Returning to nursing after a career break: elements of successful re-entry

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ABSTRACT

Background
The well reported shortage of registered nurses (RNs) means recruitment of RNs not currently in the nursing workforce is an option. Nurses re-entering the nursing workforce are widely considered to be valuable staff members across many health care settings, bringing maturity, life experience and enthusiasm to their work.

Objective
To survey the literature to identify the special needs of the re-entry RN and suggest elements of a successful re-entry recruitment, training and retention policy.

Conclusions
The typical re-entry RN is a 40 year old female with school-aged children. She may be unaware of re-entry opportunities in her area. She wants family friendly shifts and an acknowledgment of family responsibilities; a paid, on-the-job refresher course that is relevant and that guarantees future employment; as well as ongoing support to help overcome anxiety and loss of confidence. Positive support from existing staff is crucial.

INTRODUCTION

The recruitment and retention of registered nursing staff is an area of international concern. Buchan and Calman (2004) state that the shortage of health care personnel in general and registered nurses in particular is the biggest obstacle in improving health and wellbeing worldwide. Current nursing shortages in Australia, Canada, the UK and the USA are at least partly attributable to the ageing of the nursing workforce and the low number of new recruits into the profession (Buckis 2004; Durand and Randhawa 2002; NSW Health 2002; Roberts 2002; Buerhaus et al 2000; Buchan 1999; Gauci Border and Norman 1997; Maynard 1993). Adding to the shortage of Australian nursing staff is an ageing population needing more health services (Buckis 2004).

There is a large pool of educated nurses who are still registered but who are not currently working in nursing. There has been much interest in this group as a source of recruitment due to the cost efficiency of refreshing a re-entry RN compared to preparing a 'new recruit' from scratch (Roberts 2002; Quant 2001).

In 1998, the New South Wales Health Department Nursing Workforce Research Project (Nursing and Health Services Research Consortium 2000 - NHSRC) surveyed over 3,000 RNs and enrolled nurses who were currently registered by the NSW Nurses' Registration Board but not working in nursing at that time. They found the typical non-practising RN is a 40 year old woman with children under the age of 12. She is not interested in inflexible rotating rosters and is wary of physically and emotionally draining situations. She wants paid, on-the-job refresher training and part-time, family friendly shifts. She trained in a hospital and may have undertaken additional specialty training. This profile is similar to that found by other research set in Britain and the USA (eg Durand and Randhawa 2002; Kalnins et al 1994).

Re-entry RNs can be valuable members of the health care team. Life experience, previous work experience and maturity are seen as assets particularly in areas requiring autonomy and leadership. Their motivation for returning to nursing is generally a deep love of the profession, and the enthusiasm of the re-entry RN is often noted (Durand and Randhawa 2002; Stark et al 2001; Pett 2001; Wilcock, 2000). RNs educated locally have advantages over nurses educated in other countries in that language and cultural differences are minimised and they are likely to be more quickly assimilated into local settings.

Retention rates for re-entry RNs are also widely reported as being excellent (eg Blankenship et al 2003; Williams et al 2002; Templeman 2001; Nottingham and Foreman 2000; Alden and Carrozza 1997; Kalnins et al 1994). It is acknowledged however that unsuccessful re-entry programs are not as likely to be reported in the journals as successful ones.

There are many reasons why RNs leave the profession. A survey of non-returning RNs in the Norwich area of England identified pregnancy as the main reason for leaving the nursing workforce (Durand and Randhawa 2002). A large number of RNs move out of nursing to a different but complementary field (NSW Health 2000). An alarming number of non-returning RNs in the NSW survey claimed work related injuries prevented them from returning.

There is no shortage of anecdotal accounts both in Australia and in other countries of RNs leaving nursing for negative reasons (eg Meredith 2002). Night duty and rotating rosters are considered highly undesirable (Durand and Randhawa 2002; NSW Health 2000; Bentham and Haynes 1990). There are many anecdotal accounts of unsupportive management, patronising medical staff or unrealistic expectations (eg Crouch 2002). Several papers speak of the importance of respect and support from nursing colleagues (especially managers) and collegiate relationships with medical staff and note their close relationship with job satisfaction (Manion 2004; Adams and Bond 2000; Gauci Borda and Norman 1997).

This pool of RNs can only be effectively recruited and retained in the workforce if due consideration is given to why they left and how their circumstances

and needs have changed. A nurse that left due to pregnancy may now need shifts that fit increased family responsibilities. An RN that left because he or she felt overwhelmed and burnt out will not be interested in going back into a similar situation.

Surveys conducted in Australia and in other countries investigating what returning RNs want, highlight three areas that are of high concern: flexible, 'family friendly' shifts and an acknowledgment by managers of family responsibilities; the need for refreshing existing skills and learning new ones; and the need for ongoing support (Bullen 2003; Durand and Randhawa 2002; Williams et al 2002; Stark et al 2001; Templeman 2001; Nottingham and Foreman 2000; Wilcock 2000). This paper will review the literature around each of these factors.

METHODS

A literature review was undertaken using CINAHL and Medline, searching under the terms refresh, re-entry, recruitment, nursing education/courses and retention. Websites such as the NSW Health Department and the International Council of Nurses were also searched for information.

DISCUSSION

The flexible, family friendly workplace

The cost and scarcity of childcare means that many returning RNs are limited in the shifts they can work (Durand and Randhawa 2002; NHSRC 2000; Bentham and Haynes 1990). Bentham and Haynes (1990) reported that the provision of part-time work with hours to suit parents of school aged children was a major drawcard for RNs not in the nursing workforce thinking of returning to work. This need scored more highly than other factors such as the offer of better basic pay and improved nurse to patient ratios.

Family responsibilities cluster at either end of the traditional working day: from 0700 to 0900 - breakfast and taking children to school, and 1500 to 2000 - school collection, homework supervision, evening meal, bath and bed time. Some returning RNs state that they are only available from 1000 to 1400 on school days (NSW Health 2000).

Managers should be encouraged to match shift times with times that re-entry RNs are available for employment if they seek to recruit them. A 1000 to 1400 short shift has traditionally been seen as totally impractical, the most obvious problems arising in areas where RNs are responsible for total patient care. However some areas may be more amenable to this short shift. Examples include aged care facilities where team nursing rather than total patient care is more common and outpatient facilities, operating theatres (short cases) and community care where the RN's efforts are focussed on a single client for a short period of time. Outpatient departments, day surgery centres and other Monday to Friday, set day shift venues have something further to gain from an 'overlap' shift. Full day shift nurses are more likely to be able to get their lunch break on time and it allows time for regular staff to undertake research, in-services and practice assessment, something traditionally relegated to the time when afternoon and morning shifts overlap.

Half day or half evening shifts can also provide desired flexibility and should be considered.

Night duty is a major stumbling block. It scores highly on the surveys of disincentives to return to nursing (NSW Health 2000; Bentham and Haynes 1990). So once again, areas not requiring night work will naturally be more attractive to re-entry RNs.

Not all re-entry RNs who want flexible shifts are parents. The report into the recruitment and retention of RNs in NSW noted that contemporary lifestyles and expectations of work are very different from the past (NSW Health 2002). Many RNs simply want more time to do other things.

Re-entry recruitment and training

Employers may be quite justifiably wary of 'out of practice' RNs, with some health care managers identifying them as potential liabilities (Bullen 2003; Roberts 2002; Pett 2001). Re-entry training must provide some reassurance for employers. In some jurisdictions, refresher training is a mandatory requirement after a set number of years out of the workforce (eg South Australian Nursing and

Midwifery Registration Board). Other areas leave it to the discretion of the individual RN and their employer (eg NSW Nursing and Midwifery Registration Board). Some form of assessment and accreditation by suitably trained educators is desirable if not essential under current occupational health and safety legislation for employers and provides a clear and confidence boosting confirmation for the RNs themselves.

Re-entry RNs are often reluctant to return to the profession, speaking of feeling out of touch and fearful of changes such as new technology and methods (Hitchcock 2003; Quant 2002; Waibel 2002; Wilcock 2000). The majority of RNs returning after a career break say they want a refresher course (eg Blankenship et al 2003; Quant 2001; Nottingham and Foreman 2000; Bentham and Haynes 1997; Maynard 1993) and yet the NSW survey (NSW Health 2000) shows that re-entry RNs are often unaware of retraining opportunities. This may mean that a large pool of non-practising RNs is not even considering returning because they are unaware of opportunities that exist to support them. Refresher opportunities therefore need to be advertised in the public realm, not just on health department and registration board websites.

Making refresher opportunities known in the general news media has been part of a successful, initial recruitment strategy. Southampton University NHS Trust used an intensive recruitment campaign including interviews on local radio, local press articles, shopping centre displays and hospital open days to not only raise the possibility of returning to the nursing workforce but to show how returning nurses would be updated and supported on the job (Templeman 2001). The Post Acute Care Service at Prince of Wales Hospital in Randwick, Sydney, NSW, Australia, recruited re-entry RNs by advertising their refresher program locally then offering an information morning tea (Williams et al 2002).

There are several problems with refresher courses that stand apart from guaranteed employment. Firstly, the cost may be prohibitive. Many nurses return to the workforce because they cannot afford not to work. Courses such as the NSW Health Department 'Re-Connect' that allow a re-entry RN to be paid as they retrain are therefore seen as a great advantage.

A hospital based re-entry course in the United States of America found that paying a re-entry RN a salary while refreshing was only slightly more expensive than orientation of a work ready RN. However with an 82% retention rate it worked out considerably cheaper in the long run to have their RN vacancies filled with re-entry nurses rather than agency nurses (Morrison et al 2005).

Ward or area specific re-entry programs designed to develop the skills of RNs already selected for future employment are preferred to stand alone courses. The Post Acute Care Service at Prince of Wales Hospital is an example (Williams et al 2002).

The benefits of training and orienting specifically to a unit compared to moving around to many clinical areas are debated. Re-entry RNs, it may be argued already have a breadth of experience and exposure to a range of clinical areas. One of the principles of adult learning is that the content should be relevant. Orientation to the wards or services that form part of the RNs future network of patient care is certainly desirable and relevant. For example, a re-entry RN working on a surgical ward may find it helpful to spend a day in the operating theatres, tracing the journey of a patient through admission, anaesthesia, recovery and return to the ward.

It is apparent that certain areas need to be addressed in a refresher course, regardless of previous experience or how long an RN has been out of the workforce. Knowledge and skills fall into three broad areas: skills and knowledge that are retained; skills and knowledge that need updating; and skills and knowledge not yet learned.

Like riding a bicycle, certain tasks and skills are rarely forgotten. Basic nursing care such as bathing, toileting and feeding falls into this category. Benner's (1984) helping role domain contains many of the

skills that become innate for RNs, such as acting as an advocate, providing comfort and communicating through touch.

Other skills where the nurse may have been competent when previously practised may need to be revised in the interests of patient safety, such as administering medications, care of IV fluids, aseptic technique, documentation, assessment of the patient and development of a care plan.

Finally there are areas of knowledge that may be completely new: new drugs, new classes of drugs, new surgical techniques, new treatment and support technologies and the RNs role in working with these.

In one sense, there are very few things that are completely new. An aural thermometer may be new technology for re-entry RNs but taking a temperature is very familiar ground. Hall and Andre (1999), in their refresher course placed a great deal of importance on students' prior learning and skills and encouraged them to think of new technologies as extensions of that knowledge rather than something that replaced it. They report that psychologically this is a very helpful approach.

Some previously taught skills have been shown to be detrimental to the patient and need to be updated. For example in the 1970s, nurses were encouraged to give reddened pressure sites a good rub which was considered to improve circulation to the area. It is now recognised that it is more likely to damage the already compromised, underlying tissues. Similarly, it was not uncommon to use agents such as boric acid and peroxide solutions to 'clean up' sloughy wounds. It is now known that these solutions can destroy granulating tissue and actually delay healing. Re-entry teachers and developers of curricula should be aware of these former, common practices. Quant (2001) speaks of the importance of introducing the idea of evidence based or research informed practice which may be a new concept to some re-entry RNs.

Returning RNs should also be encouraged to read contemporary nursing journals to keep up with changes in their field.

One size does not fit all when it comes to course style. There are many different re-entry course models described in the literature: an on-line course with clinical practicum (White et al 2003), correspondence course with clinical practicum (Alden and Carrozza 1997); university based course (Morrison et al 2005); preceptor based (NSW Health Re-Connect 2004; NSW Health 2002; Durand and Randhawa 2002; Wilcock 2000); classroom / clinical laboratory taught courses (Blankenship et al 2003; Williams et al 2002) and mixed (Hitchcock 2003; Stark et al 2001; Maynard 1993). Most have the same philosophic framework and similar elements can be detected in each.

Experience of schooling and education differs widely with age as does styles of learning (Quant 2001). While an on-line course may best suit some RNs, others may be intimidated by the technology and require intensive support in order to use it effectively (White et al 2003).

The need for effective educators and preceptors is stressed in the literature (Blankenship et al 2003; Hitchcock 2003; White et al 2003; Durand and Randhawa 2002; Williams et al 2002; Stark et al 2001; Quant 2001; Wilcock 2000; Maynard 1993) and emphasises the need for clinical competency.

Hall and Andre (1999) make a point of including RN specialists as guest speakers in their refresher course to give up to date, practical information and to serve as role models of the modern professional RN.

Support
Re-entry RNs are often reluctant to return to the profession, speaking of feeling out of touch and fearful of changes such as new technology and methods (Hitchcock 2003; Waibel 2002; Quant 2001; Wilcock 2000; Hall and Andre 1999. Quant (2001) notes, that one of the causes for anxiety is an under-estimation of their ability to learn new things.

The importance of understanding support for returning RNs cannot be underestimated. There are several published accounts of how the presence of a sympathetic preceptor prevented the loss of an

overwhelmed returning RN (Durand and Randhawa 2002; Templeman 2001; Wilcock 2000).

Returning RNs often express a deep need for respect. They do not want to be patronised but want recognition, if not for their nursing skills then at least for their life experience (Hitchcock 2003; Quant 2002; Pett 2001; Wilcock 2000). These authors also discuss the importance of preparing existing staff to be accepting and supportive and to see the returning RN as an asset. Attitudes of existing staff are a well known, make or break factor for graduate nurses. It is similar for re-entry nurses.

Several papers talk of the positive effects that returning RNs can have on a unit as a whole (Durand and Randhawa 2002; Stark et al 2001; Pett 2001; Wilcock 2000). Returning RNs often have an enthusiasm that can reinvigorate a flagging team.

Individuals involved in preceptor roles with the returning RN also gain benefits: "There have been times when they've asked you a question and you can feel the cogs turn as you drag up this information you learned once and just stored away. You then think, it might have changed, I'll have to look it up" (RN educator) (Stark et al 2001 p.291).

CONCLUSION

The global shortage of RNs has various causes across different regions. In Australia, North America and the UK an ageing workforce and a decreasing number of recruits is a significant problem. The recruitment of RNs currently not in the nursing working is an attractive option and numerous programs have been successful in recruiting and retaining returning RNs in the workforce. Three basic needs of a returning RN are: family friendly, flexible shifts; a retraining course; and consistent, confidential support. Essential elements of a successful re-entry program centre on good preparation of preceptors and educators; providing respect for the RNs' life experience; engaging the support of other staff; and an individualised approach to curriculum. It is also important the phenomenon of 'getting back on the bike' where old skills come back easily and the

challenge of 'unlearning' things we now consider poor practice are taken into account.

The aim of an effective refresher course is to produce a competent practitioner. Adequate assessment and accreditation will ensure the achievement of this goal.

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