varied base of knowledge is important, [as well as] having a solid foundation” (Phoebe, participant) to work in resource-limited environments. Rachel emphasized that it is imperative to “be prepared to be in charge and know your shit… just be prepared to be the most experienced person in the room.” In rural healthcare settings, the findings indicate that staff require extensive

expertise, experience, and awareness of available resources to uphold provincial and national healthcare standards. In particular, Joey emphasized the importance of assessment expertise and experience in rural healthcare in the following example.

> It's a balance of art and science. You'll get all the great science if you go down to the city, but you won't get all the care. We didn't lose the art of physical assessment the same way some of the city has. We don't have a CT scan or an MRI or anything to rely on. Our assessment skills have to be top-notch. You also spend more time with the patient because you're really assessing them (Joey, participant).

This illustration refers to the intersection of time, relationships, and knowledge, as well as the integration of *Community-centred care* into various aspects of care. The participant recognized the dynamic interplay between art and science (Joey, participant), which depicts participants' understanding of *Community-centred care.*

Equitable Education Opportunities

Secondly, Equitable Education Opportunities was another sub-theme distinct from the larger theme *Knowledge Integration*. According to the healthcare workers interviewed, living outside urban communities posed challenges in accessing educational opportunities. Participants indicated that educational opportunities are primarily accessible at urban sites where resources are abundant. Julie revealed that rural healthcare workers must travel to urban areas to access the same educational opportunities. Another key point raised by Julie was that travelling to access education can be costly and "tax[es] your family if you're spending extra time away." Rachel expressed similar concerns, clarifying that accessibility challenges are not attributed to "leadership [that] isn't supportive, but just [in] the hidden costs associated with that. Not to mention, education hosted by urban educators does not always incorporate rural nuances and the understanding of resources, leadership, and point-of-care structures in smaller settings, according to Julie.

In essence, the participants suggested that while the "lack of access to education" persists, "it's getting better" (Chantel, participant). For instance, Chantel was elated with "the number of educators

now that have been put in place," and Joey echoed these remarks, affirming, "thankfully, they've changed the structure in the last few years. We have all these educators now." Furthermore, Joey explained that there is more engagement from typically urban-centric regional programs, including the Simulations Program. The Simulations team creates scenarios imitating medical situations or processes for education and improving staff competency. Access to equitable education fosters a culture of continuous learning, allowing healthcare workers to feel empowered and valued. As indicated in the data, many workers want educational opportunities to enhance their skills and enable them to contribute meaningfully to patient care. For instance, one healthcare worker emphasized the significance of a "paid education fund" (Julie, participant), noting that support for continuous education makes workers feel valued and can help alleviate feelings of being overlooked in rural healthcare positions. Despite improvements in educational resources and recent efforts by local educators, participants noted that rural HCWs face persistent inequitable access to educational opportunities, which they emphasized directly impacts their ability to maintain rigorous standards of care.

Impact of Education

The final sub-theme identified is the *Impact of Education*, which underscores the critical role of education in enhancing knowledge acquisition and sharing within rural healthcare settings – particularly in the context of inequitable access to more formal education as described in the previous sub-theme. The data reflects a strong appreciation among healthcare workers for the educational initiatives in their community. For instance, Julie noted that "when you *affect change*, it's *big change* [emphasis added]," and Rachel highlighted that "you can see the changes that you put in place like pretty directly." This revealed that even small educational projects can lead to significant improvements in care. For example, ensuring that all ED RNs and providers have Advanced Cardiovascular Life Support (ACLS) certification is a project that dramatically impacted care, as it is a standard that is mandatory in urban healthcare EDs. In addition, Julie noticed that "when you build something with these education things that you've

recently been able to establish. People are so grateful, and so appreciative, that it really makes it worthwhile when you do extend yourself to doing some of this."

Another participant, a home health educator, expressed how regional education programs help alleviate some of the burden of educating her staff. They discussed how "it streamlines the orientation, so I don't have to, like, piecemeal together things" (Roselle, participant). This expanded their ability to focus on rural-specific and community-specific information that the staff must learn as well. Along the same lines, Joey explained that, in her regional role, they worked with a team to establish a "rural remote education strategy." Part of the strategy was to bring rural healthcare educators and leaders together for a "community of practice." "None of the hospitals spoke to each other before we [they] did all that work, which speaks to the fragmentation of our healthcare systems amplified in rural. There are "such great people everywhere. We just needed to bring them together." Joey explained that many rural healthcare sites face similar challenges, and information sharing between educators and leaders was an easy way to solve some of their problems. In summary, the sub-theme *Impact of Education* illustrates how educational initiatives enhance knowledge acquisition and sharing among healthcare workers, thereby upholding rigorous standards of care.

Overall, the interviews with healthcare workers displayed an eagerness to "learn" (Mike; Joey; Chantel; Monica; Rachel, participants) and translate "knowledge" (Joey, participant) between colleagues. Maintaining high expertise improved healthcare delivery and addressed ongoing gaps in the Canadian healthcare system for rural communities, according to the findings. The data was further themed to categorize the patterns into *Leveraging Expertise and Resources, Equitable Education Opportunities,* and *Impact of Education,* which displayed the data sets in a way that supported understanding the impact of *Community-centred care* on healthcare workers in rural BC communities.

Summary

The findings presented in this chapter illuminate the concept of *Community-centred care*, illustrating how participants understand, conceptualize, and incorporate it into the rural healthcare environments where they operate. The themes that emerged from the data analysis were *Prioritizing Relationships, Personhood, and Connection*, *Demonstrating Innovation to Overcome Status Quo Challenges*, and *Knowledge Integration*.

These findings reflect the rich data collected and align closely with the overarching purpose of this thesis, which explores how the context of community-centred healthcare shapes the way healthcare workers provide care. Presenting the data in this way and then further delineating it into auxiliary sub-themes aimed to showcase the experiences of health workers in BC's rural communities. This approach highlights the intricacies of their communities, their diverse experiences, and makes *Community-centred care* a more tangible concept. During this process, participants from various rural communities support *Community-centred care*, establishing a strong foundation built on relationships, innovation, resourcefulness, and knowledge. However, despite similar barriers and challenges characteristic of rural healthcare, "there's just no way you could know all the little nuances if you didn't spend some time here" (Janice, participant).

Chapter 5: Discussion

This chapter discusses how the research findings relate to existing literature, aiming to enhance the broader understanding of healthcare delivery through a *Community-centred care* perspective. As discussed in the previous chapters, the purpose of this study is to explore how the context of *Community-centred healthcare* impacts care delivery in rural communities. As previously defined, for the purpose of this research, *Community-centred care* integrates the community's contextual nuances, culture, history, traumas, challenges, and distinct characteristics to shape approaches that promote a holistic healing environment, even while facing ongoing challenges related to resource allocation, healthcare equity, and external barriers. This study bears great relevance given the inherent aim to address gaps in how healthcare leadership can support rural healthcare sites to meet the care needs of their patient populations (Afifi et al., 2022; Malatzky et al., 2020; Malatzky & Bourke, 2018a; Malatzky & Couch, 2023). The study explores how rural communities can be supported by acknowledging their diversity while also valuing the commitment and accountability of HCWs who have adapted to overcome system-level inequities. Throughout this research, it has become evident that the inherent challenges faced by rural healthcare sites are multifaceted. Addressing these challenges requires political will to confront them. This project supplements existing research in the movement to create accessible and equitable healthcare. This research focused on a strength-based approach to discuss the impact and provide recommendations anchored in community engagement and capacity building. Still, the findings of this study uncover one aspect of a complex puzzle in identifying sustainable solutions to address rural healthcare issues.

The findings of this study demonstrate that *Community-centred care* impacts can be understood through several interrelated themes shaped by the rural social, environmental, and historical contexts, alongside the prevailing urban-centric perspectives. These themes extend additional insights into *Community-centred care* and address key challenges identified in the existing rural healthcare literature.

The subsequent discussion explores essential points, including Building Capacity, Agency Nurses, and Deficit Discourse, to provide clarity and context to the study's findings and interconnect them with relevant research.

Building Capacity – A Seat at the Urban Table

The central finding of this study highlights the pivotal role of relationships – between HCWs, their patients, and the broader environment – in shaping the delivery of *Community-centred care* in rural healthcare settings. By observing the entire data set in relation to the research purpose, it is evident that the relationships healthcare workers have with their patients are founded on personhood, strengthened by a shared understanding of the patients' community, including underlying factors related to lifestyle, as well as social, environmental, and cultural influences. This section examines the role of relationships in *Community-centred care* within the context of rural healthcare, integrating insights from current literature to enhance understanding and draw meaningful implications for the field.

As discussed in Chapter Four, healthcare workers in rural communities who are deeply embedded in the same close-knit communities as their clients often demonstrate a strong sense of accountability, likely stemming from a shared commitment to the well-being of those they serve and the shared understanding of the strengths and limitations of the community they share. Furthermore, an interpretation of the findings revealed the commitment of advocacy that HCWs have toward their communities, striving for better delivery of patient-centred care to those with whom they have built relationships. The intersection of advocacy, accountability, and relationships underpins *Community-centred care*, highlighting how these interconnected concepts shape the uniquely contextual and complex nature of healthcare in rural communities, particularly in nursing practice.

A synthesis of scholarly perspectives on this subject emphasizes the importance of ‘place’ in understanding rural health disparities and advocates for a relational perspective that considers the

social, environmental, and cultural factors of the environment as integral to health outcomes (Afifi et al., 2022; Bourke et al., 2012; Cummins et al., 2007). The findings of this study agree that contextual factors are vital indicators for fostering effective and compassionate healthcare practices. Notably, the findings also infer that relationships go beyond mere interpersonal connections between patients and HCWs in rural communities; instead, they establish a crucial foundation of *Community-centred care* built on adaptability, trust, communication, continuity of care, and collaboration. All of these factors are particularly crucial given the disproportionate impact of systemic insufficiencies on rural healthcare, where these challenges are felt most dramatically. In looking at the experiences of HCWs across the data set, it was evident that HCWs who understand the contextual subtleties and uphold their accountability to the community act as foundational pillars in fostering reliability and continuity. This is vital in addressing the well-established systemic obstacles faced in rural healthcare.

As highlighted by Afifi et al. (2022), Bourke et al. (2012), and Cummins et al. (2007), a relational perspective that considers the social, environmental, and cultural factors of a 'place' is essential for improving health outcomes. In rural communities, where healthcare workers often live and work within the same community, their unwavering accountability – fueled by shared experiences and cultural understanding – enables them to deliver care that is both responsive and compassionate, even amidst challenges like limited resources, healthcare inequities, and external barriers. When considering the literature, the findings of this study offer new insight into how community context directly impacts healthcare delivery. Healthcare workers' relationships with their communities act as both a source of support and a mechanism for navigating the unique challenges that rural communities face. Healthcare workers who have an intimate understanding of the resources in their community are often able to offer support to their patients in navigating the complexities of healthcare in the area. In circumstances where the infrastructure is not meeting the patient's needs, rural HCWs demonstrate flexibility and adaptability to meet patient needs, as demonstrated in Chapter Four. These findings suggest that the

relational dynamics within rural communities are not only integral to healthcare delivery but also essential in addressing the broader systemic health disparities that affect these populations.

Furthermore, establishing relationships between HCWs and patients supports psychologically safe environments and continuity of care. For example, in Chapter Four, the importance of continuity of care was emphasized for patients facing mental health challenges. HCWs perceived that the frequent turnover of staff and changes in healthcare workers led to frustration among patients, as they were repeatedly required to reshare their trauma and medical narrative. This not only caused emotional strain but also created significant barriers to healthcare access for vulnerable populations. However, in situations where there was a shared understanding of the patient experience, knowledge of the community, patient history, or shared community influences may support building rapport with patients.

The literature indicates that participatory praxia and collaborative leadership are favourable in health-equity-based system interventions underpinned by inclusivity and emancipatory knowing (Afifi et al., 2022; Cummins et al., 2007). Likewise, the participants in this study recognized the importance of engaging rural communities and HCWs in developing more equitable healthcare opportunities for their communities, emphasizing that this is essential for achieving buy-in for successful initiatives. Additionally, the literature emphasizes that community-engaged processes augment the rigour, reach, and relevance of interventions, as communities have an intimate knowledge of the existing foundational structures, infrastructure and socio-economic factors driving disparities among the people living within the community (Afifi et al., 2022; Nápoles & Stewart, 2018; Sprague et al., 2019). This research builds on the concept of community collaboration, emphasizing that rural healthcare institutions have navigated challenges by developing distinct solutions and workflows tailored to their complex healthcare environments. If government entities or senior leaders implement changes without grasping these specific complexities, they may encounter staff resistance and a greater likelihood of failure.

Recognizing the significance of healthcare worker, patient and environmental relationships and the influence the relationships have on care is crucial at the macro, micro, and meso levels in healthcare. This includes government bodies and regulators at the macro level, health organizations, administrators and clinical leadership at the meso level, and HCWs, patients and individual healthcare sites at the micro level. According to Sinsky et al. (2021), Health authorities strive to standardize clinical decision-support tools, policies, and care delivery across various sites. This effort aims to enhance the reliability and effectiveness of care, ultimately expecting to improve patient outcomes (Sinsky et al., 2021). The concern with integrating standardized solutions is that the nuance, passion, and empathy ingrained in rural healthcare, as seen in the findings, are lost. Still, maybe there is a way to have all three: structure, sustainment, and standardization, but underpinned in *Community-centred care*, integrating rural community-specific dynamics of relationships, connection, equity, expertise, and knowledge.

While I see the purpose of standardizing care across sites, I wonder if instead of standardizing policies, workflows and decision support, we standardize the benchmark of quality care. This will ensure that the same standard of care can be expected no matter what site you go to within a health authority or even provincially. However, then rural healthcare sites will not have to abide by urban-centric processes. Instead, they may use the connections, relationships, and adversity to influence healthcare delivery by integrating the intricacies and nuances of 'place' and community. Creating standardized benchmarks of quality of care, instead of integrating standardized approaches across rural, remote, and urban areas, the system would be held accountable for systemic inequities and all members of the healthcare network would have to do their part to create equity.

To illustrate this idea, I will provide an example. Across a multifaceted health authority, there is a drive to improve cardiac arrest outcomes in acute hospital admissions. The health authority will use standardized benchmarks to ensure the quality of CPR, timely epinephrine administration, and an

overall prompt response. At an urban site, they are introducing a code blue team to clarify roles and responsibilities, ensuring that the appropriate resources respond to the situation. However, this approach will not work at one of the rural healthcare sites, as they lack enough personnel to staff a code team.

Additionally, site leadership identifies other barriers to meeting these benchmarks, such as provider work schedules and insufficient provider coverage overnight. Therefore, they decided to optimize the scope of practice for registered nurses and enhance nursing education to meet the standardized benchmarks. Since site leadership engaged and collaborated with point-of-care staff at this site to acknowledge their perspectives, solutions that consider dynamics and relationships can be developed.

Overall, the findings from this study underscore the critical importance of fostering strong relationships, accountability, and advocacy within the context of rural healthcare. These elements and how they relate to *Community-centred care* are essential to overcoming the unique challenges rural communities face, where systemic insufficiencies often exacerbate existing barriers to care. These relationships. Whether at the macro, meso, or micro level, relationships help bridge the gaps that rural healthcare systems face and ensure that care remains accessible, personalized, and effective. Recognizing the significance of these relationships allows us to design more holistic, context-aware approaches to care that can lead to better outcomes, stronger patient rapport, and more personalized services. It also shifts the focus to creating supportive, *Community-centred healthcare* environments that recognize the unique needs of both patients and HCWs in the context of their environment. These findings may uphold the value of leveraging the intimate understanding that rural HCWs possess of their environments to address rural healthcare challenges.

Agency Nurses

Another significant finding of this study was the heavy reliance on agency staff in rural hospitals in an attempt to temporarily fill gaps in persistent staffing insufficiencies, which are deeply rooted in more complex causation, such as absent, sustainable retention and recruitment strategies. The overall perception of HCWs in this study was that agency nurses tended to be unengaged and disconnected because of the short-term nature of their work, threatening the accountability and trust in their communities built by regular employees. However, it is essential to recognize that while the standard of agency nurses justifies the reason for concern, transient medical staff should not be seen as the root cause of the issue. Rather, they represent a focal point within a broader, systemic challenge. The data revealed that rural healthcare models have grown overly reliant on temporary staffing solutions, causing essential concepts such as continuity of care, a crucial element in holistic healing, to be disregarded, resulting in increased barriers to healthcare accessibility.

Emerging literature on this topic emphasizes the dependence on agency nurses, the reasons for hiring agency staff, and the impact of opting for temporary staff on permanent nurses. The prominent narrative emphasizes that agency nurses are employed to alleviate the anomalous strain on healthcare systems globally, heavily influenced by perpetual nursing shortages coupled with an aging and growing population (Krzyzewski et al., 2024; Simpson & Simpson, 2019). The need to utilize temporary staff was intensified by the unprecedented circumstances during the COVID-19 pandemic, when infection rates placed an extraordinary strain on healthcare systems to offer a rapid response to acutely ill patients (Krzyzewski et al., 2024; Stroth et al., 2024). Recent studies have begun to challenge the notion that agency nurse performance is not what is affecting care, instead questioning the support provided to temporary staff and the effectiveness of agency staffing in overcoming the underlying barriers to sustainable staffing models (Bajorek & Guest, 2019; Simpson & Simpson, 2019). Additionally, some investigations assess the quality of care by documenting instances of ‘care left undone’ while also

evaluating if employing temporary staff is actually worsening staffing rates due to the impact the workload of agency nurses has on permanent staff (Senek et al., 2020). Although these studies do not explicitly focus on rural healthcare sites, their principles are applicable in conjunction with the findings of this study.

Agency nurses provide critical staffing relief urgently and are extensively utilized in many rural communities where structural inequities exacerbate staffing challenges. Bajorek and Guest (2019) , and Aiken et al. (2007) indicate that the increased workload of onboarding and working alongside agency staff has a significant negative impact on permanent healthcare personnel, particularly due to the unfamiliarity with the health authority, healthcare site and unit. This theme is also evident throughout the data of this study. The involvement of temporary staff can influence perceptions of fairness and commitment, as permanent staff were found to perceive temporary nurses as less committed or reliable due to the decreased level of responsibility compared to permanent staff (Bajorek & Guest, 2019). As outlined in Chapter 4, accountability was also identified as a central theme of this study, which is interlaced with this issue. Rural HCWs, who live and work within their own communities, felt a strong sense of accountability to the community due to their deeply rooted connections. The findings also suggest that heavy reliance on agency staff erodes the tight-knit culture in rural healthcare communities. There is a pattern of perception that permanent staff are doing everything they can to provide ample patient care, while agency nurses are doing the bare minimum. This was captured in the literature, affirming that temporary staff who stay longer or who are repeating contracts are preferred, as they are familiar with the unit and more integrated and require less oversite (Bajorek & Guest, 2019).

The alignment of this study with existing literature illustrates the impact of temporary nursing staff on permanent nurses' morale, organizational commitment, and workload. This reinforces the idea that the challenges associated with temporary staffing are not isolated or unique to specific settings but are widespread across healthcare environments. By demonstrating that permanent nurses prefer

familiar temporary staff and perceive them as more reliable, this study strengthens the literature's emphasis on the crucial role of familiarity in improving team dynamics and reducing the burden on permanent staff. The clear link between temporary staffing levels and reduced care quality in the literature further supports the argument that stable, committed teams are essential for maintaining high standards of patient care, as suggested in prior studies (Dall'Ora et al., 2020; Senek et al., 2020). This emphasizes the importance of considering that healthcare delivery may be impacted by hiring transient staff instead of those embedded in the community.

Additionally, the perception that temporary staff are less committed than their permanent counterparts affirm existing concerns about organizational culture and team cohesion, underlining the importance of addressing these disparities to maintain a healthy work environment. The findings also confirm the vital role of organizational commitment in enhancing nurse performance and patient care, especially in rural communities where staff are strongly interrelated to their communities. This further supports the position that fostering engagement among permanent staff is critical for sustaining an effective and meaningful healthcare delivery. However, despite the alignment of the impact of agency nurses on permanent staff and work environments, it is crucial to recognize that agency nurses are not causing staffing insufficiencies or poor care quality. Neither are they responsible for fixing these systemic challenges. These challenges existed prior to the influx of agency staff, reflecting a broader lack of permanent and sustainable interventions initiated at both the macro and meso levels of healthcare. Overall, the alignment between the study and the literature validates the existing body of work and reinforces the need for healthcare systems to invest in sustainable staffing structures to optimize engagement and staff culture and place greater value on the patient and HCW relationship. This approach may mitigate the adverse effects on staff and patient outcomes impacted by the overemployment of temporary staffing. When temporary staffing is required, it is recommended to

prioritize familiarizing these workers with the environment and the unique needs of the community, investing in proper training and education rather than simply placing them in unfamiliar settings.

Agency Staff and Providing Trauma-Informed Care

Another insight that arose from the study was the ability of agency healthcare workers to deliver trauma-informed care when they do not have a wholesome understanding of the community's historical, social and environmental contexts that impact their relationships with the healthcare system. This was particularly noted when providing care to vulnerable populations, such as Indigenous Peoples in Canada. Despite an extensive review on this topic, there was no related literature specifically exploring the relationship between temporary healthcare staff and the delivery of culturally competent care. Still, as the scope of research on agency nurses evolves, this is an important topic for consideration because of the implications for care delivery and health outcomes. This research illustrates that the connection one has with one's community leads to a deeper understanding, empathy and advocacy for the patients they care for. Given the research on the general impacts of agency nurses on permanent staff and quality of care, I find myself questioning if staff who are not familiar with the trauma and historical nuances are prepared to provide non-biased, non-judgmental and culturally competent care. This would be especially important in understanding as we work to ensure Canadian healthcare systems are more equitable, inclusive, and inviting to Indigenous healing practices in Indigenous communities. Are we perpetuating trauma by subjecting our communities to staff who have not undergone any trauma-informed care training, who are not familiar with the historical intricacies of the communities in which they are contracted, and who are perceived not as committed to the work as the permanent staff? And trauma to those temporary staff who are filling a vital purpose – often otherwise, there would be no healthcare provision available after hours.

Within the findings, it was determined for one participant that a glaring issue for them is the transiency of staff caring for Indigenous peoples living in their community, which deserves equitable,

empathetic, and trauma-informed healthcare but remains largely misunderstood. Additionally, Gahrmann and Klumb's (2024) finding that temporary staff demonstrate lower performance and commitment compared to permanent employees—due to their limited need to embrace full responsibility—may affect the dedication of permanent staff in grasping the complexities of the communities they serve, resulting in more significant disparities for these marginalized groups. Consequently, there is potential for the lack of culturally competent care to lead to further tensions and breakdowns in the relationships between Indigenous peoples and government HCWs. Our study presents an opportunity to further explore the relationship between agency nurses and Indigenous populations in Canada based on the interpretations of the interview data that suggest the potential for growing tension in their community. However, the available data cannot draw definitive conclusions about this relationship's specific impacts or nuances. Given the complexity of cultural, social, and healthcare system factors, further research is needed to investigate how temporary staffing, particularly agency nurses, affects care delivery, trust, and health outcomes within Indigenous communities. This would provide a more comprehensive understanding, help inform culturally competent staffing practices, and support determining training recommendations for temporary staff entering contracts in these settings.

Deficit Discourse

Another pertinent finding from this study was the presence of a discourse deficit when discussing rural healthcare. Undeniably, all participants spoke about the challenges that rural healthcare systems encounter, discussing many aspects of experience and rural healthcare as they relate to the disparities. However, between the discourses of insufficiency, there was opportunity. All 10 participants recognized that rural healthcare encompasses more than simply the sum of its challenges. However, participants shared examples that illustrate that decision-makers widely misunderstand rural communities.

A substantial body of literature has recognized the prevalence of deficit discourses in rural communities (Afifi et al., 2022; Bourke et al., 2013; MacLeod et al., 2017b; Malatzky & Couch, 2023). Rural communities frequently face stereotypes of lacking resources, inferior services, inadequate infrastructure, and few opportunities, leading to perceptions of their residents as uneducated and unsophisticated. Notably, this has cemented assumptions about the quality of healthcare in rural communities and the ramifications for those receiving care in these healthcare settings (Afifi et al., 2022; Bourke et al., 2013; MacLeod et al., 2017b; Malatzky & Couch, 2023). While undoubtedly rural communities experience complexities, inequities, nuance, diversity, and social and political factors affecting both health and resource structures that are inequitable to urban counterparts, there is a need to shift the current paradigm, replacing deficit mentalities with validation and celebration of rural capacities. A shift in the negative discourse has the potential to give healthcare leadership and partners a new lens in developing education, engaging in research and creating policy. This shift may enable rural healthcare staff and leadership to challenge the status quo, recognize the strengths to mitigate perpetual challenges, and leverage nuances to create connections.

Afifi et al.'s (2022) research explores the concept of 'place', seamlessly intertwining and encapsulating *Community-centred care* within the framework of my study. 'Place' is not neutral – it is shaped by culture, power and privilege. As Cummins and colleagues (2007) point out, how places are represented reflects profound political and social choices that can create equity or perpetuate inequity. The prevalent deficit discourses, particularly from urban perspectives, often reduce rural communities to a series of challenges, neglecting their inherent strengths and assets. In *Community-centred care* – care that deeply understands a community's context, culture, history, and distinct needs – discourse may cause barriers to delivering meaningful support. As my research illustrates, prioritizing relationships, personhood, connection, and advocacy, *Community-centred care* fosters accountability. It ensures that rural populations' diverse realities are acknowledged and central to healthcare solutions.

Ignoring this complexity leaves rural communities underserved and underrepresented in healthcare planning and delivery. However, these discourses are ingrained not only in the Canadian healthcare system but also in healthcare systems globally (Afifi et al., 2022; Bourke et al., 2013; Malatzky et al., 2020; Malatzky & Bourke, 2016, 2018b; Malatzky & Couch, 2023). During data collection, it was evident that even rural HCWs have become accustomed to viewing rural communities through a deficit lens. So, how do we confront and deconstruct the enduring stereotype that has shaped perceptions over time?

Reframing the discourses around rural healthcare involves confronting stereotypes, structures, and dynamics shaped by urban hegemony. Afifi et al. (2022) recommend transforming the viewpoint in rural healthcare to include strength-based perspectives while stressing the complexity, diversity, and resilience within rural communities. They advocate for placing importance on structural determinants, integrating local voices, and implementing health equity frameworks to shape policies and interventions aimed at reducing rural health disparities while also encouraging genuine community participation (Afifi et al., 2022). While I believe these recommendations are sound, I suggest these strategies can be enhanced to optimize these recommendations further.

Firstly, through data collection, I learned that staff were pulled from their leadership roles to meet baseline staffing quotas, compromising meaningful contributions to systemic changes. As this research highlighted, local leaders and health professionals are deeply embedded in their communities and understand their unique landscape. Amplifying these voices in health policy discussions, research, and decision-making processes can empower rural communities. By concentrating on locally driven solutions and leadership, the deficit-based narrative is challenged with a focus on rural innovation and self-determination. Therefore, investing in additional leadership roles, prioritizing their consistency, and providing access to ample educational opportunities is likely to build capacity among rural healthcare sites. Overall, this study contributes to the existing research by validating previous findings while

showcasing the interest, determination, and desire that rural healthcare workers must create accessible, equitable care for their communities. They are ready for change—they just need a seat at the table.

Implications and Recommendations

Drawing from the research findings on how community context influences healthcare delivery in rural communities, the following section presents recommendations to create opportunities for improvement in rural healthcare systems. Rural HCWs who are well-connected and understand the cultural, political, and historical contexts of their community have valuable insights into systemic challenges and can propose innovative solutions to encourage grassroots initiatives and subsequent change. Rural HCWs have untapped potential to contribute to developing policies and interventions that address healthcare disparities in rural communities. Furthermore, a large part of the recommendations is the call to action to decrease barriers for rural partners to participate in system-level changes. The potential and the barriers to contribution have a tremendous impact on the recommendations.

At a meso level, I recommend integrating rural perspectives into systemic decisions to leverage their understanding of 'place' and context to customize healthcare delivery for each community. Therefore, healthcare organizations must create accessible platforms for rural HCWs to express concerns and contribute to decision-making processes. While creating platforms for rural HCWs to share their perspectives may require additional resources, partnerships with local organizations and leveraging technology can facilitate these efforts. Additionally, to achieve this, there must be a focus on recruitment and staff retention, as well as stable leadership roles to ensure leaders have the capacity to partner and collaborate with regional and urban partners.

Policymakers must adopt a holistic perspective of rural health, understanding that healthcare is closely tied to socio-economic elements such as housing, transportation, and education. Collaborating with rural communities is crucial for creating policies that effectively address these varied needs and address their unique circumstances. Current policies often reflect the urban HCW experience,

referencing access to resources common in most urban settings. In rural healthcare settings, however, policies, guidelines, and procedures are often not developed with consideration of their geographic, cultural, and resource-specific nuances at the forefront, making adherence to these standards particularly arduous. Therefore, collaboration with rural communities would ensure rural applicability and representation within policies and standards, optimizing their adherence across the organization.

Furthermore, integrating rural perspectives into front-facing documents would help raise awareness of their unique experiences and the diverse, multifaceted nature of their work. For this reason, strategically partnering with rural partners would shift the focus from merely fixing shortcomings to encouraging opportunities for development and transformation. By expanding the focus of health policy to be more inclusive, we can advocate for sustainable advancements that enhance the overall health of all communities. Additionally, policies and decision-support tools that accurately reflect the realities of rural healthcare are essential for delivering safe patient care. Developing support materials that encompass the broader scope of healthcare workers' roles in these settings can enhance competence and ensure the delivery of high-quality care. This may also help build relationships between leadership and rural HCWs, as documents reflective of the reality of their work may demonstrate more concrete support for HCWs working in rural areas.

While this study has provided valuable insights, further research is needed to expand on *Community-centred care* and the concept of 'place' as it relates to care delivery. Rural healthcare is complex, delicate, and intricate and must be treated as such. It evolves rapidly, driving the demand for ongoing research to maintain understanding. Furthermore, future research should continue to integrate community-engaged approaches to enhance collaboration and continue to build relationships between rural healthcare workers and urban centers to support bridging gaps in knowledge, resources, and access to care. Rural communities should not be viewed as isolated but rather as valuable contributors to broader health discussions and innovations. By fostering mutual learning and resource-sharing, urban

and rural communities alike can benefit, challenging the narrative that rural areas are merely recipients of support.

Given the potential challenges posed by unaddressed staffing challenges temporarily voided by transient staffing, government bodies and operations leaders need to consider the root of the staffing shortcomings and invest in solutions that agency healthcare workers are temporarily fixing. Additionally, the interpretations generated from the research findings prompted me to consider the impact of transient staff on our vulnerable populations. Further research needs to be done to deepen these insights into understanding the influence of transient nursing on delivering trauma-informed care. Additional research exploring the relationship between cultural humility and short-term transient staff would benefit rural healthcare. Particularly exploring the role of staff instability, lack of continuity of care and high turnover and its impact on treatment outcomes and the perception of holistic, patient-centred care for populations with complex, ongoing care needs. Research of this nature could inform education strategies and staffing requirements for HCWs caring for Indigenous patients and patients who are impacted by structural inequities. Additionally, further research exploring the relationship between Indigenous people and agency staff would be beneficial in understanding the need for supporting orientation for staff around trauma-informed care and cultural humility, as well as continuing to integrate reconciliation initiatives into health care.

Limitations

While the findings from this study offer key insights into the complex subject of understanding care delivery's cultural context and recommending practical outcomes, this study has several limitations. The findings of this study are embedded within the specific cultural, institutional, and geographic context of healthcare in Canada, where it was conducted. As a result, applying these results to all rural communities may overlook critical contextual factors that significantly influence participants' experiences. Additionally, the context-specific nature of interpretive description limits the applicability

of the findings, particularly to populations with different cultural, social, or socio-economic backgrounds. While the contextual factors in BC's rural communities may be different, the overall approaches may be considered for the rest of Canada or globally, with similar disparities across healthcare systems. Therefore, although the study provides valuable insights into the specific context examined, caution is warranted when applying these findings to broader contexts. The interpretive description methodology requires active engagement from researchers in both data collection and interpretation processes, thereby introducing the possibility of researcher bias. As the researcher, I possess prior knowledge of this topic and may hold assumptions that could have influenced the analysis and the conclusions drawn. Given the time constraints of a master's level thesis, this study did not capture the patient experience. Additional research that includes patient experiences in understanding the impact of *Community-centred care* and 'place' on healthcare would benefit understanding the intricacies of context and its influence on rural healthcare in Canada.

Conclusion

Overall, the purpose of this study was to understand how the *Community-centred care* lens and 'place' shape how healthcare is delivered in rural communities. Through interviews with HCWs and an interpretive description of the data, the findings revealed that HCWs who were connected to their community and understood the contextual and cultural factors influencing their working environment prioritized relationships, demonstrated innovation to overcome challenges to the status quo, and maintained rigorous standards of knowledge acquisition, translation, and accessibility. By understanding how environmental and contextual factors impact care delivery, practical recommendations were identified to support improvements in rural healthcare. These results underscore the importance of adopting a holistic approach to rural health policy that integrates both healthcare access and broader social determinants. Furthermore, community engagement and collaboration are crucial to ensuring the representation of rural voices in systemic change. However, to harness the potential of rural leaders and

participatory practices, it is essential to address the ongoing challenges and the political will required to overcome them. Shifting the deficit discourse paradigm associated with rural healthcare is also an important step in the future of rural healthcare and the partnerships between all health authority partners. Equitable access and solutions must be considered in collaboration with rural representatives to instill meaningful change. While this research provides valuable insights, further investigation is needed to understand how context affects care delivery, as well as to engage patients in the discussion to understand their perspective on *Community-centred care*. Moreover, I think there is an opportunity to further investigate the relationship between agency nurses and Indigenous populations to understand the perspectives of receiving care from a healthcare worker who may not fully grasp the histories and cultural considerations of Indigenous people living in Canada. It will also help to understand the perspective of agency nurses delivering care in Canada. Overall, this study emphasizes that recognizing and embracing the distinct identity of each rural community can catalyze powerful health transformations that are both relevant and reflective of their specific needs. Ultimately, learning to balance the challenges of rural healthcare demands the consideration of *Community-centred care* to guide the integration of sustainable solutions, empowerment of communities in community engagement, and the development of policies that equip both patients and healthcare workers to succeed.

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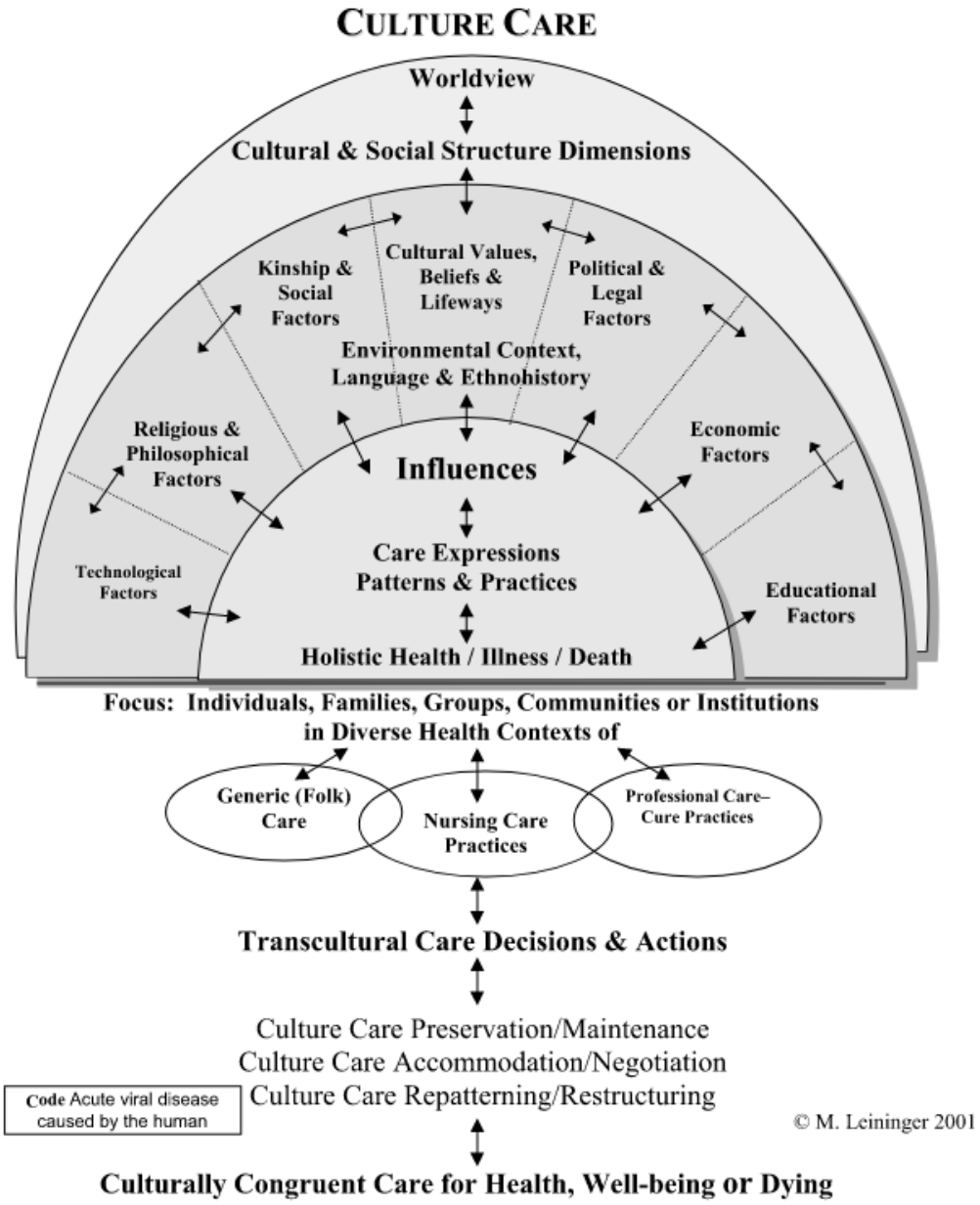
Appendices

Appendix A

Leininger's Sunrise Model Depicting the Factors Needed to Provide Culturally Competent Care



Note. From "Culture Care Theory: A Major Contribution to Advance Transcultural Nursing Knowledge and Practices" by M. Leininger, 2002, *Journal of Transcultural Nursing*, *13*(3), p.191. https://doi.org/10.1177/10459602013003005. Copyright 2001 by M. Leininger.

Appendix B

Recruitment Poster

Calling Vancouver Coastal Health (VCH) Rural Healthcare Workers

To Participate in a Research study- Community-centred Care: Intertwining Community Context and Healthcare

Why?

We want to explore **how** Healthcare Workers understand **community context** and **culture** and how it **Impacts healthcare!**

What to Expect?

If eligible, you will be invited to participate in a **45** to **60** minute virtual **Zoom** interview.

Participation is **voluntary** and **confidential**.

You will receive **$30** for participating.

Participant Eligibility

- **VCH Nurse, Physician**, or **Allied health provider, working** at a **VCH rural site** for at least **2 months** total.
- **Live** in the community in which you work (**6 mo. min**)
- **Speak English**

Research Importance

Contribution to **Community Health Improvement**

Building Trust between **healthcare** and **community**

Empowerment of Local Voices

Cultural Recognition

Professional Development

Interested in Participating?

Contact us by email or phone if you are **interested** in **participating**:

1. Gab Prosperi-Porta [redacted]
2. Dr. Allie Slemon [redacted]

Thank-you in advance, we look forward to hearing from you!

For more **information**: **scan** the **QR code** or **contact us.**

This study was approved by the Research Ethics Board at the University of Victoria, UBC, and VCH on March 15

Version 2- March 5, 2024

Page 1 of 1

Vancouver CoastalHealth

UVIC

Appendix C

Semi-Structured Interview Guide

Guiding Questions- Semi-Structured Interviews with Healthcare Workers (HCW) working in VCH rural healthcare sites.

1. What is your profession? How long have you been in this profession for?
2. How long have you worked at *insert VCH rural Site*?
3. Community Life:
    a. How long have you lived in *insert rural area*?
    b. What brought you to *insert rural area*?
    c. Tell me about the transition to living in *insert rural area*- How was it meeting people? How do you perceive your connection to the community? (If applicable)
    d. Tell me about your experience integrating into the community. (If applicable)
4. How do you think that living in a rural area shapes your role as an HCW?
    a. What are some of the ways living in *insert rural area* benefits your role as an HCW?
5. What does rural healthcare mean to you?
6. What has been your experience providing care at *insert rural healthcare site*?
7. What do you enjoy about working in rural healthcare at *insert rural healthcare site*?
8. What are some of the challenges you experience?
9. What are *insert rural healthcare site*'s Strengths? Current challenges? Is anything being done to address the challenges? Why or why not?
10. What would you tell a new staff member about the *insert rural community* before working here?
11. What do you believe to be integral to providing care in the *insert rural healthcare site* context?
12. What does the *insert rural community* need in terms of healthcare?
13. How do you think understanding the context of a community influences your healthcare approach? What approaches have you witnessed by other healthcare workers in providing care?

Appendix D

Participant Consent Form

University of Victoria | Nursing

Participant Consent Form- Healthcare Participants

Version 2-February 27, 2024

Community-Centred Care: Intertwining Community Context and Healthcare

Research Investigator
Gabriella (Gab) Prosperi-Porta
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Dr. Allie Slemon
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University of Victoria (UVic)
[redacted]

Committee Member
Dr. Lorelei Newton
Assistant Professor
School of Nursing
University of Victoria (UVic)
[redacted]

You are invited to participate in a study that explores community-centred care in British Columbia Vancouver Coastal Health rural settings. This study will examine how community context and culture impact healthcare. The study will be conducted by University of Victoria (UVic) Nursing Graduate Student Gabriella Prosperi-Porta and supervised by Dr. Allie Slemon from the School of Nursing at the University of Victoria. If you have any questions about the study, please get in touch with Gabriella Prosperi-Porta.

Purpose and Objectives

This study aims to understand how a community's values, perspectives, norms, and environment shape healthcare within rural settings. You may not have worked and lived in this community long, and that is okay. We are still interested in your perspectives, impressions, and work related to this community. I am interested in your personal and social experience living and working in your community to understand how they intersect.

Importance of this Research

While the uniqueness of rural healthcare is not a new phenomenon, examining the integration of community culture and context and its impact on healthcare delivery is not well-researched or documented. Rural communities do not always have the available healthcare resources of their urban counterpart. Yet, previous research suggests that healthcare workers who are intertwined with their community have a unique understanding of their community's healthcare needs. However, rural healthcare approaches and initiatives are often similar to urban settings, with minimal consideration for the strengths of rural healthcare integrated into improvement strategies. The goal is for this study's findings to inform knowledge about community context and its impact on healthcare. The research findings from this study will be widely disseminated to support rural healthcare settings in incorporating rural and community-centred care.

Participant Selection

You are being asked to participate in this study because you are a healthcare worker at one of VCH's eight (8) rural sites, you live in the rural community where you work and you have expressed interest in participating. Participants were selected from those who expressed interest and contacted the researchers after seeing the recruitment flyer.

You are eligible to participate in the study if:

1. You work at one of Vancouver Coastal Health (VCH's) rural sites[redacted] for at least two months in total.
2. You live in the rural community in which you work. You must have lived there for at least six months.
3. You are English speaking.
4. You are a healthcare worker: Provider, Nurse (LPN/RPN/RN), or allied health clinician.

What is involved?
If you consent to participate in this research, your involvement will include an interview conducted by Gabriella Prosperi-Porta. This interview is expected to take approximately 45 to 60 minutes and will occur virtually over a UVic-licensed version of Zoom at an agreed-upon time. With your permission, this interview will be audio recorded and transcribed. You may have a support person present during the interview to offer comfort or support. The questions asked during the interview are focused on examining the community's strengths, your impressions of the community through your healthcare lens, how your work intersects with the community environment, and your perspectives on rural healthcare. This interview will not examine detailed healthcare scenarios.

Please be advised that information about you that is audio recorded for this research study uses an online program located in the U.S. or a program that can be accessed from the US (Otter.ai). As such, there is a possibility that information about you may be accessed without your knowledge or consent by the US government in compliance with the US Freedom Act. After transcription is completed, audio files and transcripts will be permanently deleted from the program and removed by the host Otter.ai server after 7 days. Please note that your demographic information, including your name and age, will not be audio recorded and, therefore, not included on the transcript on Otter.ai.

Transcripts will be kept by the Research Investigator (Gabriella Prosperi-Porta) on a secure password-protected server for five years before being destroyed. Documents will be encrypted, and password protected. All paper copies of consent forms will be kept in a locked filing cabinet in the Research Investigator's office. Contact information for participants will be stored in a separate file from research data if follow-up is needed.

The information obtained in this study will be used in the writing of Gabriella Prosperi-Porta's master's thesis. It may also be used to inform presentations. To avoid personal identification, any names or places will be modified, and you will be given a pseudonym or numeric identifier. Other identifiable information will be blinded during the transcription to protect your confidentiality.

Risks
Gabriella Prosperi-Porta holds a Professional Practice position in Vancouver Coastal Health (VCH) as well as being a Master of Nursing Student at UVic.

Your participation in this study will have no bearing on your position, status, or employment within VCH. Involvement in this study is entirely voluntary and will not impact your professional standing or opportunities within the organization.

While this research is taking a strength-based approach, there are some potential risks to you by participating in this research. Emotional or psychological discomfort in discussing experiences and perspectives may still arise. To manage these risks, you must be aware that you can bring a support person to the interview, end the interview at any time, decline to answer a question or choose to answer the questions in as little or as much detail as you would like. You may withdraw from the study up to 2-weeks after the interview has been conducted.

Difficult emotions may also arise following the interview. You may contact the interviewer for a debrief any time after the interview. Please also see the attached list of mental health resources that you may choose to access if you are experiencing distress.

Benefits
Participating in this research allows you to share your experience, values, culture and perspectives about your perspectives working in rural healthcare. This research may contribute to knowledge translation and mobilization of the awareness of the realities and nuances of rural healthcare.

Compensation
In recognition of your time and contribution to this study, you will receive a $30 honorarium. You will still receive this honorarium if you terminate the interview or withdraw from the study later.

Voluntary Participation
Your participation in this research is entirely voluntary. If you decide to participate, you may withdraw up to 2-weeks after the interview has been conducted without any consequences or explanation. After 2 weeks, the information gathered from

the interview will have been integrated into the analysis, making it more difficult to remove without compromising the integrity of the study. Hence the outlined withdraw period of 2-weeks from the interview date. Suppose you choose to withdraw from the study. In that case, all audio recordings will be permanently deleted, and none of your information will be used in data analysis or in analyzing the results. If you do withdraw, you will keep your honorarium.

Confidentiality
Your confidentiality and the confidentiality of the data will be protected by using several strategies. A numerical identifier or pseudonym will be used to identify your interview data throughout all study documents, including publications. All documents, including recorded audio files and transcriptions, will be identified only by your confidential identifier. Your name and age, as well as other demographic information, will not be recorded in the audio recordings. After the audio files have been transcribed, Gabriella Prosperi-Porta will review the transcriptions to make sure that there is no information that identifies individuals. In the results of the study, you will be referred by a code or pseudonym if specific participant interview data is discussed. All electronic files will be encrypted, password-protected and kept on a secure server, on a password-protected computer. All hard-copy documents will be kept in a locked filing cabinet. Only the principal investigator, researcher, and research committee will have access to the original files, identified only by your numerical identifier or pseudonym. Information that discloses your identity will not be released without your consent unless required by law. All consent forms, data collection files, and transcriptions will be destroyed after five years. Audio recordings will be destroyed as soon as the research project has concluded.

Dissemination of Results
The information obtained in this study will be used in the writing of Gabriella Prosperi-Porta's master's thesis. Additionally, the results of this study may be published in academic journal articles. After the study has concluded, results will be presented in an open Webinar to VCH rural healthcare staff and VCH rural community members. There will be an opportunity for clarification questions. Participants may also choose to receive a summary of the results via email. Results may also be shared with Vancouver Coastal Health leadership to inform rural healthcare initiatives.

Disposal of Data
As stated, data from this study will be disposed of after five years. All paper or hard copies will be shredded, and all electronic data will be permanently erased.

Contacts
If you have any further questions regarding this study, please do not hesitate to contact Gabriella Prosperi-Porta at [redacted] or [redacted]

The University of Victoria Human Research Ethics Board has reviewed the proposal for this study for its adherence to ethical guidelines. If you have any concerns or questions regarding your rights as a research participant, you may contact the Human Research Ethics Board at 250-472-4545 or ethics@uvic.ca.
Thank you for considering being a part of this research. I very much look forward to working with you.

Consent Statement

You may consent by signing this form or giving verbal consent at the beginning of the interview. By giving verbal consent or by providing your signature below indicates that you understand the above conditions of participation in this study, that you have had the opportunity to have your questions answered by the researchers, and that you consent to participate in this research project.

Participant's Name	Participant's Signature	Date

Researcher's Name	Researcher's Signature	Date

☐ I wish to receive a summary report of research findings once the project has been completed.

This document may be sent to:

Email Address: _____

A copy of this consent will be left with you, and a copy will be taken by the researcher.

Appendix E

Community-Centred Care: Exploring the Integration of Community Context in Healthcare Visual Depiction of Findings