# Explaining nursing attrition through the experiences of return to practice students: a mixed methods study

## Introduction

High attrition and its attendant impact on staff:patient ratios, workload and adverse influence on patient safety and quality of care in nursing is a global problem (Royal College of Nursing, 2015; Aiken et al., 2002; 2014; 2018). In 2020, the World Health Organisation (WHO) estimated a global nursing and midwifery shortage of 5.9 million, concluding this to be damaging ultimately, to the health and well-being of entire populations. Therefore, this scarcity and the goal to maintain an adequately skilled workforce is a concern of health care employers internationally (Jirwe & Rudman, 2012; Perry 2012, McLaughlin et al., 2010; Price 2009a). The UK's National Health Service (NHS) (2019) suggested greater attention is needed to why nursing staff leave as a large-scale investigation has evidenced the harmful association between levels of nurse staffing, the calibre of nurse education, staff burnout, patient outcomes and mortality (Aiken et al, 2014); indeed, this study reports that one additional patient on a nursing workload increases the likelihood of another inpatient dying by 7%.

In 2014, Health Education England (HEE) reported that 10% of the nursing workforce is seriously considering leaving the profession (HEE, 2014a). Buchan (2002) highlighted that only 10% of nurse leavers abandon nursing due to 'natural' wastage, such as ill health or retirement. The inability to retain nurses and midwives inflicts significant financial penalties upon of healthcare organisations (Yin, 2012). Poor retention further increases direct costs necessitating recruitment, selection, training and staff support. Other undesirable consequences accrue through workplace turbulence perpetrated by the additional work imposed upon existing staff that in turn, gives way to lower job satisfaction and morale, all leading to a poorer quality of patient care (Royal College of Nursing, 2013).

These concerns pose continued challenges for policy-makers and planners in high- and low-income countries alike (International Council of Nurses (ICN), 2006). Despite attempts to plan ahead strategically to retain the nursing workforce (Mbemba et al., 2013; Twigg & McCullough 2012), healthcare employers internationally experience, at best, cycles of significant shortages, requiring short-term solutions such as actively poaching nurses from other countries (Lintern, 2013).

Arguably, the generation and sustainability of any nursing workforce depends on two pre-eminent considerations namely, the effective recruitment and then, the successful retention of the most capable staff (Centre for Workforce Intelligence, 2012). HEE is an arm of Government charged to maintain the safe staffing of the National Health Service in England. The vast majority of NHS staff work currently in acute hospitals, although, over time, there is a policy to develop more care closer to home. In fulfilment of this objective, HEE has sought to retrieve registered nurses and midwives who have previously chosen, for whatever reasons, to leave the profession (Price 2009a) through the launch of the *RtP to* campaign (Health Foundation, 2014; HEE, 2014b). In England, nurses who have practised fewer than the required number of hours in a three-year period are not legally able to re-register with the overarching UK regulatory body, the Nursing and Midwifery Council (NMC) and are therefore, not able to practice as registered practitioners (NMC, 2016). Hence irrespective of what time period has accumulated since registration lapsed, individuals must successfully complete an *RtP* programme approved by the NMC before they can re-join the nursing register. In academic terms therefore, the *RtP* programme is viewed as a good investment. It attracts nurses often with significant professional awareness, prior clinical expertise, life experience, transferable skills and an appetite to address the needs of the service; and may be accomplished at lower costs than those associated with conventional nurse training programmes.

The successful re-launch of the *RtP* campaign in 2014 (HEE, 2014b) provided a unique opportunity to examine attrition from the perspectives of nurses who had left the profession and were now re-

engaging through a *RtP* course. With this in mind the aims of the study were designed to gain detailed understanding of: why nurses had previously left registered practice; why they had let their registration lapse; their aspirations as returnees and the broader insights brought to develop a better understanding of nursing retention to inform future nursing retention strategies.

**Literature Review**

Simon, Muller & Hasselhorn (2010) undertook a study with a sample of 2119 registered nurses across a variety of departments in 16 German hospitals; finding general considerations that swayed the decision to leave nursing were low job satisfaction, advancing age and a decline in professional commitment. Distinctively intrapersonal elements linked to leaving nursing were personal background and the inability to manage work/life balance. Other researchers have determined burnout to be the strongest predictor of practitioners' intentions to depart (Aiken et al., 2014; Ishihara et al., 2014; Rudman et al., 2014; Chan et al., 2013; Choi et al., 2013), or the related concept of moral distress (Torjuul and Sorlie, 2006). Against this background, decreased job satisfaction becomes cumulative until the decision to leave becomes foremost (Barlow, 2014; Whitehead et al, 2014; Li et al., 2010).

Deficient resources have been demonstrated frequently as a root cause for nurse wastage, compounded by an unsupportive managerial culture and poor professional relationships, all contributing to sub-optimal levels of care and the subjective practitioner experience of detachment from patients and carers (Choi et al., 2013; Estryn-Beher et al., 2010). The work environment is thus much cited in exit interviews as a leading precipitant of attrition often characterised poor peer support, weak management and an institutional 'blind eye' being turned on sub-optimal standards of care (Mackusick & Minick, 2010; Currie & Carr Hill, 2012).

Stress arising from that challenging interface between both work and home is also often reported as a pre-cursor to staff attrition. Researchers have observed that if there is sufficient dissonance between competing demands of the two, then deciding to leave nursing becomes more likely (Bogossain et al., 2014; Li et al., 2011; Gok and Kocaman 2011). Leaving to care for a dependent family member is also common (Estryn-Behar et al 2010).

The often-quoted association between poor working relationships, burnout and attrition are well understood (Ishihara et al. 2014). Yet these can be significantly reduced when participants experienced remedial measures in their workplace through peer support and by supervisory and managerial backing that confers respect, provides prompt feedback and conveys the authority and responsibility to make decisions (Zhang et al., 2015).

The age of nurses has also been linked to rates of retention and attrition. Li et al. (2011) observed that nurses working in a hospital environment aged 25 and above with a minimum of 5 years' experience were more likely to remain in their career. Conversely, Flinkman & Salantera (2015) and Rudman et al. (2014) found that 20% of nurses intended to leave within 5 years of qualifying, regardless of age. Those who leave are often sufficiently dissatisfied by the experiences, are poor advocates for the profession and likely to counsel others against entering (Skillman et al., 2010).

**Methods**

A 2-phase sequential, mixed-methods design was applied (Cresswell, 2013); comprising administration of a questionnaire (Phase 1: quantitative methods) and telephone interviews of a sub-sample of questionnaire respondents (Phase 2: qualitative methods).

*Phase 1*

A researcher-generated questionnaire was distributed to all students currently partaking one the *RtP* courses from the four collaborating institutions commencing between June 2015 and April 2016; amounting to a total of 160 *RtP* participants within the HEE commissioning area. To improve accessibility, the questionnaire-based data collection tool was provided in both electronic and paper formats. Questions were informed by the literature review, generated quantitative information for descriptive and inferential statistical analysis and elicited responses relating to date of completion of initial training, level of educational attainment, years worked as a nurse, grade when registration lapsed, domain of practice, and reason for leaving/returning to practice. Open text opportunities were offered to respondents as appropriate and these responses analysed as a second, qualitative, phase of analysis.

Quality review and validity checks were addressed by consultation with an expert advisory group embracing representatives from professional, academic and commissioning interests; from statistician input to inform the instrument design and ensure data were measurable; and through a pilot study with a group of students and academics to assess the acceptability of the tool.

*Phase 2*

A series of in-depth, semi-structured telephone interviews were conducted to explore the factors that influenced decision-making of nurses leaving the profession (n=20). Theoretical sampling for this phase of the analysis was informed by analysis of Phase 1 data, with participants who had indicated in the questionnaire that they were prepared to be contacted for interview selected for interview. Of interested participants at least two individuals were selected from each 'reasons for leaving' category responses from phase one. Semi-structured interviews were undertaken by two members of the project team (JG and JH) both senior registered nurses and experienced interviewers. Questions were guided by the literature and Phase 1 initial findings, and for consistency interview prompts were agreed by the advisory group prior to data collection. Following participant consent, interviews were

audio recorded, the final interview sample was informed by a process of studying data saturation over time.

*Ethical considerations*

The Research Team enjoyed a neutrality from the four participant institutions and had no involvement with *RtP* programmes under investigation. Ethical approval to proceed was secured from its own appropriate committee and from the participant institutions. A study information sheet was distributed to individuals prior to both phases, and written consent was received before commencing data collection. All data from participants relating to their University and employer organisations was anonymised and respondent privacy and confidentiality were preserved at all stages of data collection, transcription and analysis by allocating each a unique identifying number.

*Data analysis*

The quantitative data analysis procedures comprised: (a) descriptive analysis of trends and variables in data relating to reasons for leaving nursing and (b) inferential assessment of significant associations for ceasing to practice. Quantitative data was analysed using SPSS statistical software (Version 24). Qualitative data was transcribed and analysed using NVivo software guided by a framework analysis technique (Richie and Spencer 2003; Gale et al., 2013). Following transcription, data was sifted, charted/coded and sorted accordingly into key themes in a 5-step sequential process: familiarisation; identification of a thematic framework; indexing; charting; and mapping and interpretation (Ritchie and Spence, 1994). Analysis was undertaken independently by two members of the research team.

To identify co-existing findings, the qualitative and quantitative data from both phases were compared for complimentary findings and contrasted with contradictory evidence through the

triangulation process; codes were thereby mapped, the content negotiated and themes subsequently ratified by the advisory team.

## Results

*Quantitative analysis*

114 questionnaires were returned from respondents (71% response rate). 102 respondents (89.5%) were female; 12 were male (10.5%). The distribution of work settings represented a fair approximation to the English nursing population as whole; most of whom are employed in hospitals. The sample characteristics are summarised in Table 1.

**Table 1: summary of sample characteristics**

| **Variable** | **Mean (SD; range)** |
|---|---|
| Age (years) (*n*=80) | 46.5 (6.03; 33-61) |
| Years served in profession | 9.63 (6.06; 0.5-33) |
| Time out of nursing (years) | 9.02 (6.66; 0.5-32) |
| **Variable** | **Frequency (valid %)** |
| Gender | |
| Female | 102 (89.5%) |
| Male | 12 (10.5%) |
| Grade on leaving profession (*n*=110) | |
| Grade D or E / Band 5 (junior) | 72 (65%) |
| Grade F / Band 6 (middle) | 22 (20%) |
| Grade G/ Band 7 | 16 (14%) |
| Date completed training | |
| 1970-1979 | 3 (2.6%) |
| 1980-1989 | 30 (26.3%) |
| 1990-1999 | 40 (35%) |
| 2000-2009 | 22 (19%) |
| 2010-present | 9 (8%) |
| Clinical domain (*n*=95) | |
| Hospital | 32 (34%) |
| Community | 34 (36%) |
| Education | 8 (8%) |
| Management | 8 (8%) |
| Other | 13 (14%) |
| Reasons for leaving (*n*=114)[1] | |
| Childcare or other caring responsibilities | 47 (41%) |
| Disillusionment with profession | 21 (18%) |
| Problematic shift-working patterns | 14 (12%) |
| Physical health issues | 12 (11%) |
| Mental health/burnout/stress issues | 13 (11%) |
| Career change | 19 (17%) |

| | |
|---|---|
| Other reasons | 29 (25%) |
| Employment status since leaving profession[1] | |
| Full-time employment | 58 (51%) |
| Part-time employment | 38 (33%) |
| Unemployed | 12 (11%) |
| Parent or carer | 23 (20%) |
| Self-employed/other | 6 (5%) |

[1]More than one option could be selected; percentages are based on full cohort

The distribution of years served in the profession was bimodal: whilst 30 (26.3%) nurses left the profession after 5 years or less, relatively few (*n*=8; 7%) left between 5 and 10 years. A substantial number (*n*=59; 52%) left after 10 years or more.

Phase 1 revealed a trend amongst those who had worked for longer periods of time as a nurse to enter part-time, rather than full-time employment during their vocational break. Those who took up part-time employment (*n*=17) had worked for an average of 12.0 years (SD 6.0 years); while those who took up full-time employment (*n*=48) had worked as nurses for an average of 9.1 years (SD 6.4 years).

There was a strong association between the number of years worked as a nurse and the setting in which the nurse worked. Those based in hospitals worked for a mean of 8.23 years (SD 6.17 years) before leaving; the shortest period of time for any of the four work settings represented. Those who had been community-based worked for a mean of 13.1 years (SD 6.95 years) before leaving the profession. Consequently, those based in the community worked on average 4.86 years longer than hospital nurses before leaving the profession. Disregarding those who described their setting as management or other, an independent sample t-test was conducted to assess the significance of the difference in years worked between nurses based in hospital and community settings. The difference of 4.86 years was statistically significant at the 5% significance level ($p$=0.024); with a 95% confidence interval for the difference in years being given by (0.68, 9.05).

*Qualitative analysis*

20 telephone interviews were conducted; lasting from 25 to 64 minutes.

While recognising the challenges and pressurised nature of their initial nursing role, many participants reflected very positively on their previous vocation. Positive elements of a nursing career reported professional camaraderie, supportive management, public esteem and a fervour for the job. One participant typified this view:

RtP_20: *'It was such a privilege to be in a role like that … that's never left me … I'm passionate about nursing…'*

Exploration of the rationale for leaving during Phase 2 revealed three recurrent themes: family reasons, career development and trigger incidents (i.e. an incident precipitating a decision by a nurse to leave the profession). Putting family first was a paramount concern of respondents that influenced their inability to continue in nursing. Despite their enthusiasm for their career, lack of available support for childcare was an influential determinant of attrition, with a combination of unsupportive childcare arrangements and inflexible shift patterns seriously impeding the ability to be an effective parent and maintain the equilibrium of a work/life balance:

RtP_13: *'…it was a sad day when that happened, but it was just, it had to happen and I put my children first, the family first … that was just how it was…'*

RtP_10: *'…So I did ask … to do something like a nine till whatever shift… but they wouldn't accommodate. So because they didn't accommodate…that forced me to leave …'*

Furthermore, a number of participants indicated that they decided to prioritise their partner's career:

RtP_14: *'…my husband moved job, so we ended up moving away from the area, which is why I had to leave ….'*

Several participants whose professional registration had lapsed were unhappy with the professional restrictions they attributed to losing their registration against the course their careers had taken; some had achieved levels of managerial seniority that took them away from direct patient care. Some individuals remained in the NHS while others moved to alternative health service related settings:

RtP_02 (still working in the NHS): *'…my role didn't specifically require me to be a nurse but also in discussions with the NMC, they were adamant that you couldn't re-register without having a specific number of… actual hands-on clinical practice…'*

RtP_16: *'…a letter arrived saying you're now off the register and I thought well, the job is now done. But actually, I knew within six months … I could have stayed on the register…'*

Several participants reported individually evocative events as part of personal or professional experience that triggered the desire to leave. Several narrated personal traumas, one example:

RtP_18: *'…my youngest had a [life threatening illness] …suddenly became really poorly…my other priorities took over…'.* Unavoidably such career breaks led to a lapse in registration meaning individuals were unable to return to nursing once their crisis had passed.

Several participants described a serious instance of poor management support that precipitated burnout and moral distress and triggered their departure:

RtP_12*: '…one particular experience …I was left running the [unit] on my own and it was bedlam … I asked for help and they basically told me to get on with it myself …[then] I can remember going to a side room finding that my …patient had died on his own … walking home that night after that late shift just crying and crying thinking I can't do this, I just can't do this and handed in my notice … it was such an awful experience….'*

Many participants who had continued in employment remained in health-related or caring roles. Most highlighted how they still relied on their nursing experience during the interruption. Everyone told a different story: Of those continuing employment within healthcare it was said:

RtP_02: *'I've always … worked for the NHS… so I've never been out of the NHS since qualifying…'*

RtP_08: *'…It's an [NHS project] coordinator, so it's a regional role to implement [the project], national government led…'*

Flexibility to harmonise work and life demands was important for one who worked for a healthcare research company but stayed there because the salary was also attractive*:*

RtP_09: *'…I've progressed up to project management … because of the flexibility with my family and the fact that it's a great deal more money than nursing...*'

Many participants remained in employment throughout their break from nursing, despite not being registered, still drew on their nursing experience:

*RtP_16*: *''… Although I wasn't still registered, in view of my clinical training … I've had all sorts of roles on the back of being clinically trained.'*

Exploring why the participants had decided to return to nursing through a *RtP* programme provided commonalities in feedback from many, particularly those who had left for child-caring reasons and aspired to return to the profession. Their families were growing up furnishing them with personal choice and the opportunity to return:

RtP_01: *'…my youngest two were about to go into primary school … everything that I looked at, it didn't seem worthy in comparison to nursing … I just felt like I wanted a worthwhile job … I wanted it to make a difference to me, my family …'*

RtP_09: *'…You know, my children are older now, I've got chance to look at what I really enjoy and what's best for me, rather than just what's best for the family…'*

**Discussion**

This research presents a unique study of attrition through the diverse experiences of nurses who had left the profession and chosen to return through an RtP programme. It is recognised that this is a unique group and the study participants are different from nurses who have left the profession completely. Two distinct categories of participants are apparent: those who left registered nursing practice for personal reasons through intolerable disequilibrium of their work/life balance; and those presenting with lack of opportunity to simultaneously advance in their career and maintain their nursing registration.

The mean reported age of 46.5 years, in conjunction with a mean period of 9 years out of nursing implies that many or most were leaving the profession in their thirties. This represents a significant concern for workforce planning, as these leavers still have many years of their working lives ahead to them. There is nevertheless, little evidence to indicate that age alone is a significant precursor of attrition although, Heinen *et al.* (2013) identified that older nurses and those working part-time are more likely to leave the profession than younger and full-time workers. This study does however, resonate with the previous findings that shift patterns appear to become more difficult to manage with increasing age, and contribute more strongly to the decision to leave amongst older, more experienced nurses (Gurkova et al., 2012; Bogossain et al., 2014; Gurkova *et al.,* 2012). The findings of the current study concur with those of Baum *et al.* (2015), in that an increased intention to leave amongst younger nurses under 35 years of age, regardless of working environment, was indicated.

The typical nurse who took part in this research had accrued nearly 10 years of experience before leaving nursing. Whilst recognising the challenges and the busy nature of the nursing role, many reflected positively, with a clear appetite for and commitment to the profession. This finding contrasts with the wider body of literature telling that burnout and lack of resources are

the fundamental reasons why nurses leave the profession (Rudman et al., 2014). This work repeatedly highlighted that significant incidents causing moral distress that were either personal or professional, heralded their departure. Individuals discussed the need for 'time out' to cope with these distractions, many of whom experienced often short-lived but nevertheless, life-changing events. According to their testimonies, many participants would not have departed and let their registration lapse had appropriate managerial and pastoral support been available at their time of crisis.

The timing of the participants leaving the profession demonstrated an interesting bimodal pattern. Many nurses left the profession after less than 5 years of experience in the profession: yet relatively few left between 5 and 10 years. There was then a further increase after 10 years or more. This supports the theory that the first 5 years of employment as a nurse is reported to be the time of most susceptibility to attrition (Crow & Hartman, 2005; Currie & Carr Hill, 2012).

The most common reasons given by participants for departing the profession were childcare or caring responsibilities. However, as indicated by a supplementary question, these nurses were not all leaving to become carers. Rigid shift patterns were conflicted with the maintenance of family responsibilities and were a strong indicator of likely attrition. This finding concurs largely with Simon et al. (2010) and Skillman et al. (2010), although these authors reported shift patterns also account for nurses changing position as well as leaving altogether. Conversely however, some nurses do testify that shift working when judiciously organised, can provide an acceptable work-life balance. As elsewhere, the weight of opinion sustained the view that shift work can be a potent cause of some nurses seeking alternative employment (Bogossian et al., 2014).

The finding of the current study that 83% of participants stayed in employment during their vocational break, raises the question of why so many participants felt forced to leave nursing, yet were

adequately able to work in alternative employment during their career absence. The study conformed also that nurses were leaving the hospital setting significantly earlier than nurses working in community settings.

Findings of this study are consistent with those elsewhere that the need for increased financial security for the participants and their families is a decisive reason for nurses leaving their current employment and working in alternative healthcare roles (Gok and Kocaman 2011). Similarly, we identified a trend that more of those with less than 5 years nursing experience were leaving because of profession-related issues. A career change was the most common *'alternative reason'* for the participants with less than 5 years of experience, yet Skillman et al. (2010) indicated that a greater flexibility in working hours, workload (a reduction in the level of physical work and fewer numbers of patients to care for) and pay were indicated as incentives to return. Many of our participants emphasised how child caring had adversely affected their nursing career because they simply could not afford child care or lacked support networks to help out with the children, all indicating the inflexibility health service organisations to recognise the obvious stress on staff with maternal responsibilities.

Additionally, although several participants' nursing registration had lapsed, six of the participants interviewed were still working in the NHS or health professional settings, but with roles which had progressed in either specialist or managerial positions, where they may not have had enough direct patient contact hours deemed by the NMC for retention of registration. Several had had discussions with the professional body who had advised that they were not working in tradition 'hands-on' roles; and therefore could not re-register.

Most published research has evaluated the views of nurses still actively working in practice yet expressing an intention to leave either their current employing organisation, or the profession as a

whole. This intention to leave the profession or an organisation, are clearly separate considerations yet are difficult to differentiate. It is important to recognise that leaving one organisation and yet retaining the commitment to healthcare generally within another organisation may be in evidence of career progression and development, rather than a loss to the profession.

The factors influencing nurses leaving, or intending to leave are multi-faceted, with nurses working in an environment where it is perceived that there are insufficient resources to provide optimum care and persistently asked to work long and inflexible hours. These reasons, however, are clearly more complex than simple analysis of nurse/patient ratios and/or staff skill mix, with patient dependency and complexity of need being just two further variables requiring consideration. What might make nursing an attractive career needs further exploration, as there is not always clear understanding of the influences on an individual's decision to remain in the nursing profession (Cowin & Johnson 2011; Cho et al., 2010).

**Conclusion**

Nurse attrition is an established fact with a multifarious aetiology. Choi *et al*. (2013) acknowledge that whilst addressing nursing shortfalls may necessarily require strategic planning and increased investment in supporting the current workforce, there are organisational changes capable of positively influencing the labour deficit. Organisations and employers undoubtedly need to be more flexible and find creative solutions to demonstrate the valued contribution nurses make. It is thus essential to recognise the expertise, education, level of competence, leadership, patient-focus and support of others that this professional group bring to the work place.

There is a need to establish detailed dialogue with follow-up actions so that staff feel better supported. Nurses need to feel appreciated and be heard and understood, both as professionally competent people and as individuals. Nursing is best understood as a vocational occupation, that for right or wrong, has often been articulated through concepts of motherhood. This does however, behove those managing the nursing workforce to recognise that this notion of caring is integral to the personal integrity of practitioners, permeates their personalities and extends way beyond the workplace and calls for somewhat more supportive working environments then hitherto.

Enabling professionals to maintain a healthy work/life balance requires a root-and-branch review by employers on the flexibility and fairness of duty rotas, particularly in the light of the finding that the primary reason for nurses leaving their profession is due to childcare or other caring responsibilities. Unsocial hours are an inevitable and undeniable demand on all, and decisions ~~about these to remain judicious,~~ will always be difficult to make. Yet presenting particular members of staff with unworkable propositions should be avoided in an atmosphere fostering trust and transparency. ~~while fostering mutually trust, is also and transparent.~~

There is a need to differentiate between attrition and turnover figures with greater specificity. Exit interviews need to be facilitated by staff who are able to implement change and initiate opportunities to support and retain nurses and maintain their professional registration.

Contemporary health-provider organisations require nurses to play a unique role as champions of care quality, have enthusiasm for managerial and professional accountability and standards and take a lead role in the effective delivery of local health services (Front Line Care, 2010; Willis 2012). This requires a greater understanding by policy makers and service managers of what motivates nurses to remain in practice. The finding that nurses based in hospital settings, in particular, are leaving the profession

significantly earlier than those in community settings points to a specific need for dialogue between nurses and managers in hospital settings.

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