Factors influencing nurses' intentions to leave adult critical care areas-A mixed method study

Nadeem Khan, part time PhD student & Professional Development Nurse (Adult Critical Care, Oxford University Hospitals NHSFT) and Oxford Brookes University

Supervisory team
Dr Helen Walthall (DOS)
Dr Louise Stayt
Prof Debra Jackson

Oxford Institute of Nursing, Midwifery & Allied Health Research

research • patient care • education

Oxford University Hospitals NHS
NHS Foundation Trust

Oxford Institute of Nursing, Midwifery & Allied Health Research
research • patient care • education

Background

OXFORD BROOKES UNIVERSITY

High turnover and the shortages of specialist nurses has been an ongoing issue

Local, national and international issue

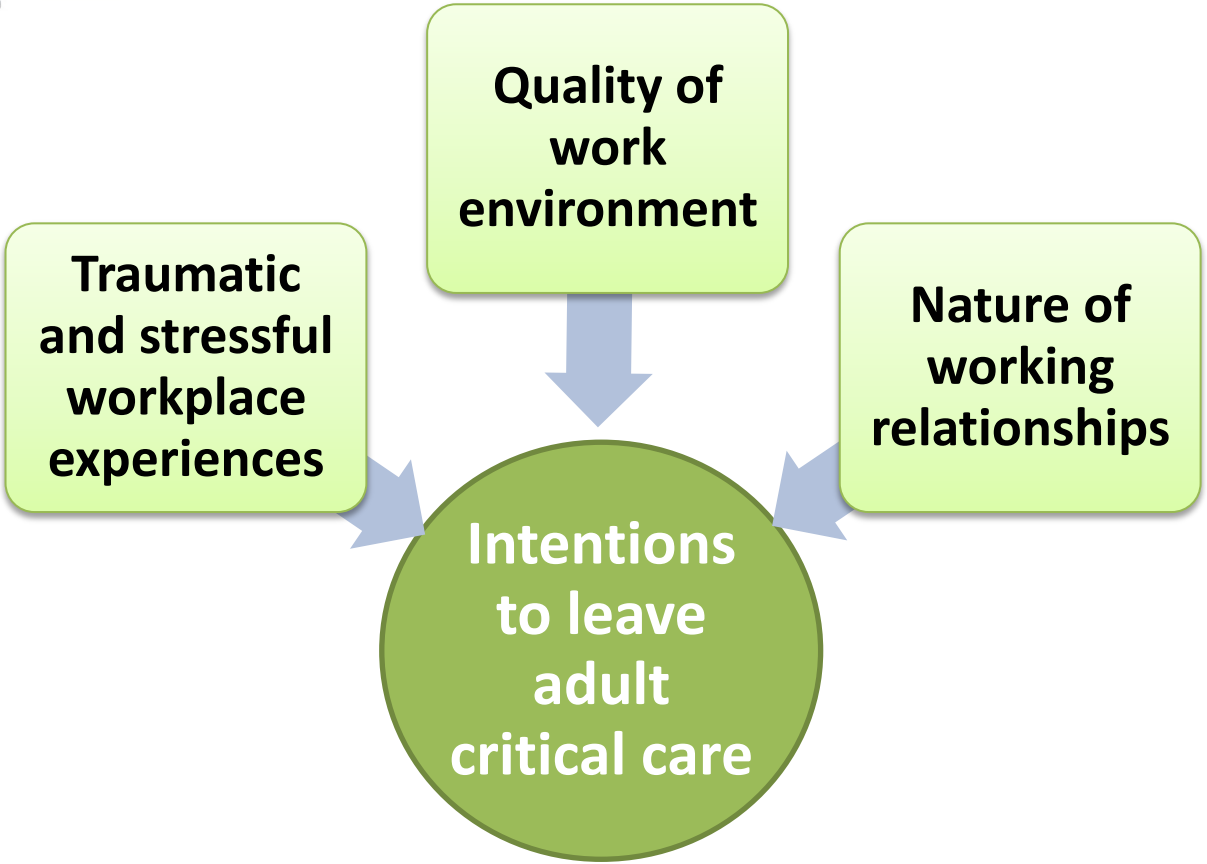
Financial implications

Impacts on staff morale, productivity, patient safety and quality patient outcomes

Gap in current/previous research

(Sawatazky et al 2015, Lu *et al* 2012, Hauck *et al* 2011 and Cortese 2012)

Results-lit rev



Khan N, Jackson D, Stayt L and Walthall H (2018) Factors influencing nurses' intentions to leave adult critical care settings. *Nursing in critical care*

Sequential mixed method study

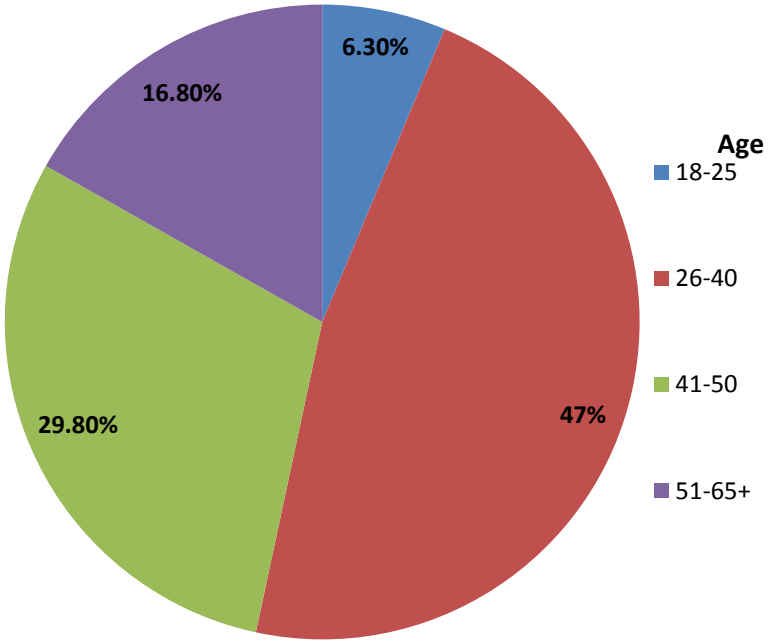
Phase 1

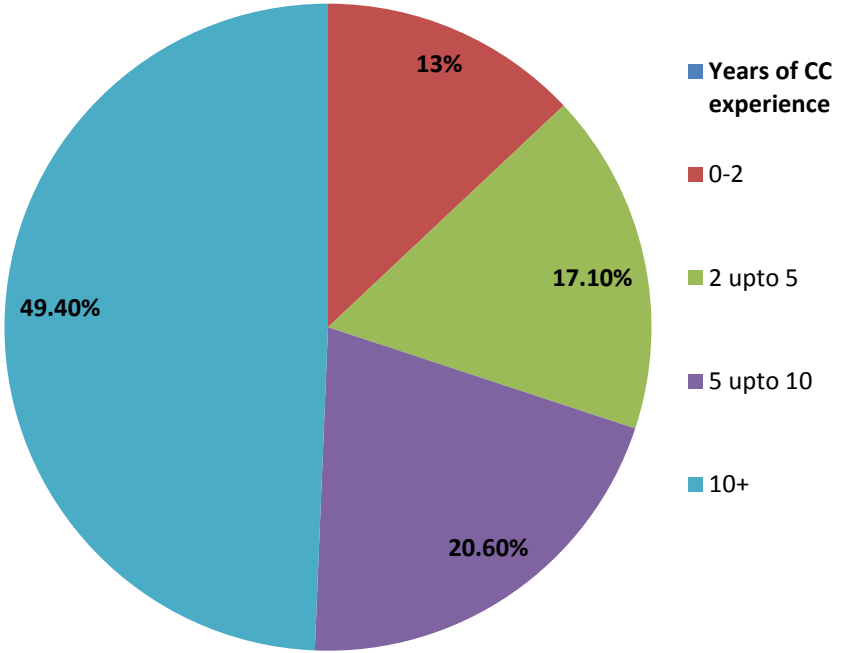
- Surveys

Phase 2

- In depth telephone interviews

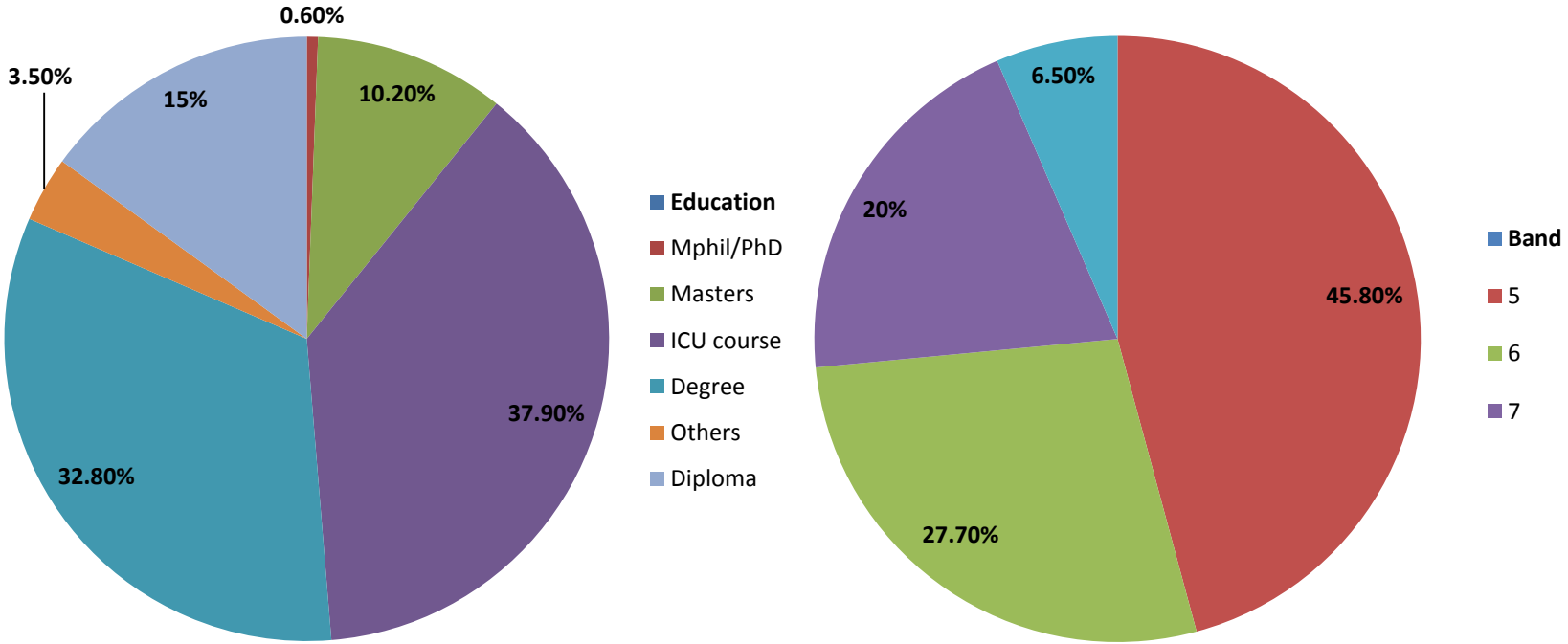
Survey responses-Demographics





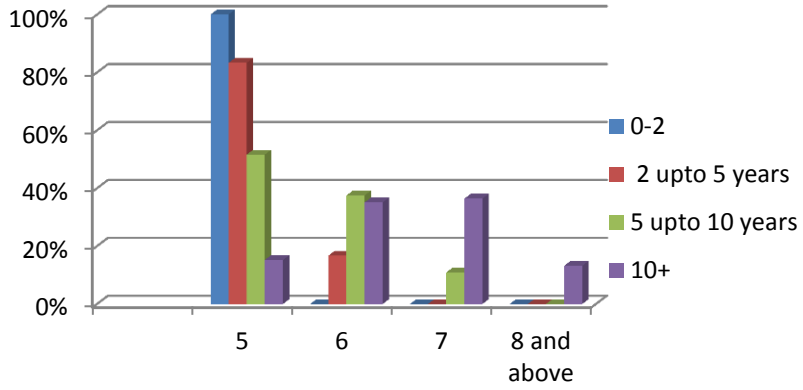
Demographics Cont……

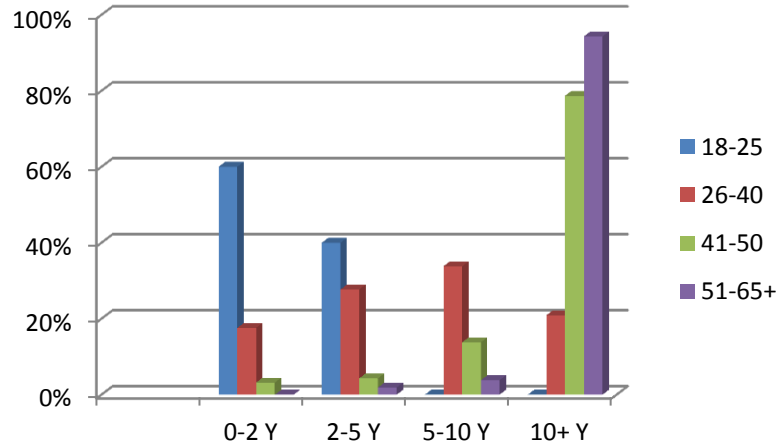
OXFORD BROOKES UNIVERSITY

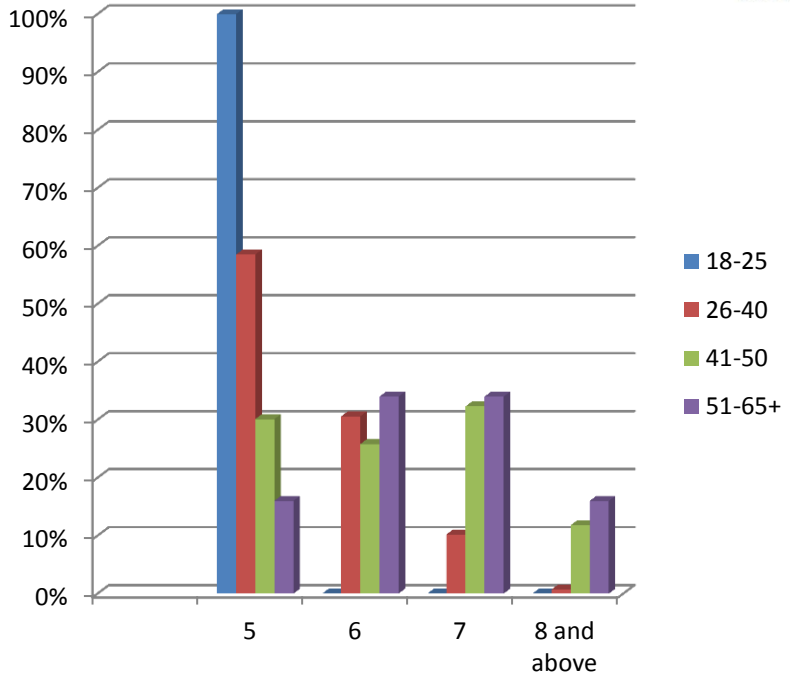


Demographics Cont…….

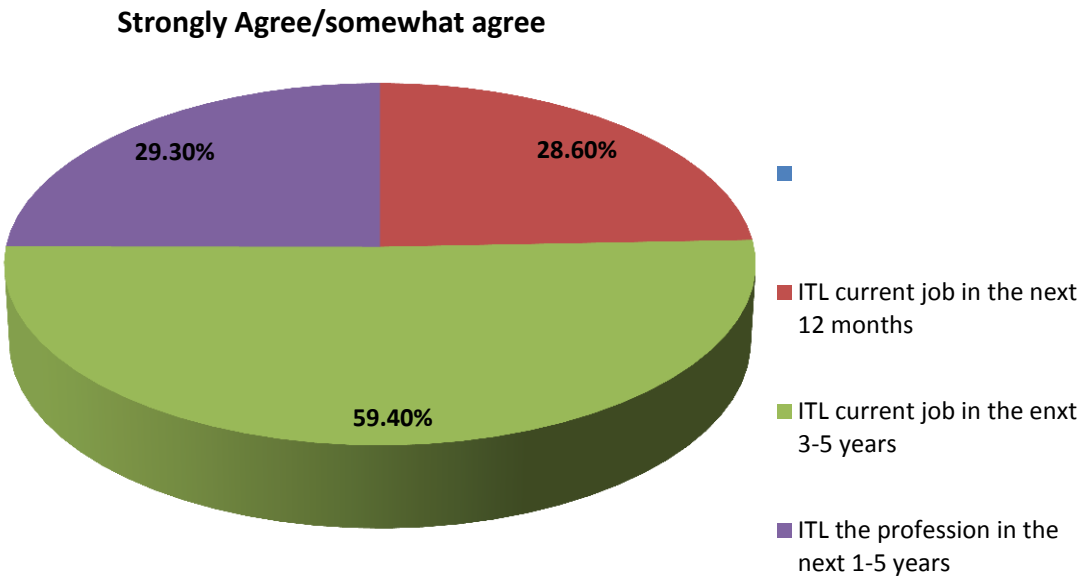
OXFORD BROOKES UNIVERSITY



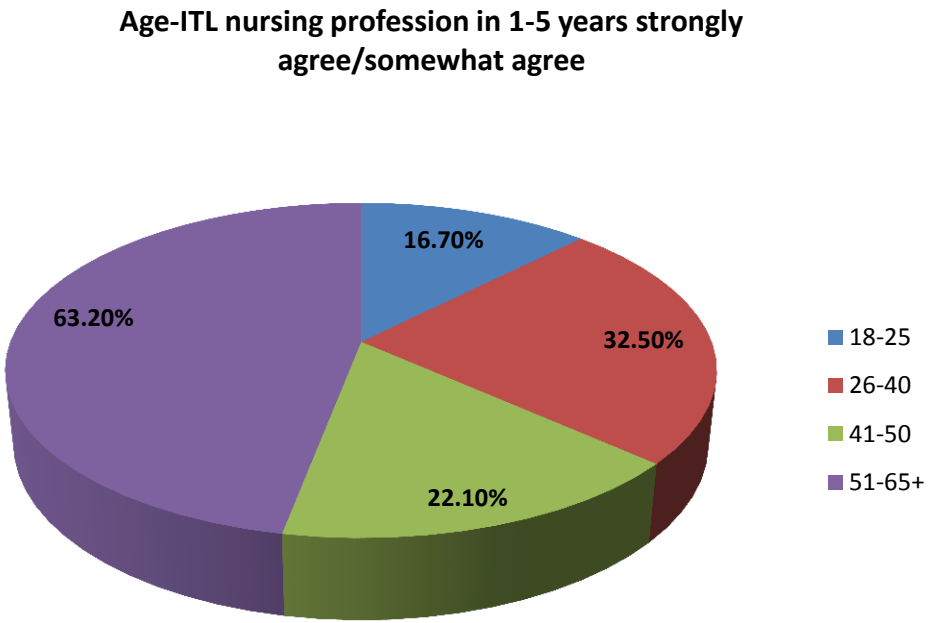




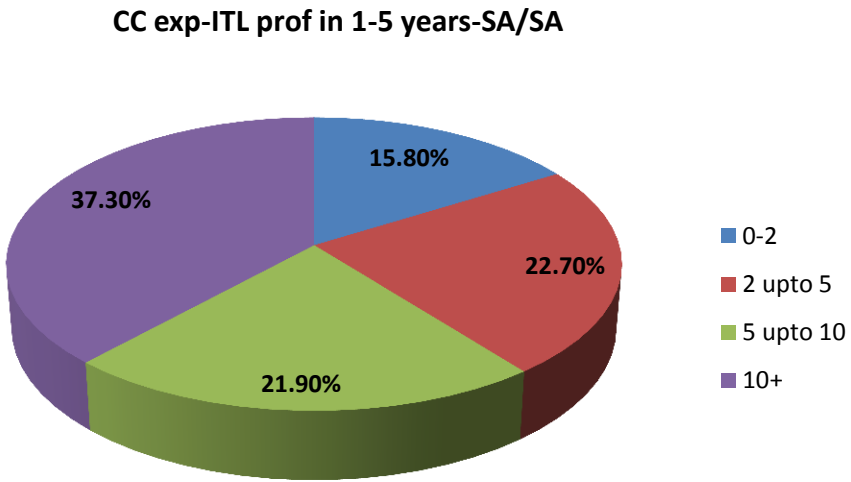
Intentions to leave



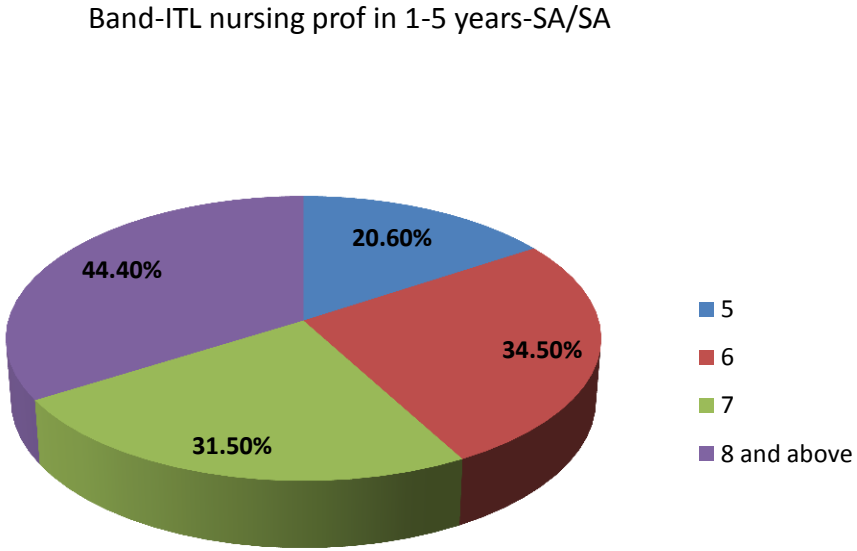
Demographics and ITL



Demographics and ITL



Demographics and ITL



Demographics and ITL

Chi Square test-P values

Age and ITL nursing prof in 1-5 years- <0.001

CC Exp and ITL nursing prof in 1-5 years -0.009

Band & ITL nursing prof in 1-5 years 0.012

Factor analysis

Four sub scales

Autonomy

Working environment

Relationships

Professional development

T-Test

OXFORD BROOKES UNIVERSITY

All 4 sub scale were found to be highly significantly Associated with ITL in the three categories;

- ITL current job in 12 months
- ITL current job in 3-5 years
- ITL nursing profession in 1-5 years

ITL current job in 12 months	
Autonomy	<0.001
Working environment	<0.001
Relationships	<0.001
Professional development	<0.001
ITL current job in 3-5 years	
Autonomy	<0.001
Working environment	<0.001
Relationships	<0.001
Professional development	<0.016
ITL nursing prof in1-5 years	
Autonomy	<0.001
Working environment	<0.001
Relationships	<0.001
Professional development	<0.002

Logistic Regression analysis

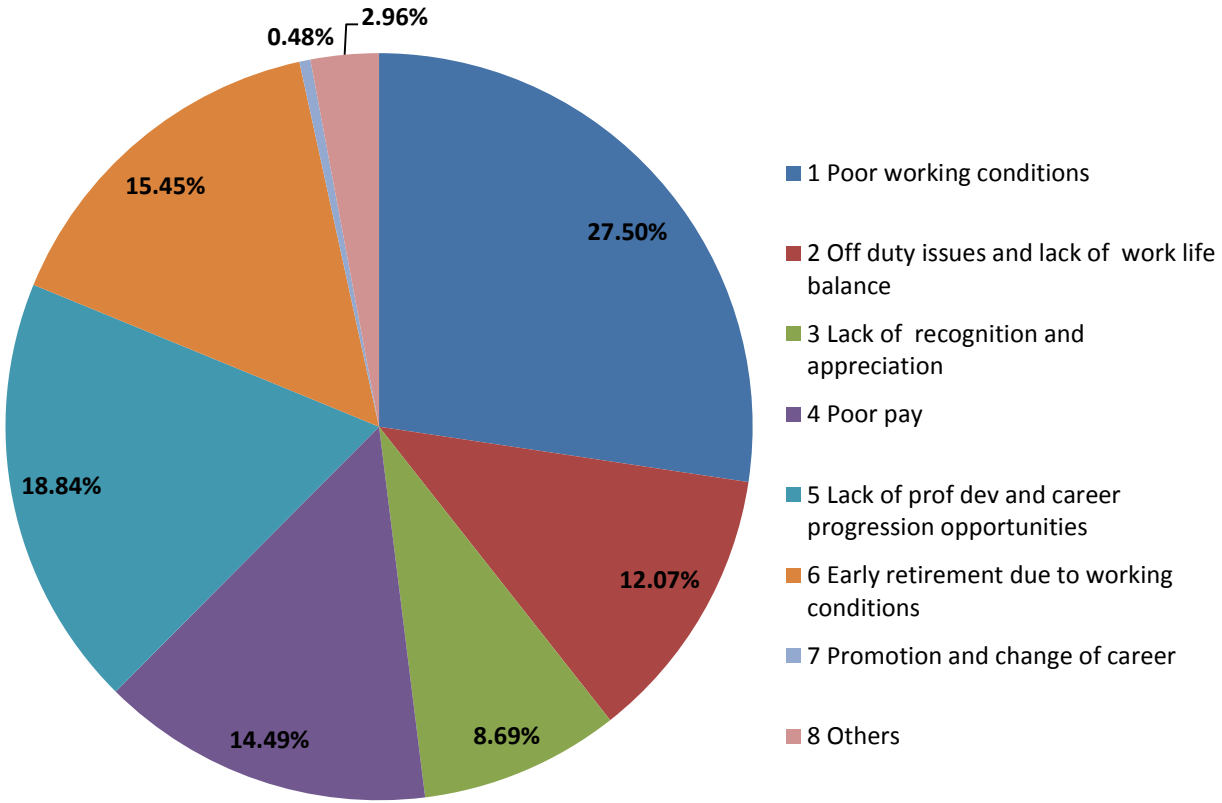
OXFORD BROOKES UNIVERSITY

ITL current job-12 M	P V	OR	95% C.I	
			Lower	Upper
Working environment	**<0.001**	**0.353**	0.193	0.646
Relationships	**0.049**	0.484	0.235	0.996
Constant	< 0.001	57.611		

ITL current job-3-5 Y	PV	OR	95% C.I	
			Lower	Upper
Autonomy	**<0.001**	**0.361**	0.216	0.604
Age	0.009			
Age(1)	0.978	1.017	0.299	3.459
Age(2)	0.082	0.52	0.249	1.086
Age(3)	0.003	0.3	0.137	0.655

ITL N Prof-1-5 Y	PV	OR	95% C.I	
			Lower	Upper
Autonomy	**<0.001**	**0.27**	0.151	0.482
Age	<0.001			
Age(1)	0.002	0.11	0.027	0.45
Age(2)	<0.001	0.135	0.064	0.286
Age(3)	<0.001	0.148	0.065	0.334
Constant	<0.001	71.14		

Content analysis



Qualitative interviews-Recommendations

OXFORD BROOKES UNIVERSITY

Providing support to enhance wellbeing

Supporting on-going education and development

Recognising and appreciating specialist knowledge and skills

Enabling multiple pathways into nursing

Increasing autonomy and shared decision making

Revolutionising model of care delivery

Quotes from the interviews

Part 6: I think there should be better pay for critical care nurses. We are more like mini doctors and I know there is lots of research been done on that over the years, maxi nurse versus mini doctor but that is definitely – we do a lot of the extended roles as a nurse and you make a lot of really important decisions, and you're very active in decision making for patients, yes, so I do think that but I don't think the government would ever get behind it. I hope I'm wrong. I think after 12 months or 2 years in ITU you should become a Band 6 automatically.

Part 1: Am… it was initially when I started, it was some of the staff were very kind of, some of the senior staff were very knowledgeable but bully, and oh there was one very bad bully. It was awful, you know the unit didn't have a good reputation around, because of, you know a few people that worked here. Am… I did learn a lot from them but they were just not nice people to work for!!!

Part 2: Well, if I was the government, getting rid of the pay cut, and a nice pay rise, that would be number one, and I think what the staff wants more than anything is training, and access to training and access to development. so I think if the ward were allocated CPD funding like the Doctors get , when you look at the study leave allocation for the medical profession compare to the nursing profession. it is far it is, its huge and I think that is one of the biggest thing and when you speak to staff apart from having a good work life balance with your roster, they want to be developed, they want to learn, they want to be taught, they want access to training.

Part 10: I think mainly, it's all about support, especially if someone's new, it's a very stressful and draining time. So as much support as we can give them, sort of from the nurse in charge, from, you know, other colleagues and things like that. And then passed that supernumerary period as well, keep continuing with the support and try and make sort of the, you know, the education, to build up their knowledge and their training so they feel more confident and that sort of thing.

Part 10: I think it's going to be difficult to increase and improve your workforce if the previous stages aren't there. So, you know, we have to increase our nursing numbers, we have to value them when they are in the post and offer promotions when they're appropriate. I think that, unfortunately, the way things are going, we'll probably be replaced by robots in twenty years, to be honest. You're always going to get patients coming to A&E too late because they can't get, actually deteriorated over the following forty eight hours. You're always going to get patients in A&E that have taken overdoses or had, you know, or have…. because, you know, the public awareness isn't there and the mental health services aren't. It all depends on what they want to spend money on and, unfortunately, I do feel that it's going to go towards a personal funded system. So we're either going to have to pay for insurance to pay for the increase in services or people aren't, or services are going to have to be cut.

Part 8: I can tell you, most nurses, as long as we get our 1%, as long as they were getting re-educated and updated, probably most would be happy. I think the unhappy nurses I see that are the ones that are not being developed or are being encouraged. I know there is no funding in the trust but actually just support from a manager, "Look, I can't give you any funding but I can give you half a day every other Thursday," so that sort of thing.

Part 15: I just want to mention the sickness, that is what's down to my heart as well, is the sickness policies and how upsetting I find it. I mean, as I mentioned earlier, I'm hardly off sick, I was last year, I wasn't sick once. And however, when I ever had to ring in sick, and that was, I had to ring in sick at the beginning of this year because I had some severe back problems. And when I spoke to our matron on the phone, because they want you to call in, and I don't know if the same applies to every other hospital, but here we have to call in every day until, you know, you get, basically, certified from your GP. So I called in and I felt that I'm not believed that I'm actually sick. And that was, it was so upsetting, you know. She didn't ask once how I am, you know, she didn't ask once how it happened, you know, or how, you know, there was no acknowledgement. I felt like, I rang in and I'm making it all up, you know, and because of it, she's going to find me another job to do, I can do with this back pain, you know. And I got so upset about it that I confronted her then on my next telephone call. And she said to me, I said, I did not appreciate how you actually were talking to me because I felt like I'm making it all up, you know, you made me feel like I'm making it all up. And she said, it's not what I think, that's what she said, it's not down to what I think, it's how it works here. And I said, oh alright, you know. And I find that, you know, and it's not, sadly enough, it's not the only one I experienced like that, it's a lot of my colleagues experience the same way.

Part 1: More and more people need to shine a light onto our little critical acre area, because I think a bit of a forgotten area you know, we talk about the pressures on A+E and A+E and A+E, you know, You know, but am… a critical care never get to mention, you know….

Part 2: The other big factor is critical care staff being moved to the ward, It's a huge problem, they will leave critical care quite happily and the promise is, I think every time we have sent a nurse, we will, you know, is so they are happy and we left short, can we have the nurse, I don't think we ever get the nurse back from where they went to work, we have lost staff, we have staff leave because they get moved regularly and they said on their exit interview that that's the fundamental reason, we had our health care assistant leave and we had our staff leave.

Part 3: They don't know where everything is, they don't know where everything is kept and that in itself could be stressful when you not sure who to ask about it or what's going on and that type of patient so it's difficult so we were trying to get a system in place before they go so they know what's their boundaries are so they feel comfortable in going.

Part 1: Because we can help the ward but the ward can't help us so it is always a one way, you know and that's the biggest thing, they can't come and help us and where is we can help them.

Part 1: The junior now that are senior staff and then of course they are the people that are teaching the younger , you know and just that they don't have the same grounding, experience that we had, and a lot of the people that I worked with back in the day have all left or retired or went down and did other things and they were replaced by just not as experienced people and that filtered down and , so the junior staff should get told like we have done , you know what I mean? There is a lot of movement in critical care and staff retention is pretty poor, then of course people are climbing the ladder a lot quicker because, you know these opportunities come up, so I think it is getting worse.

Part 8: I'm an academic. I love academia but actually I also appreciate that so and so wants to be a nurse, doesn't want a degree, is not very academic but is absolutely fabulous, hands on, totally gets it. If she needs to know something she can go and look it up, policy, procedures. I don't think anybody has ever asked me about my degree ever. I got first class and nobody has ever asked me about my degree…….

Part 2: Just get rid of the paying for the university fees, they just need to go back to bursaries system, because you missing on a huge number of people who might not be academic, or might struggle academically or may be financially, I know there are still avenues, now to do the foundation degree and there are other flexible pathways, but I think that was a disaster really, I think you should have, you know the training should be part of the degree level but the educational aspects, nurses are very different breeds to other things, so I don't know, and , I think that's one of the main thing that and the CPD funding. They need to get some CPD funding, they need to sort some study leave for nurses, because the disparity between the nursing and medical profession is disgusting really, the pay cut, you need to give them some incentives, there is no incentive for me if I was out of my career, if I was 18 years old to pay 9.5 grand a year to go and trained to be a nurse. I pay 9.5 grand to go and do something viable at the end of it.

Part 2: The universities need to be engaged, we have university lecturer who are the link and they would come to the unit on their high heels and you wouldn't know who they were if you were a visitor on the unit, you certainly think nothing to do with clinical. They will stand and speak to the student for 5 seconds and then they gone again, whereas, years ago, you know the lecturers and link lecturers would be on the shop floor, , they spend a day with the student on the unit , working with them speaking to the mentors, see what's going on and yeh, and all that changed.

Part 8: Until they address those outside issues- GPs working seven days, I don't think that's going to help at all. I think you need more community nurses; you need to keep the older folk that are well enough to be at home, at home. I think they come into hospital and then they go quicker. Hospital is not a good place to be if you're elderly. That's my bugbear that they need to start looking. I don't know how you do that. You should always have a solution if you're going to whinge about something. I would say throw more money into public health, not necessarily throw because that's bit tough but they need to start putting in perhaps more support workers. Mental health, that needs to be addressed. A lot of people end up here that don't need to be here and then I think it makes it ten times worse, especially in A&E, the worst place to put- it's a place of safety, isn't it, for someone with mental health issues but then they need a bed. Year on year they cut mental health service funding. Elderly care is shocking, the funds for elderly care. That would be my- what would I do? I would look outside the building. Yes, redirecting resources appropriately. I'd also get rid of quite a lot of management because I think we spend too much time creating layers of management that we don't need.

Part 8: Sadly, I think certainly in this trust, the attitude to critical care nurses is, "You don't really do a lot, do you? You only have one patient. You sit on your bums all day. It's not hard." I think that's quite demoralising for a team. I think when nurses do come and work with us, they're like, "Oh my gosh. I had no idea." I think our stress levels are increasing, our burnout, our sickness rates certainly because we're picking up extra shifts. The kind of patient has changed. I mean stress levels on things like discharge. We are sending patients home from the critical care ward. You just don't do that. They go to a ward.

Part 8: My bugbear is again people's unrealistic attitudes to what can and can't be done and things like that but again, that's TV, social media and all that sort of thing, isn't it? I just think times have changed. I'm showing my age now. What would I do? I don't know. I fly the flag for nursing wherever I go. I'm quite passionate about it. I must be because I've taken a pay cut. I was earning about £10,000 more seven or eight years ago. I don't know, just promote nursing I think. It's difficult at the moment because we've had no pay rise and hours are long and horrible. I don't know how you'd get people on board really.

Part 15: So in the first couple of years, it seemed to go alright with these requests. And now, the management got even tougher on it. So they started to say, right, if you want to have a fixed rota, you can't swap shifts. You're not allowed to swap any shift. So if, for example, you know, under special circumstance, you're invited to a wedding, but you have to be on the Sunday day shift, you know, you're not able to swap it, but that was one thing. Then they said, well you can't, you have to, because I generally, only worked nights at that stage, and they said, right, you have to work a day shift, that's non-negotiable. OK, so I swapped to a day shift on a Sunday because my husband was at home on a Sunday. So I've done that and this year, then they came out with, we have to do also day shifts during the week. Yes, and the reason they said, is that we are more available for training and to get our revalidation done. And bearing in mind, you know, for nursing, and I've always done my training in, mostly, in my own time. And I'm up to date, I've just had my revalidation last year, I have loads of evidence, you know, and that was mostly during my night shift. So I thought it was a pretty rubbish excuse to make me work the day shift. Also, that increased, of course, the pressure on my husband, I have more childcare to pay out, I'm losing money through my night shift.

I'm probably a hundred and fifty pound plus worse off financially, because they're making me work days. what happened then, they said, I was speaking to my manager and complained, and they said, well that's not our decision, it was HR who said that. So then I rang HR twice, spoke to HR on the phone in a lengthy time. And then, at the end of the conversation, the second conversation, she then asked me, she said, I don't know why you're actually ringing; we have nothing to do with this. they, putting fear into us that HR is demanding these kind of shifts, it's down to the management. If I'm not happy with this, then I should appeal. Fine, appealing, now we're going down this route, appealing. So my manager said, I have to appeal, which I would appeal, and she would reject it because it's down to her. The next appeal would go to the matron, which clearly, indicated to me that she will back up the manager. And the third appeal on our hospital is the manager above our matron, which is very, very good friends to the matron. You know, there's no way on earth I would have gone through this and that's what I found so upsetting, there is no chance and no hope for me that I actually would get through. And I think that's just a face with this family friendly working because it isn't, they can just do what they like with us, how we work, to be honest. going back to my colleagues, they don't have fixed rotas, and that is what I agree with your previous interviewees, there's not enough time for them to recover. Some of my colleagues, they have three nights, they're coming out of nights and that is their day off, and then they have two day shifts. And I find it extraordinary why the management actually is querying why people are off sick, you know…….

Part 15: I mean, of course, you know, if they don't have the money, they can't pay for it. But everything, you know, like the car parking, it gets privatised, you know, and then, of course, these private companies want to make money out of it, but it is just, it's just wrong, you know. I mean we are serving the community and I think that should be taken into account. And that also should be taken into account from the public but all they're saying, oh you have good pensions and this, that and the other. Well, you know, our pensions have got really, really scrapped and thinned down. And, at the end of the day, I'm looking after you when you're ill and I'm looking after your father and your mother and your sister, you know, is that not, is that not, should be appreciated a bit more.

I mean also, you know, the pay with, to get your, hold your pin number, every year is a hundred and twenty pound, I think it is. I think that is absolutely ridiculous, you know, for what? What are they doing actually, for my hundred and twenty pound? In ……. it was free. I never ever had to pay for keeping my registration

Part 15: So other things, which I think is also traumatic, you know, also what's very much in the news, you know, withdrawing of patient care and the issue with relatives if they want to carry on. And that is really, really hard going. We had a patient probably six/seven months ago, with…….. and she progressed really, really quickly, but the family didn't, want to carry on and were insisting, he did not want it being withdrawn. And he was at the end of his life and the lawyers got involved and all sorts. It was, for all of us, it was so, so hard, and especially then to get the staff to look after this particular patient, it was, yes, it was hard going, yes.

I mean occasionally we have debriefs, especially with this gentleman, with the disease, because there were lots of people affected. And I think maybe we had the debrief actually, because the management were so involved in it. But in general, generally, there's no structure and support or, you know, psychological input.

Part 1: I think more people, just have more wellbeing, I just you know, and a bit more focus on wellbeing, you know more mandatory, like I said when my boss brought the psychologist, if there had been a session where we all went to, we were all kind of, this is an hour blocked out to go to, something like that, may be onto a study day whatever, making wellbeing more of a mandatory thing.

Part 2: I think they have to be involved, and I think that's the key, you have to involve nurses, nurses understand it on the clinical floor better than anybody, but they are often not involved , not to a higher level, up to a point, at that level, you have people who probably never been in clinical environment, certainly not any kind that would make it feel for it, making decisions about us, so it is an unrealistic picture, you have to involve nurses, you have to involve genuine nurses, not nurses who have made their way up to the you know , to the senior nurse in the trust position, you have involve the nurses who are on the shop floor, the nurses who been doing it for a year or two years, they have got fresh eyes, to see the problem.

Part 10: I feel, for myself, I'd love to do the ITU course but there isn't the option down here, which that's one of the things, which I, you know, I would love to do, but I haven't got the option of doing that.

Part 7: First of all, we have got to make sure that we educate our 22-year olds. The other thing is, can we do anything that will retain our 55-year olds?

Part 13: I mean we sort of touched on it just, is age of patients really, you know. A lot of our patients are elderly or post-cardiac arrest and things like that, they're just generalised admission. But we've just had an influx of very young people and it's affected a lot of staff, you know, a couple of them have died and one's got, you know, a brain injury, and oh it's just so awful, you know, it's very, very, very hard for the staff to get their head round that. And we've all sat down and talked about it over coffee, you know what I mean? But we've sort of like grouped together and talked about it. But yes, there's nothing there other than that, you know what I mean? the only thing I would say really, is the age factor, it's very hard when they're young. Yes, it's made me think, to be honest with you now, you know, talking about it. Maybe it's something I can suggest when I go back to work tomorrow, you know, just email the manager and say, look, can we talk together about, you know, getting like a bit of a support group for the staff.

Part 15: I think the training has to be better, not as, I think nurses, we should be trained in an academic way, but it's getting too much to the academic side of it. And there's the loss of basic nursing care, it gets totally lost in that. And I think everybody should go back to basics and yes, of course, they should do some research, you know, in that year, two or three or whatever they do, but is that what you need to do when you come out of University? It is how to identify, you know, symptoms and identify basic patient's needs, and how to wash a patient, how to talk to a patient, you know. Also, what I don't find right, that the nurses have to pay to be trained.

I've done a training course in management and one, how do you say that, well they said, in one of the sessions, they said, eighty percent of staff are leaving because of the management. And I have to agree, I have to agree with this, loads of my colleagues in the last five years, very experienced, very good intensive care nurses, left because of this.

Yes, and that is, I think, that is the crucial point, that staffs don't feel appreciated. I worked part time for quite a long time, two days a week, and then it took me two years to increase my hours, two years I had to ask for my regular hours. And on one occasion I had a meeting with my manager and she said to me, and bearing in mind, you know, how experienced I am, and I don't want to do anything else actually to work on intensive care, you know, because I like it. And she seriously said to me, have you thought of changing career and go somewhere else? Yes. That's what she said to me, only because I asked for more hours. Yes, and I was so gobsmacked, you know. And then I thought does she actually not want to keep me, does she want to get rid of me? And that is one of the, yes, when lots of people also left and yes, I was, yes, it was quite upsetting actually.

OXFORD BROOKES UNIVERSITY

What’s next?

Acknowledgement

Thank you to;

- Supervisory team and OBU
- Oxford University Hospitals
- The Critical Care Network UK

OXFORD BROOKES UNIVERSITY

Thank you