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Exploring the Multifaceted and Multifunctional Roles and Activities of Rural Nurse Managers

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ABSTRACT

Research on rural nursing has produced limited insight into the complex dynamic of roles and activities fulfilled by rural nurse managers (RNMs). Hence there is a need to explore, understand and delineate these roles to help provide appropriate managerial support and training to improve their capability. This study sought to develop greater understanding of the roles and tasks performed by RNMs, drawing on nurses' own experiences and understandings. It used in-depth interviews with selected nurse managers working in rural and remote health-care facilities in South Australia. This provided detailed information about RNMs' roles, responsibilities, tasks, decision making and patterns of work. Meanings were sought from the everyday activities of RNMs who drew distinctions between their roles and those of counterparts working in metropolitan facilities. Both clinical and managerial activities were highlighted but with roles described as 'expanded,' 'extended' and 'jack of all trades' illustrating the multiplicity of activities performed by a single RNM. The nature of rural and remote health-care facilities places special responsibilities on RNMs, creating stress deriving from role conflict and ambiguity. Recommendations are made regarding ways in which the work of RNMs can be better supported whilst addressing the complexities of their jobs. More appreciation of the job stresses needs to be considered when providing support to RNMs who face particular challenges through working in rural and remote areas. Greater understanding of their roles and daily activities can lead to better management oversight and support, but the multifaceted health issues in these areas remain challenging.

Keywords: Nurse managers, clinical role, management role, rural, remote, South Australia

Introduction

Nurse managers play a vital part in managing and coordinating health activities to provide nursing care[1]. They are central to the development of nursing culture and have a profound impact on health-care settings and the health system[2]. Yet their roles are constantly evolving because of shifts in the organisational structure of health management[3], and the changing health needs of rapidly aging populations, with increases in chronic conditions and growing mental health issues. Nurse managers have retained a crucial responsibility to ensure nursing services are well-organised and provide effective care delivery, while maintaining professional leadership of nursing departments[4].

Nurse managers are central to efficient functioning of health services in rural and remote settings, where challenges may be different to those faced in city-based facilities[5]. Their work is pivotal to good quality inpatient care and achieving the objectives of healthcare facilities[6]. Despite copious literature on the work of rural and remote nurses[7], there is limited information about how these nurses view their roles and responsibilities. Hence, it can be difficult to answer questions such as 'how do the roles of rural/remote nurse managers (RNMs) differ from those of their counterparts in metropolitan areas?' 'what activities and roles do RNMs perform?' and 'how do RNMs perceive their roles?'

In seeking to investigate the work of RNMs in both rural and remote areas, we acknowledge that the definitions of rural and remote are arbitrary, but there can be differences between the situations in which RNMs perform their duties across these areas. For example, on the one hand, a manager of a four-nurse remote clinic may have quite different responsibilities, perhaps for human resource management and navigating the clinical-managerial roles, than would a front-line or a middle manager of a small hospital in a rural setting where there may be 20 plus staff members[8,9]. Mostly, though, there are certain common experiences shared by RNMs working in both rural and remote areas and it is this commonality that is emphasised in the following discussion and analysis.

This paper aims to explore, understand and delineate RNMs' roles, tasks and responsibilities, a prerequisite to tailoring managerial support and training to enhance their effectiveness. The research reported herewith investigates RNMs' general management responsibilities for planning and coordination of rural health care, their tasks, those they can delegate, and the roles they fulfil. The paper commences with an exploration of recent research on rural/remote nursing, primarily within Australia. It then asks the fundamental research question, 'what are the roles played by RNMs?' which it answers via a qualitative investigation in rural and remote South Australia.

Literature Review

1. BACKGROUND: HEALTHCARE IN RURAL AND REMOTE AUSTRALIA

RNMs contribute to service provision for rural/remote populations with limited access to medical, specialised, and allied health services, scarce material resources and a more socially disadvantaged population than in urban areas[10,11]. Health budget allocations and resource funding models are often restricted, with a small workforce, high levels of local socioeconomic disadvantage, poor service accessibility and utilisation, geographical and professional isolation, harsh climatic conditions, an ageing population, and major maldistribution of the health workforce[12]. The severity of health problems tends to be greater with increased distance from metropolitan centres, so that a 'one size fits all' model for 'rural' health overlooks important nuances associated with specific contexts[13(p.70)]. Herewith we discuss issues relating to nurses working in both rural and remote locations.

A typical scenario in these areas comprises "a hospital, a general practitioner (GP) clinic and a community health centre, all struggling to maintain staff and fund necessary services"[14(p.496)]. Health-care workers perform multiple activities but work with high levels of autonomy despite limited financial and human resources. They are closely connected to the local community, but face problems associated with "ageing of the local health workforce, difficulties in recruiting new staff, and isolation from specialist care, professional development and other health services"[14(p.496),15]. There is also an Indigenous element in this discourse as two-thirds of Australia's Indigenous population reside in rural/remote areas[16], and there are multiple health issues facing these communities[17].

The lack of resources has led to a 'deficit discourse'[13], in which there are "repeated calls for more services, more staff and more funding along with a growing body of research listing increasing problems in rural health"[13(p.66)]. An alternative view could applaud the success of rural healthcare for often attaining comparable results with "urban outcomes despite lower patient-health professional ratios and less access to specialist care"[18(p.158)]. However, the medical profession tends to favour specialisation over generalisation and this places doctors (especially GPs) and nurses working in rural/remote areas at a disadvantage[19].

Especially in remoter areas, service provision is orientated towards primary health care (PHC), with services essentially nurse-led, and medical care provided by on-call community-based GPs. RNMs often work in professional isolation and as such are required to advance, extend, and expand their nursing activities and responsibilities to function effectively in meeting healthcare service demands of local populations. They must work independently or as part of a small team in which the RNM is the first contact for a range of healthcare activities normally provided by medical practitioners and allied health professionals in urban areas[20]. On occasion RNMs may act as substitutes for doctors. The circumstances under which they work means that RNMs face exceptional daily challenges[21]. Their roles are complex, having "to contribute to policy development, manage a workforce with varying skill mix, maintain clinical currency and understand the culture of the wider rural community"[22(p.30)]. Yet, RNMs are often responsible for both recruitment and retention, with evidence that positive attitudes towards supporting colleagues can be a key reason for all staff to remain in post and to enhance the reputation of a health facility[23].

Despite the many problems facing rural/remote healthcare, research shows that nurses' positive identification with the place and community in which they work enhances the likelihood of them remaining in the health workforce[24]. Given opportunities to build skills and access career pathways, nurses can feel settled in the community (through being socially connected and having a sense of belonging), especially when working in a friendly, supportive and inclusive workplace. This is the counter to the deficit discourse, and certain aspects of career building may even be enhanced by working in rural areas because of the great variety of experience this may confer.

We now focus on these roles and the need for greater understanding of how RNMs experience and view role complexity, which has been largely overlooked, with the literature instead generally focusing on the various issues and challenges RNMs face and attempts to increase recruitment faced by low workforce retention rates[25(p.1402)]. The various points raised in this review were used to shape the questions raised in interviews with RNMs, notably by focusing on the roles they perform, the high workload leading to stress and job dissatisfaction, and the 'expanded' nature of the job. These are the critical issues covered by the literature and they affect all the types of health-care provision in which RNMs are involved.

2. THE VARIED ROLES AND RESPONSIBILITIES OF RNMS

Functions, remits, and roles can vary widely as RNMs manage multiple activities in a complex environment, supporting clinical activities and provision of care, though the range of responsibilities is not always reflected in the organisational power at their disposal. Nurse managers are primarily responsible for managing the operations of nursing departments in health-care facilities. However, irrespective of their location, they fulfill both clinical and managerial roles[26]. As managers they are responsible for governing operational systems of departments within an organisation, including developing budget and business plans, health promotion and preventative programs[27], while as clinicians they are responsible for defining the scope of clinical practice, education and training, and monitoring clinical performance. They also perform varied administrative duties, including "developing rosters, writing reports and balancing budgets, resolving conflicts and management tasks such as complex interactions with staff, patients and other health-care professionals"[28(p.377)].

So, RNMs are expected "to have excellent clinical skills, with post-basic experience and qualifications, an ability to work in a multidisciplinary team, knowledge of quality improvement, demonstrable budgetary skills, excellent communication skills and a commitment to staff development as well as leadership qualities"[28(p.378)]. In the clinical role they may mentor less experienced nursing staff and share clinical expertise with colleagues. But they also require mentoring themselves and hence references to the so-called 'sandwich support model'[29], with RNMs supported by senior managers but in turn giving support to junior staff. There is a need to explore further how RNMs cope with their varied roles and responsibilities and how they impact on their decision making and job satisfaction, the latter having a major impact on workforce retention.

3. HIGH WORKLOAD, STRESS AND DISSATISFACTION

Staff shortages and under-funding of rural/remote healthcare have led to both a growing range of tasks that RNMs must undertake and increasing complexity, so it has become harder to balance competing demands. In simple terms, there are fewer people available to perform multiple tasks, and so more tasks are performed by individual nurses, creating both positives and negatives regarding job performance[30]. There tends to be less support and limited staffing of medical and allied healthcare providers, impacting tasks performed by RNMs, which may become multifaceted and diverse[31]. Lack of resources and insufficient support from within the sector, partly associated with workforce shortages, impacts on how RNMs function, adding to nurses' stress and dissatisfaction, and to high staff turnover rates[7,32]. It is a demanding position that can contribute to RNMs being overworked, stressed, and dissatisfied[33,34]. For example, focusing on remote area nursing in the Northern Territory, Burke et al.[25] report high incidences of stress, burnout and fatigue[35].

High staff to patient ratios in rural/remote areas may produce unexpected increases in work demands on nurses, which could contribute to certain aspects of care being neglected and failure to provide optimal patient outcomes[36]. Typically, nurses may feel they cannot devote sufficient time to comforting/talking to patients, providing proper explanations to patients and family, and maintaining adequate surveillance of patients[37]. This places increased stresses on RNMs in managing a favourable practice environment for both staff and patients. There is a major challenge to provision of effective care, especially as people living in rural/remote areas have poorer health due to multiple factors including lifestyle differences between rural and urban areas[38].

4. ROLE EXPANSION

The high workload has led to the terms 'extended,' 'expanded' and 'multi-skilled' being used to describe the advanced practice role of RNMs, including the skills and knowledge demanded to ensure effective delivery of care[39,40]. These demands are often exaggerated by professional isolation associated with working in rural/remote areas. There is a general expectation that to fulfil the demands of care RNMs must embrace activities usually associated with other healthcare professionals[41]. Consequently, they may wear multiple managerial hats, and this impacts on both their clinical and managerial roles, creating confusion and possibly lower self-esteem[42].

In a single shift, RNMs may work in obstetrics delivering a baby, care for a dying patient in a medical–surgical unit, and initiate care of a trauma patient in an emergency department. At other times they may be required to carry out tasks usually reserved for a pharmacist or dietitian, so the work of RNMs can range across different healthcare disciplines, such as respiratory therapy, laboratory technology, dietetics, pharmacy, social work, psychology, and medicine. They may be expected to perform ECGs, arterial punctures, drawing

blood, setting up cultures, dispensing drugs, ordering x-rays and medications, and delivering babies. It is common for RNMs not to be confined by being assigned to a specific unit or department, but rather they perform multiple tasks, possibly even during one work shift. They may also have to develop special skills, such as implementing 'telehealth' to overcome problems of distance and enabling virtual access to health services, which has become increasingly important[43,44]. Despite limited financial resources, they may be involved in health promotion and its clinical implementation. So, an RNM's activities are multifaceted, with demands to possess a high level of knowledge, to be multi-skilled and to function in an 'extended and expanded' role: 'extended' implying tasks usually performed by a doctor and 'expanded' developing the role so that it focuses on patients' needs and not just delegated medical tasks[45].

Methods

The roles, responsibilities, and tasks performed by RNMs were examined, initially as part of a broader investigation exploring their decision making[46]. A phenomenological approach was used to focus on the lived experiences of RNMs, seeking meanings from everyday occurrences by describing and interpreting these experiences as RNMs executed their daily duties. The research was conducted in non-metropolitan health-care facilities in South Australia, in communities classified as Regional (Rural) or Remote /Very Remote (Australian Statistical Geography Standard (ASGS) Edition 3). Ethical approval for the research was obtained from the Human Research Ethics Committee of the University of South Australia (Reference Number P235/07).

Using simple random sampling, each non-metropolitan health facility in the state had an equal chance of selection. Once a facility had been selected, individual RNMs were selected purposively, aiming to maximise the range of different positions occupied by the chosen RNMs: nurse unit managers, after-hours coordinators, residential care managers, clinical nurse consultants, and directors of nursing. The process was completed once no new themes were being generated from interviews and observations of the individual RNMs (i.e., data saturation). This occurred after selection of 15 RNMs, eleven of whom worked in areas classified as regional (rural) and four in remote areas.

Face-to-face semi-structured interviews, direct participant observations of RNMs during their shifts, and document review (e.g., review of handover and meeting reports) were utilised, producing data that captured RNMs' lived experiences, activities, responsibilities and roles. Minutes of managers' reports were reviewed to determine types of issues/problems discussed and decisions made. The semi-structured interviews encouraged participants to engage and self-reflect, thereby revealing personal views about their experiences and enabling researchers to broaden their understanding of the meanings RNMs attached to their experiences[47]. The interviews lasted for about an hour and questions related to RNMs' roles, decision making, challenges and education received to manage their roles. Observations focused on types of activities carried out, the handling of issues and related decisions made during the shift. Participants could engage and self-reflect, providing personal views and giving meaning to their experiences. The use of interviews and observations ensured collection of detailed, rich data capturing the participants' lived experiences and allowing an understanding of their managerial and clinical roles, responsibilities, and activities[48]. The RNMs granted permission to record the interviews, which were transcribed and coded for analysis.

We used NVivo software to analyse transcripts, indexing segments of text to themes and examining possible relationships therein[49]. Through inductive analysis, the most frequently occurring terms and phrases in the transcripts were used to recognise themes and patterns. Four processes were used; first, organisation of the data, via coding; second, summarising and categorising; third, identification of patterns and themes; and finally, linking themes and examining relationships. Triangulation, using data from the interviews and observations, helped draw meaning from and understanding of the phenomena under study[50]. This approach generated significant insights into nurses' experiences. Quotes are used to highlight views expressed by individual RNMs. Pseudonyms for the RNMs are employed to ensure anonymity and confidentiality.

Results

1. THE VARIED ROLES AND RESPONSIBILITIES OF RNMS

The respondents referred to the provision of hands-on care and supporting other staff to provide care to patients as their primary role. They felt that clinical work '*comes first*' and should account for the highest proportion of their workload, though this was not necessarily the case. In providing direct care to patients, thirteen (87%) of the RNMs provided care in an A&E department within a hospital where the activities ranged from relieving staff for meal breaks to providing hands-on care. "*On weekends, I make a decision to authorise if x-rays need to be taken and call the x-ray man in*" (Debbie); "*I may go and help to make beds or help with the showers, so there is a bed available because the staff on the ward are too busy. If the ward is busy, then I do not stay in the office but go and do whatever needs to be done out there*" (Molly); "*Something is happening, and you've gone from the managerial role to being out there helping out on the ward*" (Cassie).

Estimates regarding the proportion of time RNMs spent on clinical care varied, but in general it was from 40 to 60%, whereas in a metropolitan setting management/administration may occupy 70% or more. "*60% of the role is clinical and 40% is managerial. This means you have to be clinically sound and you have got to be managerially sound, and that is just it in a nutshell. We are not just a manager or whatever we are called; we are nurses and that comes with the caring and nurturing and all the rest of it*" (Molly). So, although they are managers with responsibility for management and administration, RNMs perform clinical and care-provider duties when needed. The RNMs indicated they were the 'go-to' people who are consulted on how to perform certain tasks or skills: "*Most times I get on the wards and I am used as the consultant for wound management whereas a wound consultant role in metropolitan hospitals is usually performed by a specialist nurse*" (Molly).

Table 1: Selected activities carried out by RNMs

Activity	Content
Bed management	Allocating a bed to patients for different procedures in the health facility.
Community engagement	Involvement in community projects, such as fundraising and advocacy activities; participating in meetings and community awareness; health promotion activities.
Education	Planning and executing all staff development activities.
Human resource management	Activities concerned with staff management issues such as conflict resolution and performance appraisals, recruitment and retention of staff. Also includes promoting networking activities with other managers.
Patient care	Delivering nursing care activities; working in clinical areas; performing care activities.
Procurement and resourcing	Proposing purchases of equipment to ensure stocking of key materials and equipment needs.
Quality improvement	Improving quality standards; developing and adhering to Department of Health policies, e.g., infection control.
Rostering	Planning and executing the monthly roster, involving flexibility with rostering and consideration of staff needs and requests.
Safety, security, and maintenance	Monitoring hospital activities, including safety of patients and staff.
Staff allocation and skill mix	Allocating and moving staff around to meet staff and patient needs.

Source: Interviews with a sample of RNMs in rural/remote South Australia.

RNMs' managerial activities include education, bed management, staff skill mix, rostering, human resource management, supervision, staff support/mentoring, inter-relationships, and general administration (Table 1). These are partly operational because they deal with everyday management issues across an organisation or in a sub-unit like a hospital ward. They are related to activities concerned with liaison and coordination between the executive, the clinical area and general staff. The RNMs' views of this role are reflected by Leslie's comment, "*As managers, we are dealing with multitudes of things, clinical or professional. We are also dealing with human relations issues and all sorts of things.*"

RNMs are expected to apply and interpret policies and regulations, including policies supporting practice. For example, they both review and action various policies, like infection control and patient transfer. Some participants also indicated they are responsible for developing business proposals and fund-raising activities for equipment procurement. "*We have to revise and modify policies and systems. We may also be involved in collecting audits for the occupational health and safety representative for the acute area, but because we did not have any one person, I had to take two days in a week for about six/seven weeks just to do work dealing with the accreditation*" (Cathy). "*For us in rural areas, we fund raise but for those [hospitals] in big cities, people donate to them*" (Sue). They might also do associated administrative work without personnel assistance, in contrast to the experience of urban counterparts. Key aspects of management most discussed were human resource management (HRM), supervision and support to ensure good working relations amongst staff, and education.

HRM includes conflict resolution and human development, e.g., conducting staff appraisals and interviews, reference checks for new staff, and providing references for staff leaving the organisation. Appraisals and interviews are not everyday activities, nevertheless they are time consuming. A minority of RNMs were confident in addressing conflict issues and performance appraisal issues while others feel inadequately prepared, especially those in an acting position. In general, RNMs were uncomfortable in addressing conflict situations, mainly because they did not feel competent to do so, and they did not like being confrontational with staff. "*I actually wrote and brought in a new performance appraisal tool, implemented it and did all performance appraisals and I find that quite difficult because I did not think that being in the role for three months that I could actually really do it*" (Debbie). "*I find it quite daunting because I have never done it before on my own even though I have been involved in peer reviews and I have done students' evaluations before, so it is not like I have never had any experience, but it was quite daunting once I got into it*" (Cassie). When asked about the most challenging tasks, the majority referred to conflict resolution, followed by issues resulting from professional misconduct. "*I guess the conflict ones make me uncomfortable and as such I procrastinate attending to such issues*" (Debbie). Development of new policies/regulations and making decisions concerning peer reviews and appraisals are also problematic: "*Changing procedures and doing that sort of thing, I find that a little bit hard to get my head around it*" (Leah).

RNMs direct the work of others and act as supervisors, providing support for junior staff to foster a sense of confidence, manage conflict and provide assurance and support to staff and other health-care providers. Participants indicated they spent a significant amount of time providing support: "*There is so much social support, which is to deal with staffing. [..] a lot of time is spent trying to support staff with their personal issues* (Cassie); "*The whole role of a nurse manager can be summed as 'giving*

support.' You can paint this support with many labels: academic, knowledge, resources, mentor [..]" (Lou).

RNMs stated that developing good working relations with colleagues requires effective communication and collaboration. There are various advocating and liaison activities with other health professionals within the organisation, the community and across departments. These involve creating positive relationships between health-care institutions and the community and using good people skills, which helps managers to collaborate with colleagues (including those in other health-care providers) to accomplish objectives. The participants' comments indicate the tension between ensuring amicable professional relationships while also fulfilling the demand to be the 'go to' people in the organisation. "*In this role, I am trying to keep everyone happy. It is like a change of guard all the time*" (Cathy). "*This may not necessarily sit right with either the staff or the executive, but I have to remain neutral and take on everything that comes from either side*" (Debbie). "*The community have a great say in the care of residents so we have to listen to what the community are saying*" (Diana). "*Being in aged care, you are not only dealing with the client but with their families too*" (Laurie).

In metropolitan hospitals educational duties are usually assigned to a designated nurse educator, who is responsible for teaching and skilling nurses to respond to the health needs of the populations they serve. Some facilities may have a nurse educator for each ward or clinical specialty area. However, for RNMs, education is just one of several activities, as confirmed by most of the participants. Their education-related duties include formulating strategies to provide learning activities as part of staff development (e.g., determining educational needs), planning and executing educational plans, supporting staff to undertake educational programs in facilitating mandatory requirements, and designing in-house staff development programs.

RNMs work on planning and executing these education activities and mandatory requirements for staff: "*We are encouraging our own staff to do further studies and we aim to educate and develop in-house programs for some of the junior staff and to up-skill them in some areas*" (Robyn). Yet, most RNMs had no specific education qualifications. The highest qualification for the majority was RN (Registered Nurse) supplemented by attending relevant in-house workshops and management seminars. One nurse possessed a Masters' degree in Nursing. The general view was that RNMs were able to draw upon many years of nursing experience in order to guide younger nurses. Indeed, RNMs indicated that they played a key role in the provision of support for new graduate nurses for retention and recruitment purposes: "*We want to attract students as carers in our aged care division and we are developing 'grow-your-own' strategies*" (Daisy). The long-term job experience of RNMs was vital when performing this role[7].

2. HIGH WORKLOAD, STRESS AND DISSATISFACTION

There are various activities carried out by nurse managers in metropolitan areas, but which are rarely all performed by one person as is often the case for RNMs. For example, tasks may include referral, discharge and transportation of patients, and after-hours coordination of activities, including security issues, maintenance, and community queries and complaints. Arguably, the number of nurse managers decreases with increased remoteness, so instead of having one nurse manager per ward, there may be one nurse manager for the entire rural/remote hospital, expanding the breadth of that person's activities. Thus, greater multiplicity of activities distinguishes RNMs from their metropolitan counterparts, and results from RNMs taking on numerous tasks because of limited human resources and professional isolation. It is not surprising that there are claims of increased workload compounded by lack of support, insufficient training in managerial roles, and an aging RNM workforce as the job may be unappealing to younger nurses. It was observable during the interviews that these issues could lead to growing physical and mental health demands, exhaustion and burn out, job dissatisfaction and issues relating to retention and turnover[34,51]. "*It is kind of overwhelming most of the time*" (Debbie).

Successful communication as a strategy for building inter-relationships was linked by RNMs to job satisfaction, work efficiency, and employee retention. They argued that providing support improved efficiency at individual and organisation level, promoting individual job satisfaction, work-life balance, continuous professional development, and a positive organisational culture. In contrast, it was argued that if staff are not supported, this may contribute to ineffective work performance, stress and burn-out, and absenteeism. If not addressed this may compromise quality of care by leading to significant staff turnover. For example, "*There is too much work and whether or not I am not efficient with my time is another question. You are always working to your full capacity and more. Having to do too many things at once and that is particularly hard when you are hands-on in the clinical area and again you are the manager, particularly if you have got unwell patients and especially in our job when our resources are limited. Tiredness is because you are being overworked. You do not really feel that you are tired until you are home and some days you have a good day and then sometimes you feel 'flat,' you can't get out of your chair or you just fall on your bed*" (Cathy). And, "*I put in long days to try to manage it" (Sue). " You are working to your full capacity and more" (Daisy). "I do rostering at home and I do a lot of work on the weekend*" (Lou). It is therefore no surprise that two-thirds of RNMs interviewed experienced stress and burn out.

3. ROLE EXPANSION

The RNMs generally felt they performed a wider range of duties than their urban counterparts. For example, in urban health-care facilities clinician and manager are often separate roles held by different persons, whereas RNMs fulfill both: "*In big hospitals, the staffing structure is different: they have the Director of Nursing (DoN), Nurse Unit Manager (NUM) and the Clinical Nurse Specialist (CNS). In the rural, we have the combined role of the CNS and the NUM; we have lost a layer in the structure*" (Robyn).

Several views referring to multiplicity of activities emerged from the research in response to how RNMs characterised their job. Management activities varied according to the degree of rurality and professional isolation. Several RNMs referred to engaging in activities

to 'fill gaps' to ensure continuity of services and provision of care. Multiplicity contributes to the extended and expanded nature of the job as described above. It blurs the distinction between managerial and clinical duties: "*It is just little things … which really are not nursing duties and yet we are doing them*" (Leah). It also symbolises ongoing conflict between the clinical/care-provider role and the managerial role, the latter encompassing administrative tasks as shown in Table 1. However, it was these managerial and administrative tasks that attracted by far the most attention in the interviews despite the clinical role being regarded by the RNMs as the most important. The RNMs pointed to significant evolution of their jobs over recent decades, moving from a focus on clinical care to a broader range of managerial and administrative activities, brought about by competing demands as well as advances in medical technology that impact on diagnosis, modes of treatment and care delivery.

Several participants referred to themselves as 'jack-of-all-trades' due to the miscellaneous and unplanned management activities, including the sporadic issues that arise during the day. In some rural hospitals for instance, RNMs have to deal with activities like pharmacy orders, coordination and monitoring the theatre operation list, and authorising X-rays after hours and during the weekend. This reflects the high number of activities in the various areas deemed to be the RNMs' responsibility. It was referred to in various ways: *mother-hen, overseer, the middleman/woman, go-between,* and *point-guard of the organisation.* This range is not necessarily reflected in standard job descriptions and is perceived by RNMs as contributing to increased workloads within the broad scope of being both a clinician and a manager. They felt that taking on activities such as ordering of an x-ray or ensuring security issues extends their job and they highlighted differences between them and their urban colleagues.

The RNMs argued that changing social, economic and political demands have further contributed to the multiplicity of activities they perform. Indeed, they pointed out that their job is having to change rapidly as underlying expectations in the health-care system evolve. Changes include new systems, a shift in orientation from service to business, and extensive redesign of many workplaces. The extension of RNMs' roles implied that new responsibilities are being introduced: "*The role keeps on changing and they keep on adding responsibilities to this role*" (Robyn). "*I see this job not getting any easier; hence I just can't keep on going. They seem to be adding more to this position. The job is growing and expanding and it is growing again and it is being taken to another level. It is getting more to a strategic level and away from the clinical area which is scary*" (Wendy). "*Without the support of my husband, I would have left this job or I would have gone mad*" (Debbie).

RNMs filled the gap when there was no one else available to do the job. This eventuates in RNMs having no time in which to complete assigned tasks during the normal allocated working hours, and work snowballs into long extended hours to accommodate for the lack of time. "*I am at the aged care while I should be at the acute and, sometimes, I am at the acute when I should be at the age care. I feel frustrated with it but you tell yourself this is likely to happen. I get more frustrated than stressed*" (Sue).

Discussion

The participants in this study confirmed and extended findings from previous research, namely that RNMs in rural/remote health institutions are expected to be multiskilled and adaptable to respond to issues associated with geographic and professional isolation and lack of resources[52]. They must perform multiple duties while experiencing numerous demands that can contribute to over-work, stress and dissatisfaction[7]. The increase in activities compared with their metropolitan counterparts exacerbates the unpredictability of their 'extended and expanded' roles. The increased workload may impact on their performance, causing stress and leading ultimately to retention issues as staff turnover may be rapid. Particular stressors are scarcity of resources, responding and adjusting to change, and staffing pressures[53,54]. This highlights the need for good staff upskilling and staff development programs to promote competence and to update rural nurse leadership, managerial roles, and practices, functions and responsibilities.

The RNMs who participated in this study indicated that because they operate as both clinicians and managers, carrying out multiple tasks, at times they felt they were being pulled in different directions and experienced role conflict and, sometimes, incompatible role pressures. This could impact negatively on their performance and functioning. Indeed, some RNMs felt they struggled to understand their work objectives, responsibilities and expectations, contributing to uncertainty as to how they should divide their time to perform activities. The responsibilities and objectives for the roles of clinician and manager vary greatly, with conflict between the roles and ambiguity as to what to prioritise, contributing to stress. It seems clear from this that where possible more consideration should be given to improving support and guidance for RNMs[55,56].

Support can take various forms. For example, appointment of an administrative support person for nurse unit managers may contribute to improved manageability, job satisfaction and wellbeing, freeing-up RNMs' time to deal with management and leadership issues[57]. Support promoting positive interaction and capacity building among the staff can promote a sense of confidence in patient-care decisions[58]. However, use of such support has been applied unevenly in rural health institutions due to limited resource allocation[59]. Yet, lack of support can lead to job dissatisfaction, resulting in diminished job retention[60].

The emphasis that health services place on quality of care, safety, standardisation, and efficiency must be managed within the constraints of limited resources compounded by distance from metropolitan hospitals, which puts high demands on RNMs. Moreover, in small communities RNMs must deal with lack of anonymity as they will be known by most inhabitants. This can blur professional boundaries and raise ethical issues[61], but may also be a positive as it has been shown that when staff identify with a particular community and place it enhances a sense of belonging and commitment that can

enhance job satisfaction[62]. Coupled with the opportunity to develop a wide range of general nursing skills that might not be possible in urban health facilities[63], this has been used as a basis to recruit nurses in rural and remote locations[64].

This study found that a supportive work environment can attract individuals to the health professions, encourage staff to remain in the workforce, and enable them to perform effectively to positively influence the quality of care. This notion of 'support' can be translated into the potential actions discussed below, primarily aimed at senior administrators/managers, echoing some of the proposals in the *National Preventive Health Strategy 2021– 2030,* produced by the federal Department of Health[65,66].

Better understanding of the demands and challenges faced by RNMs would help determine how best they can be supported[67]. This may entail reviewing the tasks performed by RNMs within the context of improving health policies, funding, manpower allocation to rural health settings, and embracing strategies to support and upskill RNMs. Potential for reducing the tasks that RNMs perform should be reviewed if staffing, recruitment, and retention issues for rural health-care institutions are to be fully addressed.

Staff capacity and development programs should be considered in light of the multiplicity of tasks discussed above, which can contribute to stress and inevitably impacts on retention of RNMs. Targeted recruitment and retention strategies can ensure individual primary-care workers are an optimal fit in the communities in which they work, allied to improved professional and personal support for staff. In the medium and longer term these measures could reduce both costs and staff turnover[32] and they lie at the heart of the recent Australian government initiative, *The National Rural and Remote Nursing Generalist Framework 2023–2027*[68], which identifies opportunities to strengthen the rural and remote nursing workforce. However, further research is required on how the rural/remote nursing workforce can be supported to translate the Framework into practice[69], perhaps by extending the nurse practitioner scheme introduced in 2000 "to reduce pressure on the health system, address workforce shortages and improve rural populations' access to health care services"[70(p.1)]. Meanwhile, barriers to implementing and sustaining practitioner roles persist[71].

Staff development and capacity building programs are important to all nurses but especially for rural/remote nurses who shoulder multiple responsibilities. It is important that rural health organisations encourage RNMs to engage in ongoing staff development programs tailored to the rural locale and which are both management specific and accessible. The importance of staff development and mentoring programs tailored to the rural/remote workplace and individual needs should be a key strategy[72]. Support for the RNM role, with upskilling to improve functionality and efficiency, needs to be deliberate and continuous with ongoing workshops and on-the-job training programs for managers. However, it has been argued that concerted improvement to training of rural nurses is already evident through rural clinical schools and university rural health department programmes[73].

Hartung and Miller[74] recommended regular conversations, diverse messaging, and conferencing 'huddles' to improve information dissemination and workflow in rural health-care settings. This can enhance the dynamics of teamwork and organisational politics, extending RNMs' flexibility to respond to community needs. However, we acknowledge that rural health-care settings have limited monetary resources and inadequate professional support, so continuing or upskilling development programs in rural settings can be challenging.

Finally, resource allocations for rural health settings should be revisited. Models of funding, such as Estimated Resident Population by Remoteness, which determine funding based on the population size, need to address the changing demographics of aging rural/remote populations and the growing complex health conditions and care needs[75], including those of Indigenous groups. Greater understanding is needed of the dynamic issues impacting on service provision in rural-health settings. Models of funding for rural/remote areas need to align services with local needs. Provision my require novel approaches such as multi-purpose services now developed in parts of rural/remote Australia[76] or supporting a specific focus, such as extending nurse-led models of care in community health settings, which have been shown to produce benefits such as prevention and management of chronic disease[77], or developing strategies to improve the experiences of rural early career nursing[78].

Conclusions

Much of the current research on rural and remote nursing provides limited insight into the multifaceted nature of RNMs' roles and responsibilities that ultimately influence nurse managers' capacity. This paper sheds light on the varied and complex tasks undertaken by RNMs. The breadth and scope of these tasks are substantial and demanding but they are paramount to meeting nursing and organisational goals. RNMs are at the forefront of clinical and managerial activities. They contribute meaning, dynamism, and operational insights, making their leadership and guidance roles invaluable in the presence of limited resources and professional isolation. They are front-line personnel who are central to spearheading and carrying out clinical and managerial actions and decisions, and are therefore central to fostering change by creating a positive work environment for nurses and allied staff, and putting policies into action.

The nurse manager's position is pivotal to the efficient functioning of health institutions both in rural and metropolitan health settings. The coordination and delivery of nursing-care activities and supportive services from allied health care providers rest heavily on the shoulders of the nurse manager through the chain of command from the bedside nurse to the multidisciplinary team, which is often limited in numbers and scope in rural/remote settings. Without the nurse manager, care activities could be chaotic and result in failure of the organisation to maintain effective care delivery. Varying

issues such as complexities of cases, distance from a metropolitan hospital, and lack of availability of specialty services contribute to the role of RNMs being particularly stressful and managerially complex. However, the multiplicity of tasks is likely to increase, driven by a growing aging population, chronic and mental health conditions, emerging new diseases, and new modes of treatments, which are not easily accessible in rural areas. It is evident that the RNM's roles, both as clinician and manager, are demanding, and the activities carried out are often characterised as time-pressured and, consequently, this impacts on how the multiple tasks are carried out or balanced.

The research discussed in this paper raises awareness of the multiplicity of the tasks performed by RNMs, with a need for health-care leaders to be more empathetic, appreciative, and understanding of the position of the RNM and their roles and underpinning responsibilities, with the desired intention to encourage wider support for RNMs via review and developing changes to this position. A multiplicity of activities and combined roles does not increase efficiency but instead can contribute to stress and therefore the need to review its impact. Flexibility and balanced discussion can develop solutions to meet the organisational needs of health institutions while still acknowledging that nurses, and especially older nurses, are people with health needs too. The time has come when the 'martyr-like sacrifice' of nurses' own health is not a solution anymore[79].

Finally, it should be noted that this study is based on interviews with RNMs at only 15 health-care facilities in rural and remote South Australia at one point in time. While this is a small-scale investigation of RNMs, it highlighted clear understandings of RNMs regarding their roles and daily work experiences. Saturation regarding topics raised was reached, but a more comprehensive survey could reinforce and give additional nuance to these topics.

Conflicts Of Interest Statement

The authors have no relevant interests to disclose.

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