

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

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Background

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

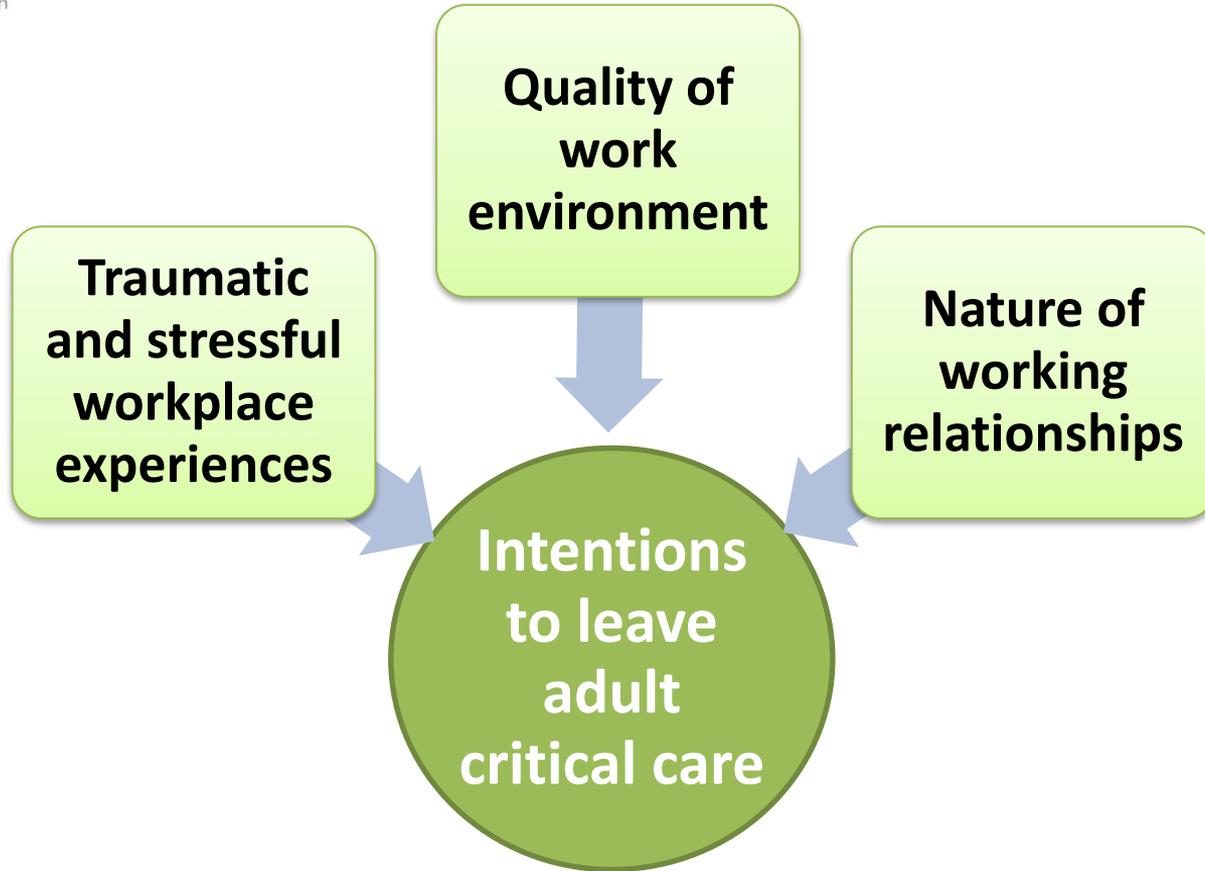
Local, national and international issue

Financial implications

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

Gap in current/previous research

Literature review



Sequential Mixed Method Study

Phase 1

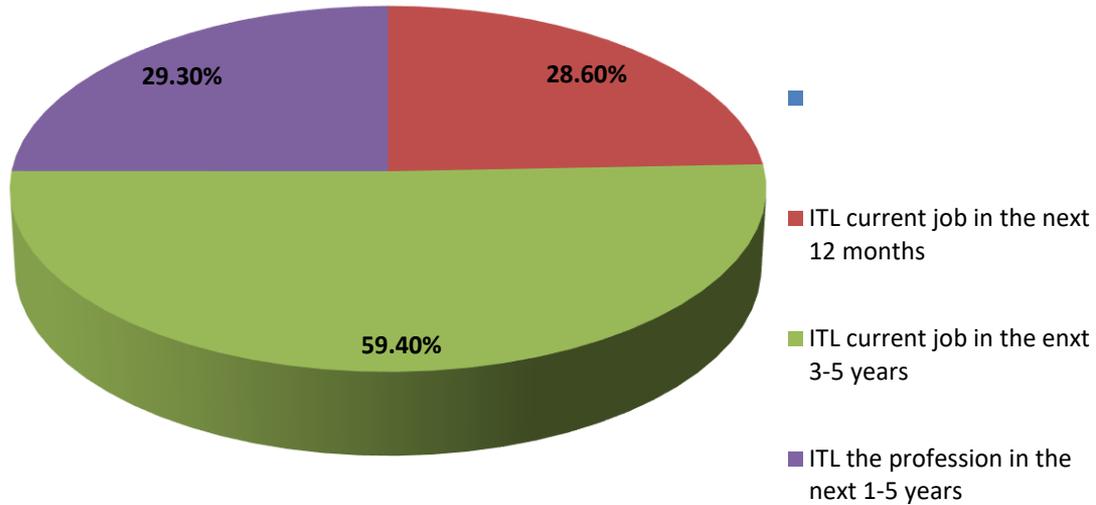
- Survey

Phase 2

- In depth telephone interviews

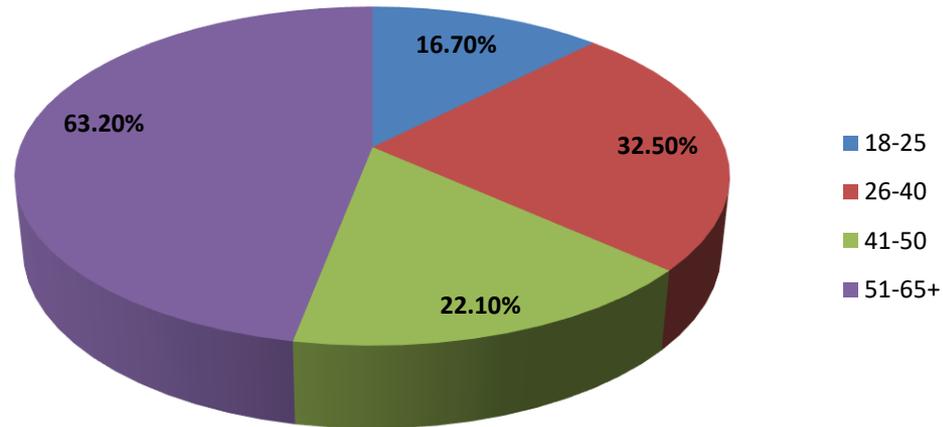
Intentions to leave

Strongly Agree/somewhat agree



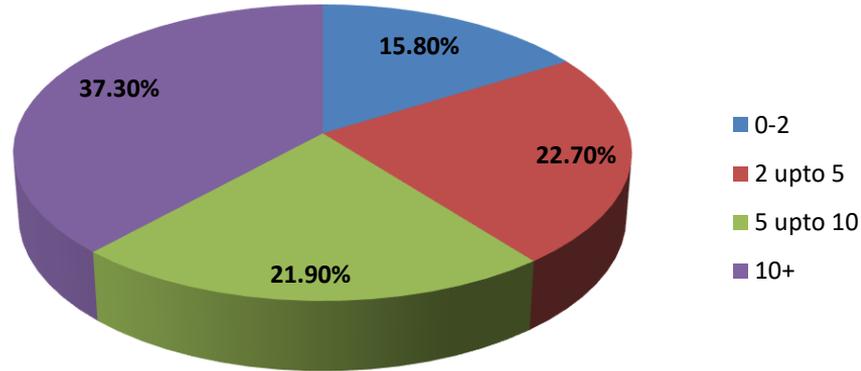
Demographics and ITL

Age-ITL nursing profession in 1-5 years strongly agree/somewhat agree



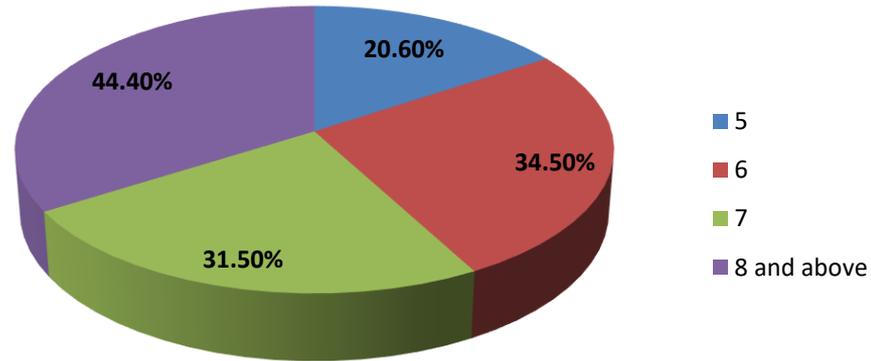
Demographics and ITL

CC exp-ITL prof in 1-5 years-SA/SA



Demographics and ITL

Band-ITL nursing prof in 1-5 years-SA/SA



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

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

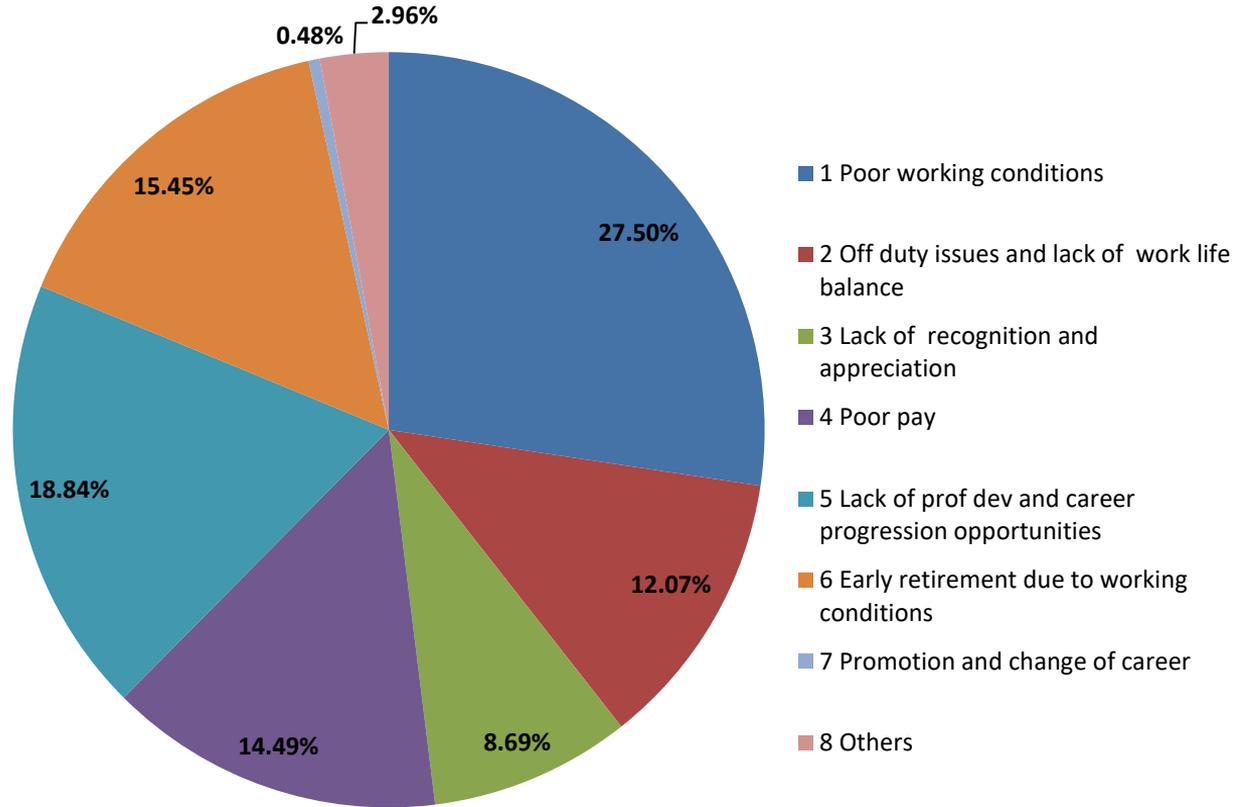
- ITL current job in 12 months
- ITL current job in 3-5 years
- ITL nursing profession in 1-5 years

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 in 1-5 years	
Autonomy	<0.001
Working environment	<0.001
Relationships	<0.001
Professional development	<0.002

Logistic Regression analysis

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 Data-initial themes

- Lack of appreciation and acknowledgement
- Lack of support and well being
- Increased work load/lack of resources
- Lack of professional development and career progression opportunities
- Lack of autonomy and empowerment
- Quality of working relationships
- Off duty issues and lack of work life balance
- Lack of financial incentives
- Traumatic and stressful experiences/incidents
- Generational changes
- Quality of patient care
- Moving CC staff to other areas

Qualitative data-Recommendations

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 interviews

Part 1: “No body, the only people who work in intensive care know, how busy you could be, people just see, oh you only got one patient, it must be so easy for you. More and more people need to shine a light onto our little critical care 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: “I feel like we are always fighting for that kind of , like the midwife you qualified to a midwife, you come out and you are going to be a band 7 or whatever after each , they always had that, you know what I mean?”

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”.

Part 14: “OK, so I think that it's always been quite a, like a highly pressured area, critical care, but it, I think definitely, over the last few years it's got busier and busier. And the patients who you see now in critical care are really sick. So whereas years ago, people would come for a short stay, and ITU a bit longer, but they were a lower dependency. Those patients now, those low dependency patients are on the ward. So with things like people stay out on the wards a lot sicker, so by the time they come to us they're really unwell”

Part 15: “It is specialised and I would really much want to see that it’s recognised as a specialism and being reflected in pay, because we are dealing with the sickest of the sickest. And, as I said, we have the impact of, you know, well we need specialised training with all the equipment, we need to, the in-depth of looking after relatives and the sick patients is so much more complex, you know, than on a ward. Don’t get me wrong, I think the ward nurses, they’re working really, really hard and they have their own issues, but it doesn’t get recognised as much, you know, what we’re doing. Also from the public, especially from the public, how often I’m hearing from relatives when they’re coming on our ward, you know, oh my god, I did not know, and they can’t believe how hard we’re working”.

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 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 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”.

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 7: “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”.

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 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 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 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 14: “So I think that if you’ve got, if it’s bad, then I think it impacts quite significantly. Because I think that the way critical care is now, everybody needs to be happy working in the team. I think that if you have unhappy staff, then there’s no way they’re going to be able to deliver good quality care. I think that only comes if your workforce is happy. So we need to make sure that the workforce is, you know, like the nurses and the doctors and everybody, physios are happy, and that we can all work together, otherwise, you just won’t get the quality of care that you’d like for the patients or their relatives”

Part 12: “No, I think that’s absolutely true, it’s not acknowledged or appreciated at all really. I think that it’s, and actually, almost to the point where actually people think that you’re a bit of a prima donna but yes, and just sort of think that, I don’t know, that we don’t really do very much because we only have one patient. So I think actually, the general view on the wards is certainly that. And yes, I agree definitely, that there’s no, there should be more remuneration for being a critical care nurse”.

Part 7: “It is in the selection process. When I was interviewed at the university, before all this highfalutin degree perspective came in. “What is your experiences?” “Oh, well I used to look after my nana.” You would say, “Oh, has she peed on your shoes before? Has she bitten you? Did she spit at you?” They look at you, but those are the sort of questions you could ask, and then you would wait in hear the humorous answer, or the clever answer or whatever. They would come out with all sorts of different things and you would think, “Yes, you will make a good nurse.” But now, they sit in a circle and they compete with each other and they’re all sat there, in their fancy clothes and their Prada handbags and all the rest of it, and I just think, “Sorry, you’re more interested in yourselves than you are in patients.” That’s the big problem. They’re not bothered, all they’re thinking about is what the... And some of them, I’m sure are doing it for matriculation to other degrees”.

Part 10: “I think we’re going to always have these problems because we are always going to have waste. Waste in the NHS is our biggest problem and our biggest cost. And everyone says it’s the workforce that’s the biggest cost but I think if you look at everything properly and restructure properly, we could get away with a lot of waste and save the money that we actually need. But you are going to have to break down the barriers of the last sixty/seventy five years of nursing to ensure that that waste is recuperated because people are stuck in their ways. And I think our whole procurement of items needs to be changed and we need to be able to get the best deal for the NHS, rather than being a free ride for some companies”.

Part 11: “I know a lot of people have left recently and quite a few of them are sort of new starters, and they feel like they’re isolated and they’re not supported. I know, and I think a few of them have felt sort of that the older ones that have been there for years are a bit sort of clicky and they’re not really willing to support them. So a lot of them have left because of that reason”.

Part 14:”So I think our retention here has improved since we, since we reviewed things, like the career progression and the development pathways and the education opportunities. So we support people to go on their Masters and PhDs and we’re developing the academic roles and that sort of thing. And I think that it’s about looking at all of that really, so that, more than just people working on the ITU and then leaving again.

It’s about what you can offer them while they’re here, and I think that’s only going to get more over the next few years. And I think it is about sort of being a bit wider with your thoughts. So it is about, you know, allowing time for people to go away and do their PhDs and maybe only do one or two clinical shifts a month, but then they’ll come back to you with a PhD, having done, you know, and then they can help other people to develop on their research or, you know. And it’s about allowing people to make changes and to get the recognition or go to conferences, you know, all of that sort of stuff, I think is the way that we’re going to have to look. Because I think you have to look and see what would keep nurses at your unit, rather than them going to another unit, especially in places like where there’s so many units so close together, that actually, nobody has to be loyal to a unit” because.....

“Cont.....they can easily, if you think, oh I’ve had enough at just think, right, well I’m just going to go and work atyou know, and it’s bound to be advertised and they’ll take, because we all ask for the same standard things, an ITU course and, you know, mentorship, then you can move around. And it’s how you keep them once you’ve got them and for us it’s about investing in the staff, which can be difficult at times because you have to balance it out with having enough nurses clinically. But I think if you make them feel really valued and that it’s about them and their wellbeing, and that you’re not there to work them really hard to get, you know, cases or your patients through, I think that’s what keeps them. I think that that’s what we’ll have to do in the future”

What's next?

Acknowledgement

Thank you to;

- Supervisory team and OBU
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- The Critical Care Network UK

Thank you

