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Rural Nurses' Safeguarding Work

Reembodying Patient Safety

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Practice-based evidence includes research that is grounded in the everyshift experiences of rural nurses. This study utilized institutional ethnography to reembody the work of rural nurses and to explore how nurses' work experiences are socially organized. Registered nurses who work in small acute care hospitals were observed and interviewed about their work with the focus on their experiences of providing maternity care. The safeguarding work of rural nurses included anticipating problems and emergencies and being prepared; careful watching, surveillance, and vigilance; negotiating safety; being able to act in emergency situations; and mobilizing emergency transport systems. Increased attention to inquiry about safeguarding as an embodied nursing practice and the textual organization of the work of rural nurses is warranted. **Key words:** *institutional ethnography*, *nursing work*, *patient safety*, *rural nursing*, *safeguarding*

PRACTICE-BASED EVIDENCE includes research that is grounded in the everyshift experiences of rural nurses. This article begins from the embodied standpoint of rural nurses and their everyshift experiences with nursing work. It is the result of sustained research attention over a 4-year period (2005-2009) to rural nurses' experiences with providing maternity care. The nurses interviewed and/or observed in this study talked about caring for patients (including women and newborns) in ways that were orientated toward keeping patients safe. The goal of this article is to further explore the work of registered nurses (RNs) working in rural acute care hospitals with a focus on their "safeguarding" work. After reviewing the literature and describing the study, I will present some of the ways that nurses enacted their safeguarding work with particular attention to caring for childbearing women and their babies. The activities and practices of rural nurses will then be described with the goal of making visible some of the complexities of their work. I will draw upon 3 feminist inspired sociologists—Dorothy Smith, Marjorie DeVault, and Liza McCoy—to reembody current discourses that surround patient safety in the nursing and management literature. Finally, I will discuss how this beginning understanding of the safeguarding work of rural RNs presents an opening for further study into how rural nurses' experiences are organized through discourse and institutional work processes that permeate their immediate everyshift experiences.

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RURAL NURSING LITERATURE

Rural nurses have consistently reported that the complexity of their work is vastly underestimated.[1] Rural nurses work as "expert generalists" in both hospital and community settings.[2-4] Rural nursing has been described as different from nursing in urban and suburban settings because of geographic and social isolation, increased visibility within and social connections to their community, limited access to resources including continuing education, and varied and extended professional responsibilities or scope of practice.[5-8] Differences across the practices of rural nurses have also been identified, as these communities range from small geographically isolated towns to remote nursing stations.[9] Rural nursing work is grounded in knowing the people living in these small communities, their health needs, and available resources.[10,11] Rural nurses care for their neighbors, their friends, and sometimes their family members in a setting where "everyone knows everyone."[12]

The work of RNs in small acute care hospitals has been described as a form of "multispecialist" practice.[13] In addition to excellent health assessment and triage skills, rural nurses need to be able to provide care for older persons, for childbearing women and their families, for people injured in accidents, and for people with mental health challenges and addictions. Rural nurses provide maternity care, critical care, emergency care and stabilization before transfer, chronic disease management, wound care, and palliative care and are held to the same standards of care established for specialty nursing.[14] Rural nurses also do the work of other professionals (eg, physicians, pharmacists, or physiotherapists) and nonprofessionals (such as housekeepers) particularly on weekends and during the night shift when these other workers are not available at the hospital.[14,15] The experiences of rural hospital RNs with professionalism has been described in terms of the interactions with the community and the workplace.[16]

This article is built upon 2 related studies that explored the experiences of rural nurses with providing maternity care in a Canadian setting. The rural nurses who participated in these studies were proud of the work they do and revealed this passion, commitment, and creativity in their everyday work activities. They also described feeling more visible and (perhaps more) responsible for the people living in their communities.[10]

Maternity care was particularly troubling for these rural nurses. Nurses shared, "we don't take any chances where babies are concerned." They noted that "bad obstetrical outcomes" (baby deaths) had resulted in some nurses and other health care providers leaving their rural communities.[17] In the hospital setting, rural RNs reported that they never knew when a maternity patient might "walk in," sometimes did not feel adequately prepared for their work of caring for childbearing women and their families, and provided care for women during labor and birth while at the same time being responsible for the safety of all the patients in their small rural hospital.[10,17] The social organization of rural nurses' experiences of continuing professional education has been reported elsewhere.[17]

THE STUDY: RURAL NURSES' EXPERIENCES WITH THE PROVISION OF MATERNITY CARE

The purpose of the study reported here was to explore the nature and social organization of rural nurses' work of providing maternity care. Specific objectives included (1) describing the work that rural nurses do when providing maternity care in rural/remote settings; (2) exploring how interactions with women, health care providers, administrators, and the rural community influence nursing work in rural settings; (3) identifying the institutional structures, resources, and textually mediated work processes that affect nursing work; and (4) identifying possibilities for change at the local and institutional level that would better

support rural nurses in their work. This study was guided by institutional ethnography (IE), an approach to inquiry developed by Dorothy Smith, a Canadian sociologist.[18–20]

This article provides a detailed exploration of the safeguarding activities that rural nurses described when sharing chronological accounts of what they do everyday and reflecting on what it was like for them to provide maternity care in a small rural hospital. Here "work" is taken up without preconceived ideas about professional nursing; focusing instead on what nurses do and the knowledge, skill, and discourses they draw upon in their everyday work practices.[20,21]

INSTITUTIONAL ETHNOGRAPHY

Dorothy Smith drew upon Marxist materialist method and Foucault's writings on discourse to develop an approach to inquiry that focuses on textual forms that replicate discourse, and the power relations that underpin discourse, over separations of space and time.[22] Institutional ethnography is a theoretically informed approach that draws on ethnographic methods and traces or maps out the social and institutional determinants of experience. Institutional ethnography utilizes 3 powerful tools for analysis: ethnomethodology, Marxist attention to historical and material social locations, and poststructural attention to textual processes.[23] Institutional ethnography is oriented to uncovering oppressive power relations and "the researcher's purpose in an IE investigation is not to generalize about a group of people interviewed, but to find and describe social processes that have generalizing effects."[21(p18)]

Marjorie DeVault[24] has studied women's work in a variety of settings including the work of feeding the family. She described talking and listening from women's standpoint suggesting feminist strategies for interviewing and analysis.[23] She utilizes IE as a way to shift the focus of study from the women themselves (a sociology of women) toward a mode of inquiry that explores "how it happens" or how local practices and experiences are tied into extended chains of action "many of which are mediated by documentary forms of knowledge."[21(p19)]

Liza McCoy described a 2-step process for conducting an institutional ethnographic investigation. The first step is to "make the researcher acquainted with the work and concerns of some group of people"[25(p123)] in this case rural nurses. The second very important step is to "move the investigation into the sites and processes of the institution."[(p123)] For McCoy, "work" is an "orienting concept" that directs the researcher's attention to the "interface between embodied individuals and institutional relations.[(p110)]

The integrity of an institutional ethnographic study is enhanced by keeping the researcher visible within the research process and by not generalizing about experience.[20,23] "The project of inquiry from the standpoint of women is always reflexive . . . it is always about ourselves as inquirers—not just our personal selves but our selves as participants."[26(p94)] Reflecting on the researcher's contributions to the research process is important for the trustworthiness of an IE investigation. Results are not intended to represent generalizations about experience but rather to recognize that because people are always embodied, experiences vary across social locations. Institutional ethnography provides a way to learn about how our various experiences as women and nurses are organized by things outside of our everyday/every night experiences. Institutional discourse and practices may be generalizing and can affect the experiences of nurses in more than one setting of practice.

THE RESEARCH SETTING

This study was conducted in one geographically large and relatively isolated eastern region of British Columbia (Canada's most western province). The working definition of "rural" used for this study was communities of less than 10,000 people living outside

a 1 hour commuting distance of an urban centre.[27] This health area had a total population of approximated 56,000 people spread over more than 27,000 km^2 (population density of 2.0 per square kilometer).[28] Forestry, mining, tourism, service, and transportation were the main industries with some farming and ranching.[28] The only city in the region was Cranbrook, a geographically isolated town with a population of approximately 18,000 people,[29] The regional hospital in Cranbrook provided some medical and surgical specialty services (including obstetrics) for many patients from the health service area.[30]

Being located in the mountains posed considerable challenges to air and road transport particularly during the winter months when the mountain passes could be closed and air transport limited by visibility and weather conditions. The closest large urban center to the region studied was Calgary; located on the other side of the Rocky Mountains (about a 3 to 4 hour drive under good road conditions) and in the neighboring province of Alberta.

The 4 rural acute care hospitals in the health area ranged in size from 8 acute care beds (co-located with residential or long-term care services) to 20 acute care beds. Over a 5-year period (April 2003-March 2008), the average number of births per year in these rural hospitals ranged from 26 to 94.[31] Emergency and inpatient acute care services were also provided by nurses working in these small rural hospitals.

PARTICIPANTS: A PANEL OF EXPERT INFORMANTS

For this investigation, rural nurses constituted a *panel of expert informants* about their daily activities, and the research was undertaken collaboratively with the nurse participants. Thirty registered nurses who worked in the 4 rural acute care hospitals described earlier participated in this study. The work experience of the rural RNs ranged from new graduate (n = 12) to nurses with more than 30 years experience. Most nurse informants were diploma prepared and had been working as a nurse for more than 15 years. Rural nurses provided feedback on the early descriptions of their work (confirmed the initial findings) and helped identify areas for further investigation. More detailed information about the larger study, and the participants has been published elsewhere.[10,17]

Investigative and analytic methods

Ethical approval for conducting the study was obtained from the university and from the health authority where this study was conducted. Investigative methods included observations of nurses as they went about their routine work, interviews with nurses, other health care providers and front-line managers, and the collection and analysis of texts that the nurses used or referred to during their work and/or interviews.

Analysis in an IE investigation begins with embodied experience. "Through informant's stories and descriptions the researcher begins to identify some of the translocal relations, discourses, and institutional work processes that are shaping the informant's everyday work."[21(p21)] Marjorie DeVault and Liza McCoy note that some IE researchers can spend considerable time trying to understand the complexities of peoples' experiences. Questions addressed in this analysis included: what is the work, what knowledge and skill are required, and what does it feel like to do this work?[25]

Rural nurses' safeguarding work

Rural hospital RNs who participated in this study suggested that much of their work focused on anticipating problems and protecting patients. The goal in this analysis is to make visible aspects of their everyday/everyshift work that are not fully described in the nursing literature. Although the primary focus of the larger study was on the experiences of rural nurses with the provision of maternity care, the generalist nature

of rural nursing work provided many opportunities to observe their practices more broadly. Rural nurses' safeguarding work included the following: anticipating problems and emergencies and being prepared; careful watching, surveillance, or vigilance; negotiating safety; being able to act in emergency situations; and mobilizing emergency transport systems. Rural nurses also described advocating for local health services and safe health care environments.[32]

Anticipating problems and emergencies and being prepared

This form of work included having things set-up in advance and being ready for who might "walk in the door" or who might "present" in the emergency department.

> And it's rough because you can go from anywhere on the floor. Well, today's not bad. Yesterday we had a lot of old people, very complex . . . To a maternity walking in and having a precipitous delivery or bleeding or any kind of complications. [RN]

This nurse went on to describe the kind of preparatory work that was also required when accompanying a patient (in this situation, a maternity patient) in the ambulance during a transfer to the regional hospital.

> I was orientating one of the RNs and she was extra and you know what? The mat [maternity patient] had to go out. She was a multip (multiparous), it was her third baby. And I said, "you know, when I go out I take everything with me. So we're going to get the epinephrine drawn up, we're going to take all our tools with us. And we get the Narcan, whatever we need, we take it all, we draw it all up." Would you believe it, she delivered in the back of the ambulance, the babe was flat and she had a postpartum hemorrhage. I mean, talk about needing to be prepared. So we had all the stuff ready . . . So, *anything can happen*. [RN]

Rural nurses also described knowing the hospital, so being prepared also meant knowing what was happening in emergency, whether or not an ambulance was available and knowing how (and how long it takes) to mobilize local resources such as the laboratory or surgical team (if available).

Careful watching, surveillance, or vigilance

Rural nurses described watching carefully for early signs that something was going wrong, particularly when a transfer to a higher level of care might be necessary. Some nurses described sensing that "something was wrong" in an almost intuitive, yet highly skilled way. Here an RN described a recent situation where she identified a developing problem early . . .

> She's been having headaches. Her pressure was up the last time she was in, she's in an abusive relationship, she has a history of crack cocaine, and smoking marijuana. She came in with the epigastric pain and her pressure was okay, it was 128 on 85, something like that, but it wasn't terrible. When I phoned the physician . . . no contractions, no nothing, but when I . . . oh, and she had been vomiting . . . [RN].

What stands out in the aforementioned description is that this nurse has identified a serious problem (preeclampsia or pregnancy-induced hypertension) that was still in the early stages of developing. Her description provides many clues to the informed reader about the seriousness of her concerns but the way she has articulated her concerns might not be that obvious to a physician who was awakened in the middle of the night by the nurse's phone call. This nurse went on to describe calling the woman's physician to come to the hospital to assess this young woman.

Negotiating safety

This leads us to the discussion of the nurses' work of notifying and getting action from the patient's primary care provider, usually a physician. Continuing with the situation described earlier, the following excerpt demonstrates how the nurse tried to advocate on behalf of this particular women.

> And I told him, "I really think she's sick."... And he said, "Did you want to do blood work? Well, you're just going to do it anyway, aren't you?" And I said, "Exactly". So, sure enough they [blood enzymes] came back elevated, so I phoned him back, and said, "Do you want to come in and assess her?" And

he . . . it was sort of like pulling teeth. And that was a safety issue for me because he . . . And *he never did come in*. And you know, when I went to the patient she said, "Well if I'm not bad enough for him to come in then I'll just come back tomorrow." And she did go. And I came back my next shift and she was being flown to [urban hospital] for an emergency transport. [RN]

The example illustrates that the nurses were not always successful in their attempts to mobilize medical assistance with the goal of ensuring patient safety. Several rural nurses said that advocating on behalf of patients was much harder for new or for less experienced RNs. They also described situations where some physicians resented the interference of the nurses and they sometimes had to find subtle ways to coach the physician who lacks experience and/or patience. This kind of "work around" suggests ongoing power differentials between nurses and physicians and is particularly disturbing in a small rural center, where good working relationships are essential for patient safety. In larger centers, early warning protocols and rapid response teams have been established to respond to situations where the nurse is unable to negotiate a timely response from the primary care provider.[32]

Being able to act in emergency situations

Because nurses staff rural hospitals (notice here that "staff" is a verb not a noun) around the clock and are frequently the only health care provider on site in the middle of the night and on holidays or weekends, the safeguarding work of rural RNs also included being able to act skillfully in emergency situations. For maternity care, this work also included being able to safely assist the woman during childbirth and deliver the baby in situations where there was no physician or midwife* available in the hospital. Recognizing that bad road conditions or conflicting priorities for care might influence the ability of physicians and midwives to attend a rapidly evolving birth situation, it would seem reasonable for rural nurses to receive additional education and opportunities to practice the skill of assisting with childbirth (delivery) so that they are able to competently and safely care for women living in their rural communities. Removing this skill from the normal scope of nursing practice has implications for nurses working in small rural hospitals, including those hospitals where maternity services are no longer provided and this usually normal situation becomes a local "emergency."

The skills needed when helping women give birth has recently received more attention from the provincial nursing regulatory body, and competencies and decision support tools are now available to assist rural nurses "if the primary maternal care provider is absent."[33] Although rural nurses participated in the development of this useful document, which includes information about what to do in specific maternity care situations, the document is constructed in ways that do not recognize rural nurses as a "primary care provider" for childbearing women when they come to the hospital for assistance. In many of these rural hospital settings, the nurse is the primary care provider who is always immediately available. Something interesting about negotiated power relationships is embedded in the text of this important document, which makes rural nurses' fairly common embodied work of delivering the baby invisible. Further analysis of this document is, unfortunately, beyond the scope of this article.

The work of rural RNs also included being able to stabilize and care for patients (sometimes including preterm or sick newborns) until the transport team or air ambulance arrived from Vancouver or Calgary.† Some descriptions of this work included highly

*In Canada midwives are community-based practitioners and are not employed by hospitals.

†At the time of our study, perinatal and neonatal care was being reorganized with a central hub in Vancouver at BC Women's Hospital. Routine transports to Calgary were no longer supported.

sophisticated neonatal resuscitation skills, for example, including umbilical artery catheter insertion in some settings. Rural nurses described "needing to depend on ourselves" and also the importance of working in interprofessional teams where the nurses and physicians learn to trust each other.

> And the doctors who act as the pediatrician, there's always somebody on call, they are very good. But they will rely on the nurses and say, "What do you think? What should we do?" Because some nurses have lots of experience (dealing with sick newborns). [RN]

In addition to biomedical and nursing knowledge, rural nurses also needed detailed/contextual knowledge about their local community (resources, people, and equipment). Some of this contextual knowledge has been described elsewhere[10] and includes knowledge of the people who work in their rural community. In relation to the safeguarding work of nurses, this knowledge included understanding the knowledge, skills and attitudes of physicians, other nurses, and other health care providers such as surgical and ambulance staff, and their availability and ability to respond quickly to provide safe care.

Rural nurses need excellent assessment skills because they are responsible for anticipating and recognizing problems so that they can be dealt with early so that poor outcomes can be prevented. They also need to know how to mobilize local resources (including medical care) and how to act independently stabilizing patients until additional help arrives.

Mobilizing emergency transport systems

Rural nurses also needed detailed knowledge about how to mobilize emergency transport systems. Registered nurses reported that mobilizing maternal and neonatal transport entailed considerable work for nurses and physicians and was more difficult than mobilizing help for other medical emergencies. They described this process as complex and time consuming.

> The two things that . . . one that's frightening and frustrating is that when we've got high risk moms that we want to transfer out, it's a *huge amount of phone calls and time and politics* and everything else to *get these women out*. And so therefore, sometimes they deliver here, where we have no pediatrician, we've got a high-risk, preterm infant. We have to look after these high-risk babies, but it is very frightening, having these little babies, these preterm or sick babies born here. And sometimes we can't, you know, we just don't have time to get them out. The mother comes in and delivers, or she has an abruption and delivers. [RN]

Rural nurses also described how their knowledge about the weather and local road conditions influenced decisions about the timing of transfers saying that it was important to get the person to the next level of care "before things go south" and avoid having to provide emergency care in the ambulance (eg, preterm twin delivery). Registered nurses expressed other concerns about the provincial transport system because people utilizing ambulance transport services were also charged a fee (more than $350) for this service even when the required health service was not available in their local health region (such as neonatal intensive care). They also identified the local effects when skilled nursing and/or medical staff were required to accompany people in the ambulance and noted that it affected their ability to maintain safe staffing levels at their local hospital.

Rural nurses found it particularly difficult when they initiated ambulance transport early (to avoid a preterm birth on the road) only to be criticized by staff working at the regional or receiving hospital when the woman's labor slowed down or stopped on route. Although screening for fetal fibronectin (fFN) in vaginal secretions can sometimes be helpful, preterm birth remains very difficult to predict.[34] The safeguarding work of rural nurses, when performed expertly, will still result in some "unnecessary" transfers. Rural nurses recognized the stress that "transferring out" caused women and families but justified

this work in terms of being extra cautious where the health of babies was concerned.

Rural RNs also stressed the importance of knowing their own limits and appreciated working with health care providers who knew when to consult or ask for help as important considerations for their safeguarding work. New or less experienced nurses identified that sometimes it was difficult to "know what you don't know" and were particularly concerned about lacking mentorship when providing maternity care.[17]

Part of the safeguarding work of rural nurses was having detailed local knowledge of the context of care and particularly knowing about factors that influence timely and safe emergency care and/or transport. Maternity care was described as particularly stressful because of its unpredictability in a rural hospital context, where a wide range of issues were already underway at any given moment when "a maternity" arrives at the hospital. Rural nurses working in the hospital setting also described their concerns about having insufficient numbers of skilled nursing staff to identify developing concerns early, anticipate and be prepared for emergencies, mobilize other health care providers and the emergency transport system, and be able to act skillfully in emergency situations.

In this analysis, I have described how rural nurses enact their commitment to the people who live in their communities through their embodied work of keeping their patients safe. This analysis draws our attention to how a skilled, committed professional nurse enacts her responsibility to her patients through a form of work that I have called "safeguarding."

DISCUSSION: REEMBODYING PATIENT SAFETY

As each rural community has a unique set of challenges and resources, it is sometimes difficult to tease out in these descriptions how much the local setting for nursing work (in this case in small rural communities) influences the work described. I suspect that some nurses working in larger urban and suburban settings may also recognize their safeguarding work in these descriptions. However, the context for rural nursing work (small hospital settings with fewer resources including nurses available at any one time) may make the nurses' work of safeguarding more visible.

Over the last decade, there has been an exponential growth in the patient safety literature.[35] Much current patient safety discourse constructs potential harms to the patient as something that can be efficiently managed.

Patient safety is the reduction/elimination of adverse events that are caused by medical/nursing errors. As a concept, patient safety does not support blaming the erroneous practitioner, but rather emphasizes a review of the entire health care system to better appreciate the systemic factors that result in harm.[36(p31)] Current patient safety discourse focuses on managing complex health systems and shifts our attention away from supporting nurses and their work.[36,37]

In this article, I have described how rural nurses enact their commitment to the people who live in their communities through their work of safeguarding their patients. What is interesting about the current patient safety discourse is how the nurse, as a source of "medical/nursing errors,"[36] is constructed as a source of danger or potential harm and as part of the problem to be managed. I am not disputing here the importance of preventing medication or treatment errors that result when an overworked, overtired, or underprepared nurse provides complex medical treatments in complex health care environments or, as in rural settings, in situations with little backup or support. Rather, this analysis draws our attention to how a skilled, committed professional nurse enacts her responsibility to her patients through a form of work that I have called "safeguarding." This analysis also provides an opening to further explore how this safeguarding work is organized by textual practices that are beyond her/their everyshift

experiences. Rural nurses' work of safeguarding gets lost in a larger patient safety discourse that focuses on developing high performance teams working in large urban environments.[37]

Dorothy Smith, 26, describes a woman's standpoint, not as a general attribute of women, but as a common mode of experience. Taking up a nurse's (frequently a woman's) standpoint as a place to begin inquiry locates the knower in her body in a lived world and helps avoid the theory/practice split.

Standpoint as the design of a subject position in IE creates a point of entry into discovering the social that does not subordinate the knowing subject to objectified forms of knowledge of society or political economy. It is a method of inquiry that works from the actualities of people's everyday lives and experience to discover the social as it extends beyond experience.[20(p10)]

For Smith, there is no experience that is not structured by discourse and the social, historical, and political contexts of our lives. Smith conceives of the social as existing in, and only in, actual people's activities and practices, which shifts the ontologic ground for inquiry. Understanding social relations as the coordinated activities of actual people provides an opening for inquiry, as social practices are observable in people's work or purposive activity. Because nursing is largely a social practice, IE has relevance for nursing inquiry and for the development of practice-based evidence.

Unlike predominant discourses of "patient safety," a review of the CINAHL database revealed that "safeguarding" has received little attention in the nursing literature other than in the United Kingdom, where safeguarding legislation was introduced in 2006 to protect vulnerable people (particularly children and frail seniors) from abusive caregivers.[38,39] One notable exception is a paper written by Francine Wynn who explored the possibilities of nursing as "embodied cultivating safeguarding."[40(p36)] Drawing on Heidegger's questioning of the regime of "technicity," she suggests:

> The current emphasis on measurement, protocols, and standardization of practice within nursing, as a means of keeping patients safe, can be seen as a striking example of the pervasiveness of technicity's claim on us. It is assumed that standardizing and ordering nursing actions will control patient safety. As a consequence nursing care increasingly becomes a series of structured processes in which data elements are identified, time frames are established, and outcomes are determined in advance of the interaction between the nurse and the patient.[41(p36)]

Wynn's thought-provoking reflections and the analysis presented in this article raise the following questions or areas for further study. How does working in a rural hospital with little backup and with few resources immediately at hand, influence nurses' safeguarding work and patient safety? How can the nurse's work of anticipating problems, being prepared, careful watching, negotiating safety, skillful action and mobilizing emergency systems be supported? It is people (nurses and other health care providers) who do the work of keeping people (including women and their babies) safe. How can we keep embodied nurses and their work active and visible within our health care institutions and our conversations about patient safety? What happens when nurses become part of the problem rather than being recognized as having an important role to play in keeping patients safe within the hospital environment? What other texts organize the safeguarding work of rural RNs? Increased attention to inquiry about safeguarding as a nursing practice would seem warranted.

CONCLUSIONS

The social organization of rural nurses' safeguarding work

Rural acute care nurses' embodied safeguarding work has been described including anticipating problems and emergencies and being prepared; careful watching, surveillance, and vigilance; negotiating safety; being able to act in emergency situations; and

mobilizing emergency transport systems. Rural nurses also shared many examples where they felt compelled to advocate for safe health care environments. Their work of ensuring that skilled health care providers (primarily nurses) are always available at their local hospital also requires further consideration or study.[32]

Beginning inquiry from the embodied experiences of rural nurses makes visible some of the complexities of this work. This analysis draws our attention to how a highly skilled, committed rural nurse enacts her responsibility to her patients through a form of work that I/we have called "safeguarding." It also provides an opening for further research about how the nurses' work is organized by textual practices that are beyond her/their everyshift experiences. Inquiry about safeguarding as a nursing practice or activity and further exploration of the discourses and institutional work processes that organize the safeguarding work of rural RNs would seem warranted.

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