Exploring the workforce experience of intensive care nurses
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EXECUTIVE SUMMARY

Qualitative research with current and former intensive care nurses was undertaken on behalf of the Department of Health (the Department) to provide an understanding of issues relating to recruitment and retention of intensive care nurses in the Victorian public health system. Understanding the perspective of intensive care nurses on intensive care nursing workforce recruitment and retention will enable programs within the Department of Health (such as Nurse Policy Branch) and health services to tailor recruitment and retention initiatives to issues or aspects identified as having greater importance.

WHAT DOES INTENSIVE CARE NURSING LOOK LIKE FROM THE INSIDE?

Across the sample of current and ex- intensive care nurses included in this study, intensive care nursing was seen as a satisfying and dynamic role, particularly as it is defined against other, in-hospital nursing roles. As they tell it, each shift involves navigating challenging, 'life or death' circumstances, based on a specific body of professional knowledge. Intensive care nurses described themselves as: problem solvers and thinkers, people who thrive on adrenalin and emergencies, people who can continually master new technologies and ideas, and confident personalities. In addition, these nurses see that the intensive care nursing role has been glamourised through its showcasing on prime-time television. As such, the role is seen as highly aspirational, and an area these nurses saw as subject to considerable competition.

SO WHAT'S THE PROBLEM?

Given the intrinsic positives associated with being an intensive care nurse, and working in an intensive care unit, it might appear odd at first glance that such units experience difficulties in retaining their nursing staff. However, this makes more sense upon further examination of the factors associated with retention and attrition. The factors associated with retention strongly correlate with the core function of the role itself. That is, the nature of patient care in an intensive care unit, relationships with colleagues, increased status within a hospital environment and the professional and specialist nature of the work. In turn, the factors associated with attrition appear to strongly correlate with 'non-intensive care specific' factors. While these can be exacerbated by working in intensive care – e.g. the way in which intensive care nursing requires increased night shiftwork – they are essentially driven by aspects that are...
external to the core role.¹ Hence, the factors that cause intensive care nurse attrition are likely to reflect broader nursing attrition factors. Across the sample, nurses identified a range of these external factors, which can be broadly divided into those that are structural, hospital-specific and personal, as follows:

1. **Structural factors**: These are factors that are broadly common to the nursing profession. They include the shiftwork requirement, pay, the changing nature of patients, and support in managing patient families and dealing with traumatic circumstances.

2. **Hospital-specific factors**: These are factors specific to the resourcing, management and leadership of individual hospitals (which appeared divergent even within the small qualitative sample for this study).

3. **Personal factors**: Reflecting how the personal requirements and life situation of individual nurses also impact upon attrition and retention.

However, while these factors might seem to ring true for all nurses, the skill set and specialist training of ICU nurses makes them very employable in other organisational contexts, including academia, pharmaceutical and medical equipment companies. The inference is that, in turn, extra effort is required to retain ICU nurses.

**HOW DO WE ADDRESS RETENTION?**

Victoria is faced with a challenging set of issues in relation to the retention of intensive care nurses. Limits on actions are particularly clear at a structural level – it is not likely for instance, that the shiftwork and pay arrangements of the nursing industry will undergo wholesale change in the near future. The very personal nature of some of the issues (for instance, the increased difficulties involved in shiftwork when nurses are in a stage of life transition) means that there are also areas where employers may have limited control.

However, while it may not be possible for attrition drivers such as shiftwork, financial reward and nurse life stage to be removed, their management can be addressed to ensure that they cause the least possible detriment to retention. For each of the work areas addressed, this study has identified clear and immediately actionable strategies that can be put in place to positively impact retention. This is particularly true in relation to the clear variation in different

¹ As factors external to intensive care, we would note that many of these factors have been identified before and in other contexts, including the 2009 study undertaken by Hall & Partners I Open Mind for the Department of Health about the needs of mature age nurses.
hospital settings in relation to resourcing (staffing levels, provision of sufficient and up-to-date equipment, staff training) and leadership.

In fact, a key learning of this study is the extent to which the experience and expertise of the intensive care workforce can be built upon in relation to developing retention strategies. In particular, many of the ex-intensive care nurses who had considerable experience at senior levels offered a wealth of suggestions about how processes could be improved, and were very interested in contributing to such improvements. They were also gratified that their expertise was being recognised and consulted. Offering more avenues for ICU staff to have a say on, and contribute to, the way in which they and their areas are managed, will clearly be beneficial to staff, health services and the Department. Using social media technologies as a facilitator both within and between hospitals could be of real benefit here.

We would suggest that there is also an opportunity, more broadly, to think about the positioning of the intensive care nurse role. This relates to the way in which the role is positioned as a lifelong career (accommodating life stage, offering a sense of career progression). However, it also requires a more strategic focus in terms of how reward and recognition reflect the elite way in which intensive care nurses see themselves. This is not just a matter of incremental or ad hoc change but a re-think of the way in which the status of ICU nursing is positioned as a whole (for instance, as compared to medical specialists).

The key areas for action are outlined in the diagram below and expressed in more detail in the body of the report.
AND RECRUITMENT?

Overall, recruitment was not a top of the mind issue for the nurses in our sample. They say the highly aspirational nature of the role means that there isn’t a lack of staff. However, there are barriers to the take up of the role, particularly in relation to the cost of the critical care diploma and what some see as the intimidating nature of the intensive care environment, for those who have never worked in the area. In addition to addressing these barriers, we would also suggest that recruitment take into account the ‘right’ intensive care nurses. The role requires a quite specific type of personality, intellect and skill set. Nurses noted that without these attributes it is likely to be very difficult to cope in an intensive care environment. For example, those who are lacking these qualities can find it difficult to keep up with the required learning, perform in stressful situations or interact successfully with patients’ families. Ensuring the right mix of skills and experience in each intensive care unit – the right nurses – as well as overall numbers, is perhaps an issue that requires some consideration.

We would further suggest investigating casual nurses as a potentially un-tapped pool of experienced talent that can be attracted back into permanent intensive care roles. In addition, while not part of the current study, we recommend seeking the views of non-intensive care nurses regarding their perceptions of intensive care, as this may clarify any negative views or misconceptions held about intensive care work and the factors attracting this group into intensive care nursing.
BACKGROUND

SETTING THE CONTEXT IN WHICH THE RESEARCH WAS COMMISSIONED

Victoria’s intensive care units (ICUs) form an integral part of the public health system: they “provide care for patients who have life-threatening illnesses, injuries and complications and require sophisticated technology and medical management and a high level of staffing and other resources”.2 In the Victorian public health system, there are currently 24 hospitals that provide adult intensive care services: 13 in metropolitan areas and 11 in regional areas. Two Victorian hospitals are equipped with comprehensive paediatric intensive care capability.

Victoria’s intensive care services – Future Directions, released by the Department of Human Services in 2009, sets out priority areas to inform future activity and investment in intensive care services in Victoria, working towards the improvement and enhancement of these services for Victorians. There are three priority areas for improving access and quality of care in Victoria’s intensive care services:

- building a sustainable system
- access: the right level of patient care when required, and
- quality: safe and effective intensive care services.

Future Directions was released in the context of an increasing demand for intensive care services in Victoria, and as with the broader health system, in the context of significant workforce shortages. However, to successfully implement the strategies and work towards the priority areas set out in Future Directions (including increasing the capacity of our ICUs), ensuring we have a flexible, highly-trained and satisfied intensive care workforce is critical. This challenge becomes particularly acute in rural and regional areas.

Nurses comprise a large component of the intensive care workforce, and are therefore a central focus for any strategies focusing on recruitment and retention of employees in this setting. While there has been much work undertaken by the Victorian Government since 1999 to address workforce shortages (including programs addressing nursing workforce shortages), as we understand it, there has been limited work undertaken to specifically explore the experiences, attitudes and motivators of intensive care nurses.

The Department of Health has sought to undertake qualitative research with members of this workforce to inform future recruitment and retention strategies to assist with the positive promotion of intensive care nursing as a career. The study was designed with a particular interest in exploring those factors that may be of greater (or less) importance to the intensive care workforce, relative to the broader nursing workforce.

RESEARCH OBJECTIVES

The primary objective of the research was to explore the attitudes, views and responses of intensive care nurses in the Victorian health workforce with respect to retention and workforce participation. Specifically, the research sought to explore:

- factors that initially attracted nurses to work in the intensive care environment
- benefits of working in the intensive care environment that lead nurses to continue to work in this environment
- aspects of working in the intensive care environment that may influence or have influenced nurses to leave the intensive care environment
- potential strategies to help retain intensive care trained nurses in the intensive care environment
- potential strategies to attract nurses to the intensive care environment.

METHODOLOGY AND SAMPLE DESIGN

Fieldwork was conducted in Melbourne (Carlton, Glen Waverley and Coburg) and Ballarat between 16th August 2010 and 2nd September 2010. Seven group discussions (with six to eight participants per group) and five individual depth interviews were completed.

The sampling approach, whilst qualitative in nature, was designed to ensure that:

- a broad sampling of the intensive care nursing population in Victoria was achieved, but with sufficient depth to ensure we could distinguish between sampling/artificial and real differences between segments and across locations
- best practice methodologies were utilised for each of the target audiences
- fieldwork was undertaken across different geographic locations and with nurses from a range of hospitals.
It is noted that the sample comprised nurses of varying levels of experience and who were of varying age (exact ages of participants was not recorded). Staff who were working in intensive care at nurse unit manager level and above were not included in the sample.

The final recruitment design, as achieved, was:

<table>
<thead>
<tr>
<th>METROPOLITAN MELBOURNE</th>
<th>BALLARAT</th>
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<tbody>
<tr>
<td>CARLTON</td>
<td></td>
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<tr>
<td>COBURG</td>
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<tr>
<td>GLEN WAVERLEY</td>
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<tr>
<td>Current intensive care nurses (permanent)</td>
<td>x 2 groups</td>
</tr>
<tr>
<td>‘Non-practising’ intensive care nurses (permanent)</td>
<td>x 1 group</td>
</tr>
<tr>
<td>Nurse bank / agency staff currently working in intensive care settings</td>
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<tr>
<td>TOTAL: 7 group discussions, 5 depth interviews</td>
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Qualitative statement: In reading this report it must be borne in mind that this research is essentially qualitative and must be interpreted as such. Qualitative research explores ideas and develops hypotheses. It is not intended to be a precise and definitive index of what happens in the marketplace. The approach adopted in the study was basically interpretive and relied upon a relatively free and unprompted conversation between participants. The report is based on observations and interpretations of the moderators, together with analysis of the recordings. Verbatim comments from respondents have been included in the report to illustrate opinions. Differences across locations and segments are noted as they arise.
DEPARTMENT OF HEALTH – INTENSIVE CARE NURSES RETENTION PROJECT

DETAILED FINDINGS

WORKING AS AN INTENSIVE CARE NURSE

Across the sample of current and ex-intensive care nurses included in this study, intensive care nursing was seen as a satisfying and dynamic role, particularly as it is defined against other, in-hospital, nursing roles. As they tell it, each shift involves navigating challenging, ‘life or death’ circumstances based on a specific body of professional knowledge.

“The difference you make in ICU is more subtle...bringing a patient closer to wellness...it’s not even about getting someone better, but sometimes it’s about helping them to die with dignity.” Current ICU nurse

“First time I walked into ICU I made a difference to that patient’s care...I go home feeling like I’ve achieved something...you don’t get that every day when you’re a ward nurse.” Current ICU nurse

“You do things that you can’t do on the wards...some of the more ambitious nurses do have this plan to go into critical care.” Current ICU casual nurse

“I just wanted to be challenged, so ICU was always up there [as a goal].” Current ICU casual nurse

In addition to their professional expertise, intensive care nurses consider that they bring a type of care to units that doctors are not able to. Our respondents say that where doctors deal only with ‘treatment’ or ‘therapy’, they feel nurses have a holistic focus on ‘patient care’. In this way, they establish specific and valuable relationships with both patients and family (assisted through the 1:1 ratio of nurse to patient care in an intensive care environment). The nurses in our study felt that they were ‘privileged’ to care for patients and their families in a time of extreme need and vulnerability.

“You don’t have 6 to 8 patients to look after.” Current ICU nurse

“In the wards, you feel snowed under with the small, mundane tasks. In ICU, you get to treat a patient with the whole picture in mind.” Current ICU nurse

“It’s [ICU] challenging and dynamic, it encompasses everything about the patient and the relatives and working in a very controlled environment.” Current ICU nurse

“It’s very satisfying…it’s never dull.” Current ICU nurse

“You’re supporting patients and their families through some of their most difficult, vulnerable times.” Current ICU nurse

 “[The families] are so happy and grateful, the patient doesn’t often remember, but the families do. I’ve had family members come up to me and hug me and they remember you forever.” Current ICU casual nurse
“It’s a privilege to take care of someone in the hour of their greatest need...that’s the patient and the relatives...you need to have the right attitude or you will struggle in the environment if you look at it as just a job...it’s very special.” Current ICU nurse

“We have a warped sense of what’s a good thing....the more complicated the better.” Current ICU nurse

However, despite the intrinsically interesting nature of the work, and the rewarding nature of the patient and family relationship, there are difficulties with working in an intensive care unit. Nurses describe the pay as relatively poor, shiftwork as arduous and say that the work can be emotionally fraught. At particular hospitals, resourcing, lack of leadership, training and development can all be influential issues. Overall then, working as a nurse in the intensive care environment is described as “rewarding, but stressful...”

“When you get in you need know how to prioritise your day and what needs to be done” Current ICU nurse

“You have your own resources and power...autonomy...it requires people to think outside of the box” Current ICU nurse

WHAT ATTRACTS NURSES TO ICU: PATHWAYS TO BECOMING AN INTENSIVE CARE NURSE

The intensive care nursing specialisation was described by those in our sample as highly aspirational, and an area that they see entrance is subject to considerable competition. As a specialised area of nursing it provides nurses with an intellectual challenge, and a chance to broaden their knowledge and practical skill base to a greater extent than other areas of nursing would offer. This in turn means experience as an intensive care nurse can open further or wider career doors. (As might be expected, this is particularly attractive to the career-minded who wish to develop a career or progress up the career ladder.)

“I’ve encouraged quite a few people to do nursing in ICU. Your knowledge base becomes greater.” Current ICU casual nurse

“In ICU nursing, you need to have a much deeper knowledge base. It’s another step up from ward nursing.” Current ICU nurse

“Nursing’s people-focussed. Critical care is quite complex, challenging, lots of opportunity...and I think when you are young and you have lots of enthusiasm it’s a great avenue to go down.” Current ICU nurse

In addition to being one of the more specialised fields of nursing, these nurses saw that the image of intensive care nursing also appears to have benefited from being showcased on
television programs (along with emergency medicine), and hence ‘glamourised’. This is seen to have contributed to the perceived increasing popularity of intensive care nursing amongst nursing students and graduates.

“We’re the ones who get to talk to George Clooney on the box!” Current ICU nurse

“TV shows often focus on ICU and it seems glamorous to grads.” Current ICU Nurse

The desirability of the role is also driven by the appealing nature in which intensive care nurses are generally perceived (albeit, as reported by intensive care nurses themselves). Amongst our sample, intensive care nurses are nurses to look up to, to aspire to become – possessors of characteristics that are both admirable and personally desirable. Throughout the study intensive care nurses were described as:

- **Problem solvers and thinkers:** intensive care nurses were described as the intellectuals of the nursing world. The life and death situations intensive care nurses deal with on a daily basis mean they have to think through and solve difficult and complex problems in relation to the care of their patient as a matter of course. Rather than undertake their work to a set template they need to be able to react to, and address emerging situations.

- **Thrive on adrenalin and emergencies:** The acute and unstable nature of the intensive care unit patient profile means that it is suitable for those who can deal with emergencies. Those who are good at intensive care nursing are able to react calmly and immediately in highly pressured situations.

- **Able to master new technologies and ideas on an ongoing basis:** The continually evolving nature of technology and medical theory means that intensive care nursing is suited to those who adapt to change well. The intensive care environment has much to offer those who thrive on new experiences and challenges.

- **Confident personalities:** And finally, the nurses in our sample described the culture of intensive care units as being typified by larger than life personalities who value gregarious colleagues and very high levels of individual achievement. For many of those in our sample – who indeed presented as outgoing and dynamic in the context of group discussions – working with others who shared these traits was very appealing. They appear to be confident, highly admirable role models.

The following verbatim quotes illustrate the positive way intensive care nurses talked about themselves and their role:
“Before you go into ICU, you look at an ICU nurse and they’ve got this air about them. They’re calm and have this confidence about them and you think, ‘that’s the kind of nurse I want to be.’” Current ICU nurse

“It’s probably not for everybody, because it is so fast-paced and there is so much happening.” Current ICU casual nurse

“You’ve got to be able to think on your feet, to be a problem solver. You’ve got to be quite technically motivated.” Current ICU nurse

“Patients can be quite unstable, each patient is totally different … That’s why we work there, it’s exciting, it keeps you entertained.” Current ICU nurse

“When something happens the adrenalin kicks in…I went in for the excitement and that’s what keeps me there.” Current ICU nurse

“You have to use your brain, to think. Being a ward nurse is task-oriented.” Current ICU nurse

“ICUs are full of strong personalities – it’s not suited to everyone.” Current ICU nurse

“[ICU] not a place to be intimidated, you need confidence.” Current ICU nurse

“I love creating order from disorder.” Current ICU nurse

“Most of us are control freak, I think!” Current ICU casual nurse

“ICU nurses are maybe a bit more anal [than other nurses]...I guess there’s lots of high-achievers there as well.” Current ICU casual nurse

This strong shared understanding of the character of intensive care nurses and the culture of intensive care nursing in the nursing fraternity appears to be the primary basis on which nurses are drawn to the role. Nurses talked about in some way having had some exposure, and feeling an affinity with intensive care nursing as a work type that suits their character and their skill set, and then actively seeking out work in the intensive care environment. This sense of active choice is underpinned by the need to complete the required tertiary or hospital-based education component. This component alone means that working in intensive care is an active choice involving a considerable financial and resource commitment, and not to be undertaken lightly. Thus entering into intensive care nursing is a matter of active, engaged choice and structured education activity.

However, having said this, nurses across the sample acknowledged that initial exposure to intensive care nursing is largely accidental or incidental – the nurses we spoke with saw an inconsistent exposure of undergraduate or novice nurses to ICU across the hospital system.
WHAT KEEPS NURSES IN INTENSIVE CARE: RETENTION FACTORS

As might be expected, given the extremely positive perception of who intensive care nurses are, the core tasks of the job itself were spoken of in glowing terms across the sample. Both current and ex-intensive care nurses presented as highly passionate about the work of an intensive care unit. The diversity of the role, the different patterns and challenges of every working day, and the holistic one-on-one nature of patient care were each seen as key aspects of the job that keep nurses engaged with the care they provide to patients.

Hence the key positives that impact on retention very much reflect the positive characteristics of the intensive care nurse as described above, as well as the description of what working as an intensive care nurse is like.

- Fit with who they are: As described above, there is a real sense that what draws people to become intensive care nurses is a strong sense that it matches their skill set, personality and character. This match also appears to act as a retention factor: it means that they can achieve highly in their chosen area of practice, adding to the sense of satisfaction they gain from their work. The degree to which their work allowed them to use their problem solving and thinking skills, thrive on highly-pressured situations and master new technologies and ideas on an ongoing basis was therefore very much valued: “It’s in my blood. I can’t leave ICU now.” Current ICU casual nurse

- The nature of day-to-day patient care in an intensive care unit: The autonomy and control that comes with caring for a patient on a 1:1 basis and making care decisions and plans for that patient was seen as a highly valued component of the intensive care nurse experience, as was the importance of the role (that is, dealing with life or death on a daily basis). In addition, the rewarding nature of establishing close relationships with, and being able to support, the families of patients was a common theme, as was the diversity and variety of the work – an ever changing environment.
  “Other areas hand it over when they get an emergency, our priorities are different, with us it’s life or death.” Current ICU nurse
  “I like having the closeness with a patient, with their family. The autonomy and the control.” Current ICU nurse
  “The nursing work on the wards is laborious, the physical labour is under-estimated and undervalued. I prefer the intellect involved with IC patients, and the way you share that with colleagues.” Current ICU nurse
• The professional and specialist nature of intensive care nursing: Having a specialisation grounded in theory was valued for the status it gave nurses, but also because of an appreciation of the difference the specialisation made to the practice of nursing, and the way that knowledge was advantageous for enabling them to nurse in better ways: “When we do something we have the theory to back it up.”

• Relationships with colleagues: Intensive care nurses very much value their relationships with the medical staff, and the equality that characterises this relationship (which they saw as more equitable than the ward nurse-medical staff relationship). Intensive care nurses feel respected by medical staff in a way that they feel doesn’t exist between medical staff and nurses more broadly. In addition, the collegiate and collaborative nature of the way they work with each other is also highly regarded. They say that the difficult experiences they undergo together makes for very close relationships. In addition, there is a sense that they enjoy working with the confident, ‘big’ personalities that intensive care units attract.

  “We’re listened to by the medical staff. They respect our opinions.” Current ICU nurse
  “There’s strong binds when you go through something together.” Current ICU nurse
  “I’ve made some great friends through ICU. We would have a great laugh. You view the world the same way.” Ex-ICU nurse
  “I’ve felt really well supported by my colleagues.” Ex-ICU nurse

• Approximation of career ‘growth’: Nurses themselves noted that in a career where it seems there is limited potential for progression and development, ICU nursing provides a sense of variety and diversity that is very appealing to those who are ‘career-minded’.

WHY WOULD INTENSIVE CARE NURSES LEAVE SUCH A BELOVED JOB? THE ATTRITION FACTORS

Given the intrinsic positives associated with being an intensive care nurse, and working in an intensive care unit, it might appear odd at first glance that such units experience difficulties in retaining their nursing staff. However, this makes more sense upon further examination of the factors associated with retention and attrition.

Those factors associated with retention strongly correlate with the core function of the role itself. That is, the nature of patient care in an intensive care unit, relationships with colleagues and increased status within a hospital environment and the professional and specialist nature of the work. In turn, the factors associated with attrition appear to strongly correlate to ‘non-intensive care-specific’ factors. While these can be exacerbated by working in intensive care –
e.g. for the way in which intensive care nursing requires increased night shiftwork – they are driven by factors external to the core role. Hence, the aspects that cause intensive care nurse attrition are likely to reflect broader nursing attrition factors. Across the sample, nurses identified a range of these external factors, which can be broadly divided into those that are structural, hospital-specific, and personal, as follows:

1. Structural factors: These are factors that are broadly common to the nursing profession; they reflect the status of the industry in the broader community and changes that can be leveraged at a profession-wide level.
2. Hospital-specific factors: These are factors specific to the resourcing, management and leadership of individual hospitals (which appeared divergent even in the small qualitative sample for this study).
3. Personal factors: Reflecting how the personal requirements and life situation of individual nurses also impact upon attrition and retention.

The following discussion looks at the make-up and drivers of each of these factors.

**STRUCTURAL FACTORS**

The key structural factors of the nursing profession – pay and shiftwork – are not new issues. However, given their impact upon retention, the issues associated with these areas are worth re-stating here.

Shiftwork: By and large, shiftwork appears to be accepted as a routine part of nursing. However, the face value acceptance of the inevitability of shiftwork should not remove the need for acknowledgement of the potentially heavy impact of shiftwork on the lives of intensive care nurses. In our sample, nurses talked about the physical, emotional and social impacts of undertaking shiftwork, including driving social isolation and exacerbating the difficulties of balancing work and family. Clearly, work-life balance is a challenge faced by a myriad of professions and workplaces, and is not an issue unique to nursing. However, shiftwork was noted as being more burdensome in intensive care units rather than a ward context, particularly because of the increased incidence of night duty.

“They’ve said that doing shiftwork is an occupational hazard…it’s the equivalent of being forced to take up smoking.” Ex-ICU nurse

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3 As factors external to intensive care, we would note that many of these factors have been identified before and in other contexts, including the 2009 study undertaken by Hall & Partners I Open Mind for the Department of Health about the needs of mature age nurses.
“Night duty knocks you for six. It’s harder with families...there aren’t family-friendly shift times unless you step into an auxiliary role.” Current ICU nurse

“My boyfriend works shiftwork and when he went on nights the thought of me going back to that made me physically ill.” Ex-ICU nurse

“It’s the shiftwork. I know that for myself. Why would I not work full-time in critical care? It’s because I was doing 12 hour shifts, and you have a family.” Current ICU casual nurse

“I think one of the hardest things is the night duty. You’ve got one-on-one nursing in intensive care, whereas on the ward the nurse-to-patient ratio changes at night.” Current ICU casual nurse

In addition, the impacts of shiftwork appear to become exacerbated in a number of other circumstances. These include when nurses:

- have children who are starting school and it becomes more difficult to balance working and taking care of children
- are trying to balance work and study requirements
- are getting older and shiftwork starts having a physically higher toll
- when inexperienced people or people who are not good problem solvers develop rosters, or develop rosters that appear ‘unfair’ by placing a higher burden on others
- when there is little transparency or good communication about why and how rosters have been developed.

Shiftwork was cited among ex-intensive care nurses as the key driver as to why they left, and the key barrier to returning to, the intensive care unit workforce. Many had taken up the option of being able to move to (what they saw as) “easier” and more constant, predictable nursing-related jobs like dialysis, organ and tissue donation coordination, education, or other projects that are still intellectually rewarding but without having a shiftwork component. It will be important to address and optimise the shiftwork requirement (and manage it well) to minimise the extent to which it drives attrition.

Remuneration and other types of reward and recognition: The low pay described by nurses (slightly ameliorated by shiftwork) was cited as an attrition factor, specifically because of the tendency for intensive care nurses to be ‘poached’ by other industries that can offer higher pay than nursing. Nurses across the sample noted that the intensive care skill set and specialist training makes them very employable in other organisational contexts, including academia, pharmaceutical and medical equipment companies. In particular, pharmaceutical
and medical equipment companies are said to value intensive care nurses for the way in which they can speak to doctors on their own terms and in their own language. Another option (as adopted by the casual nurses in our sample) appears to be for nurses to cut down to four days and pick up one casual shift a week to boost their income. Further, there was some sense that intensive care nurses ‘deserved’ higher pay relative to other areas of nursing, given the high level of skill, and the life or death nature of the work involved. This frustration is exacerbated by the requirement to, in most cases, contribute around $17,000 out of their own pocket to complete their critical care diploma for no perceived financial reward compared with working in other nursing roles.

“Coming out from ICU, you’re so employable.” Current ICU Nurse

“For casual nurses, if you work in intensive care, or you work in the wards, you get the same amount of money. Say, if this day I work in ICU with all of the stress and rushing and no support it’s $30 an hour, or I can work in the ward and have four patients and not so much going on and talk to other nurses, I also get $30 an hour. So there is no difference.” Current ICU casual nurse

“You actually lose money doing the [diploma] course. All the cost, time, effort you put in to earn the same rate of pay as ward staff. Yet, we have so much more responsibility…it’s a miracle they can find staff at all. I recently found out that a girl who packs shelves earns more than I do. I was devastated for a month afterwards. People’s lives are in our hands.” Current ICU nurse

“You may be lucky to get a two or three thousand dollar grant to help with your course. But often, you don’t get to receive that money until the end once you pass. So you need to have the money anyway.” Current ICU nurse

In addition to pay, nurses noted that the profession is characterised by a lack of formal recognition and reward more generally, which can be contrasted with the intrinsically rewarding nature of nursing, as well as of the informal feedback they receive from patients and their families.

“Sometimes the doctors will have a beautiful tea room and the nurses will have some broom cupboard.” Current ICU casual nurse

“Our consultants can do nice things sometimes. On a Sunday, they’ll go to Laurent on the way to work and bring in cakes and things…” Current ICU casual nurse

“We do get a nice gift voucher for Readings bookshop every Christmas so there are little things that they do. It makes a difference.” Current ICU casual nurse

So while ICU nursing is characterised by high levels of personal satisfaction and meaning, and rewarding relationships with colleagues, patients and their families, ICU nurses felt it had poor
remuneration, lack of formal workplace award and reward structures, and no sense of real professional status (especially in comparison to medical specialists). This makes for a rather extreme disjunction between ‘informal and private’ and ‘formal and public’ layers of reward and recognition, as expressed below:

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<tr>
<th>PUBLIC/FORMAL: AD HOC/DOESN’T EXIST</th>
<th>PRIVATE/INFORMAL: DEEPLY INGRAINED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remuneration (salary and benefits)</td>
<td>Personal sense of satisfaction or meaning</td>
</tr>
<tr>
<td>Formal workplace awards/rewards</td>
<td>Informal feedback from colleagues</td>
</tr>
<tr>
<td>Professional status/clear career pathway</td>
<td>Feedback from patients and their families</td>
</tr>
</tbody>
</table>

The notion of altruism as a main or sole reward is one that appears to be so solidly ingrained in nurses’ own expectation of the requirements of the nursing role, that its existence is not questioned. However, from what nurses say it appears that, in relation to the reward and recognition of nurses within their organisations, the altruistic nurse orientation gives rise to complacency. Given the other options open to intensive care nurses, it appears that this complacency is likely mis-held. Even though the private/informal rewards exist, it does not mean that they can partly or wholly replace the need for a more public and formal system of reward and recognition (especially given the other options available to intensive care nurses) and hence, the lack of public/formal rewards can act as an attrition factor. This could be addressed without necessarily altering pay scales as detailed in the discussion of retention strategies section later in this report.

“You’re expected to do all the extra, out of the good of your heart.” Current ICU nurse

“You’re expected to be martyrs, there’s no recognition for what we do, you have to find it personally rewarding. Knowing a patient is clean and pain-free, that you’ve had a good day.” Current ICU nurse

“Sometimes families give recognition, thank-you cards, chocolates.” Current ICU nurse

“One of my colleagues worked four hours overtime and had to fight tooth and nail to get any recognition. She managed to get half an hour’s overtime pay, and the management gave it to her reluctantly.” Current ICU nurse

The need for emotional support: While nurses cope with the traumas and deaths that are an integral part of intensive care nursing in their different ways, ICU nurses felt they received little formal emotional support, which adds to the strains of the job. They note that paramedics and police, in comparison, have access to many more formal resources and would appreciate similar infrastructure in nursing.
“Nurses suck it up, my husband is a paramedic, and they’ve got a guy employed to do crisis counselling.” Current ICU nurse

“There’s not a lot of debriefing after a major incident, it’s accepted that we’ll get over it, not even thought of.” Current ICU nurse

“There was one young girl who passed away, and it was one of the girl’s first arrests with CPR. The charge nurse knew and didn’t offer any support.” Current ICU nurse

“Sometimes you have to put your hand up and say ‘I want support’. It isn’t the way it should be. One of my colleagues passed away and I had to attend their arrest, and it wasn’t even mentioned.” Current ICU nurse

“We often comfort each other.” Current ICU nurse

“It would be nice to have something more formal, sitting down in a group, talking about what happened. Saying that you didn’t do the wrong thing. As it is, you just have to go off to the pub.” Current ICU nurse

“Every hospital should have a debrief space for nurses. Every hospital has a chapel for quiet reflection for patients, so also think about the nursing staff. If you look at how nurses debrief, and doctors as well, they do it by getting together and they talk about it. Or just have a great tea room!” Current ICU casual nurse

Negotiating patient families: Family management is described as the most difficult aspect for some nurses. Families are often distraught and seeking what these nurses described as ‘signs of hope’ for the patient’s recovery. It is imperative that intensive care nurses are not only equipped to deal with these relationships, but also have the skills to manage the families’ expectations and convey the patient’s condition. This is particularly seen as an issue for nurses working in Australia from other cultures, who may need further support to acclimatise to Australian culture. However, this is more broadly described by these nurses as an issue for all nursing in intensive care. They described a notable lack of training and support in dealing with the relatives of patients during a highly emotional time.

“There is a support issue for nurses from other cultures who are not used to having to answer difficult questions and deal with patient’s families.” Current ICU Nurse

“You have to be strong and speak up. You’re working with families seeking a grain of hope and they will say ‘Oh the temperature’s down today, they are getting better aren’t they…’ and the less assertive person will acknowledge that and can give the wrong impression…with experience you will say ‘yes, but they are still very ill and so on.’” Current ICU Nurse

“You’re not just looking after the patient; you’re managing their relatives too who are often distraught and emotional.” Current ICU Nurse
While many of the nurses we spoke with pride themselves on their ability to stay calm under pressure and to confidently manage patient and family crises, they do acknowledge an emotional toll. Working with patients and their families in a time of utmost vulnerability was one of the most unique and rewarding parts of the job; however, given the traumatic nature of the circumstances that bring people into intensive care, it can also be one of the most challenging aspects. Many nurses we spoke with felt that while they did the best they could, they felt ill-equipped at times to ‘counsel’ family members, while concurrently providing medical care to their patient.

Lack of career progression: Intensive care nursing is clearly seen as a specialised area of nursing where nurses can be intellectually challenged and broaden their knowledge and practical skill base, than would otherwise be available in other areas of nursing. As such, intensive care is an attractive place to work for nurses who are particularly driven and motivated career-wise; however, while the continually evolving nature of technology and the clinical practice in ICU serve to continue to challenge and assist nurses to grow in their skills and capabilities, this is not always enough to keep nurses intellectually stimulated (as some of our ex-ICU nurses shared).

**HOSPITAL-SPECIFIC FACTORS**

Resourcing: There appear to be notable differences between hospitals in relation to provision of adequate resources in relation to staffing levels, staff training and education and proper equipment. This impacts upon the individual nursing experience – a lack in resourcing can be seen to signal a lack of support and often a more exhausting, stressful and frustrating nursing experience. Nurses also felt a lack of resources translates to poorer patient care (and hence undermined the sense of meaning and personal satisfaction they gained from their work). For example, some pointed to what they saw as a systematic lack of government funding, as it undermines the quality of the health care the public receives and their ability to do their job. In contrast, and across the sample, a large city hospital was cited as an institution known for more than adequate resources (staff numbers, technical equipment for instance, a computer per bedside), and a leadership team who strive to support and provide for the intensive care unit.

“It’s emotional blackmail to work the long hours, it’s expected and we are under-resourced.” Current ICU nurse

“It’s all about the money – I’ve never not had a break anywhere else, it’s a different culture in [public hospitals], I’ve never seen it so hard to get overtime.” Current ICU nurse
“When staffing to acuity they might say, ‘oh, we only have six patients’, you only get five nurses, but then the stress...if someone else comes in you have seven patients but only five nurses...you end up having more adverse events and you are stressing out the people who are less experienced.” Current ICU casual nurse

“I always feel that government’s said oh we’ve wasted so much money, so they spend money on the administration, to make it tighter and make it better, but they’ve spent money on them instead of down here [on the floor in ICU].” Current ICU casual nurse

“Grads are being taken straight into ICU and there is pressure to take them so we are not under-resourced.” Current ICU nurse

“We had four computers and one broke…it’s been broken for 6 months and still hasn’t been fixed…we are working with just 3 computers and often have to queue to get on it for patient work…I can’t see being able to complete an e-learning package on there whilst people are waiting to use it for patient care…they need to think about how and when they expect us to use these packages.” Current ICU nurse

“The educators can’t cope with the demand and are relying on clinical staff but we can’t cope either.” Current ICU nurse

Example of limited resourcing across the sample included:
| Provision of sufficient, up to date equipment | Some nurses noted that their intensive care units did not have the facilities or equipment required to smoothly undertake their required work. For example, one outer suburban ICU was described as an environment where leadership conflicts resulted in little support on the ‘shop floor’ in relation to equipment, including limited computer access. |
| Adequate staffing levels | Under-staffing appears to impose a significant burden in some hospitals. For example, the nurses in one small ICU noted that a smaller staff base, and unwillingness of management to use casual nurses to deal with unexpected absence (a cost saving), makes for rostering inflexibility, nurses having to work additional shifts to a usual workload and at times under-staffing. The reported consequences of understaffing include impacts on patient care and OH&S adherence – such as the ability for nurses to take required breaks; nurses taking sick leave (without being sick) to be able to meet other responsibilities (i.e. family). In addition, they noted that under-staffing in the rest of the hospital means that they are rostered onto wards when intensive care is not seen to be particularly busy. This was seen to undermine their professional status and their ability to undertake learning and development. |
| Lack of trained staff; effective training programs | Senior nurses and former intensive care nurses noted that intensive care units are being pressured into employing nurses before they are adequately trained for critical care nursing. Nurses also described feeling pushed into senior roles too quickly. They spoke of completing their critical care diploma and then being considered ‘senior’ whilst feeling like they were still finding their feet. These staff were feeling inadequately equipped to train and mentor junior staff, when they too feel the need to be mentored. Nurses also reported situations where, for juniors, and following the supernumerary period, there is seemingly an inadequate allocation of continued support as they begin to build their patient load. This seems to reflect an assumption that the senior nurses will provide support and guidance. However, senior nurses said that they do not have the capacity to support junior/inexperienced nurses. This is not because they do not enjoy mentoring, but because it means that they cannot focus on their core job (patient care). In this, they say, there is a contradiction in the nurses’ code which encourages the sharing of knowledge and learning with others, however in practice no time is allocated to this knowledge-sharing. They say that mentoring should be specifically staffed. In addition, they note that the ‘sharing’ and support role can become more challenging in some intensive care units where partitions create a physical barrier between patients, and also nurses. |
Ensuring existence of, and access to, ongoing learning and development and career planning

Across the sample, nurses noted poor levels of support for training and learning and development, which, combined with the pace of change required to keep up with advancements in intensive care units, meant that this area can be seen as stressful. While e-learning packages do provide a flexible learning option, nurses report that they are often expected to learn on their own time, and are not necessarily given access to the computers that would allow them to complete this learning. In addition, in some hospitals the education team appears to work weekday shifts, meaning that they are not always accessible to those with different workloads.

A sub-issue here is lack of training in relation to new equipment: While the ongoing introduction of new equipment is accepted as a given, the up-skilling nurses in how to operate this equipment is seen as a challenge in some ICUs. These nurses feel there is not enough focus in ICUs in ensuring that all nurses are adequately familiar with new equipment.

Some also expressed concern over a lack of support when it comes to training and development and long-term career-planning among intensive care nurses. This generally motivated, high aiming group of professionals crave both formal and informal opportunities to learn and grow professionally; but are disappointed that it all has to occur in their own time and out of their own pocket.

Keeping resourcing up to the changing nature of patients

Those who had worked in intensive care environments for significant periods of time noted the changing nature of patients, and the impact this has on their ability to successfully undertake their role as an intensive care nurse. In particular, the increased levels of obesity in patients (more frequently cited by those nurses working in regional or outer metropolitan hospitals) as well as an increase in violent patients requiring restraint (including in relation to drug-induced incidents of psychosis). Both of these factors add to the physical and mental strains of the job if resourcing does not address the changing nature of patients.
Quality of leadership: Across the sample, nurses reported very different standards in relation to the quality of leadership they experienced. Quality of leadership is an important factor, both in relation to their immediate supervisors, and to the senior management of the hospital as a whole. The relationship and influence immediate supervisors have with senior management is also important here, as is continuity of management when the leadership changes. If any of these are poor, they can have a very negative impact upon the quality of the working experience and hence — it appears — on nurse retention. In addition to securing adequate resourcing, as described above, leadership impacts upon:

- **Sense of unity and camaraderie**: Nurses reported that environments subject to continual change reduced their sense of unity and camaraderie. In part, this was driven by an increased reliance on casual nurses, but was also attributed to resource cuts and shiftwork patterns. Addressing this is critical given the importance of the peer relationship to the quality of the intensive care nurse experience.

- **Nurse ‘buy in’**: The quality and transparency of communications appears to have a real impact on whether or not nurses ‘buy in’ to management decisions on all sorts of levels. For example, shiftwork was seen as much more onerous when the rationale behind it was poorly-defined or communicated. In addition, when nurses feel they are not consulted with or heard on matters of major structural change they say they are less likely to support them. In particular, the latter is a problem when management ‘re-tries’ solutions — for instance, in relation to rostering — that have been previously attempted, and failed. Recognising that nurses possess long-term specific knowledge would help avoid such situations. All these factors appear to increase the levels of frustration that ultimately impact upon attrition levels.

- **Management of bullying and harassment**: while not a common theme across the sample, there were a few instances cited by nurses where management failed to recognise and deal with quite severe levels of bullying and harassment. The nurses themselves felt that this had direct links to poor retention levels.

  “We get a new HR manager, and every time we have to start again to address some of the issues with the senior managers, then they leave and we have to start all over again!” Current ICU nurse

  “We get a new person in who doesn’t look over the history of what has been tried, and hasn’t worked in the past, trying to make changes to put their stamp on things…it’s so frustrating.” Current ICU nurse
PERSONAL FACTORS

In particular, changes in life stage appear to make it more likely that the negatives described above, particularly in relation to shiftwork, are exacerbated. For instance, nurses noted that having children, having children move into primary school, and having to begin caring for elderly relatives, all made undertaking the intensive care nurse role much more difficult as these life situations made them less flexible in the hours they could work. This raises a question about whether ‘intensive care nursing’ as a role can be seen as a life-long career. Certainly for some, the intensity of the role and the degree to which it ‘clashes’ with other aspects of their lives means that it cannot. To a degree, this is perhaps true for all nurse roles. However, ironically, the investment in intensive care nurse education and training (which provides an incentive for the health system to retain them in the role long term) also makes them highly desirable in other roles. If intensive care nursing is to be seen as a possible life-long ‘career’, one of the areas to be considered is how the role can be adjusted to suit those at different life stages.

This can be illustrated by the way in which nurses transitioning back into intensive care units is currently managed. For new mothers in particular, returning to the intensive care environment after a period of maternity leave can be seen as quite daunting. Given the fast-paced nature of the intensive care environment, and the continual learning that occurs on the job, being away from work for even six months can create a sense of being left behind. For those on leave for even longer, they can feel they are ‘missing out’ on even more. The perceived hurdle of ‘transitioning back in’ to intensive care is seen as a deterrent to returning to practise, as there is a fear that they won’t be ‘good enough’ on return, or have lost some of their skills. Nurses we spoke with who have returned to intensive care after maternity leave, or even other extended leave, spoke of feeling lost on their return and struggling to keep up with the changes that had occurred in their absence – thus, their fears had become realised.

“It was really confronting coming back into ICU after I returned from having a baby...you feel like you’ve missed out on so much, that you’ve lost your touch.” Current ICU nurse

“Once you leave ICU, it’s hard to get back. People might want to come back, but they’re terrified.” Current ICU nurse

Senior nurses also noted that potential to diversify the role – for instance, the ability to combine patient nursing with an educator role – would help relieve the pressures of shiftwork and achieve balance in their lives.
In this context, we would also suggest that there is learning to be gained from the way in which casual nursing shifts are managed, and that this is an area worthy of further investigation. For some ICU nurses, casual nursing is one way to address work-life balance issues, particularly when it comes to caring for young children. Casual nursing can provide that additional flexibility that permanent work doesn’t offer to the same extent.

“I’m on maternity leave at the moment, but I’m doing casual shifts, because I didn’t want to work at a set time.” Current ICU casual nurse

“[Casual work] was recommended to me. When I was about to go on maternity leave with my first child, the unit manager said ‘Why don’t you put your name down [as a] casual and that way you’re not pressured to come back, you can come back gradually.’” Current ICU casual nurse

SUMMING UP: ERODING THE POSITIVES OF INTENSIVE CARE NURSING

Among our sample, and as described in the discussion above, two key drivers of attrition were notable: the impact of shiftwork and a ‘critical mass’ scenario.

As already discussed above, shiftwork is a larger issue pertinent to nursing as a whole, and of which there is a large body of research. As agreed with the Department, this is not a primary focus of this study. However, the critical mass scenario is, perhaps, an area that can be more easily addressed. This situation appears to occur when frustrations around resourcing, stress or lack of a clear career structure build up to the point where nurses leave, not because they no longer feel affection for the job, but because the negatives of the components outside the job overwhelm the positives of their work. That is, a job that essentially gives ICU nurses satisfaction and contentment can become something which they feel frustrated about, and have reported as feeling “burned out” or “exhausted”. The following illustrates how nurses talk about this erosion of positive feeling and goodwill:

“Drained and exhausted.” Current ICU nurse

“Sometimes frustrated if dealing with confused or angry patients.” Current ICU nurse

“The lack of support can leave you feeling frustrated.” Current ICU nurse

“It’s a love-hate relationship…you need to get the balance right each day” Current ICU nurse

“You leave it at work…if you didn’t you would go crazy.” Current ICU nurse

The positives and negatives of the different aspects of the ICU nurse experience have been summed up in the diagram below:
<table>
<thead>
<tr>
<th>VALUED AS CORE TO ICU NURSING ROLE</th>
<th>WORK AREA</th>
<th>AND THE EXTERNAL FACTORS THAT ERODE SATISFACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rewarding work with patients and their families – making a difference.</td>
<td>Meaningful work: the nature of the ICU nurse role and ICU patient care</td>
<td>Shiftwork and under-resourcing (including counselling; training in strategies to deal with families) can lead to physical and/or emotional exhaustion – hence satisfaction is lessened or becomes less important.</td>
</tr>
<tr>
<td>Diverse, autonomous, interesting work feeds sense of self – as a member of the 'nursing elite'.</td>
<td>Exciting and challenging work</td>
<td>Can be intimidating for those who are ‘out of the loop’ (e.g. for mothers returning after maternity leave) if transitions are not managed – an issue for whole of career retention.</td>
</tr>
<tr>
<td>Shiftwork is valued as flexible and portable to some.</td>
<td>Work-life balance</td>
<td>Night duty and inflexible rostering makes it hard (impossible for some) to balance with family responsibilities; social life – an imbalance that some clearly see as affecting their health.</td>
</tr>
<tr>
<td>Excitement of learning, being intellectually challenged. For some the appearance of career progression/ access to management/ teaching roles is highly desirable.</td>
<td>Career growth, learning and development</td>
<td>Lack of resourcing can mean that keeping up with new technology can be hard/unaffordable. Senior nurses have to balance the pressure to perform their own role and teach others, leaving younger nurses under-supported. Lack of career development opportunities mean that some leave to seek advancement.</td>
</tr>
<tr>
<td>Valued sense of friendships and sense of camaraderie; mutual respect from medical staff.</td>
<td>Work environment and culture (including relationships)</td>
<td>Poor leadership exacerbates the frustrations, difficulties of ICU nursing (i.e. rostering), and can result in horizontal violence &amp; poor management of cultural differences with overseas-trained nurses. These were cited as factors in ‘burn out’ and feelings of frustration respectively. Lack of sufficient/up to date equipment can erode nurse satisfaction and effectiveness.</td>
</tr>
<tr>
<td>Strong personal sense of satisfaction driven by above factors.</td>
<td>Remuneration: salary and benefits</td>
<td>Lack of monetary and other recognition can lead nurses to feel underpaid and undervalued. Exacerbates the above negatives.</td>
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</table>
DISCUSSION: STRATEGIES FOR RETENTION

Victoria is faced with a challenging set of issues in relation to the retention of intensive care nurses. The limits on action are particularly clear at a structural level – it is not likely for instance, that the shiftwork and pay arrangements of the nursing industry will undergo wholesale change in the near future. The very personal nature of some of the issues (for instance, the increased difficulties involved in shiftwork when nurses change life stage) means that they are also outside the control of employers. (In fact, as part of future work in this context, it may be worth considering the impacts of life stage change on nurse’s ability to undertake shiftwork, and the possibility of targeting particular age groups for particular types of nursing work.)

However, while attrition drivers such as shiftwork, pay and nurse life stage may not be able to be removed overall, their management can be addressed to ensure that they cause the least possible detriment to retention. In fact, for all the work areas addressed in the above diagram, this study has identified clear and immediately actionable strategies that can be put in place to positively impact retention. This was particularly true in relation to the clear variation in different hospital settings in relation to resourcing (staffing levels, provision of sufficient and up-to-date equipment, staff training) and leadership.

In fact, a key learning of this study is the extent to which the experience and expertise of the ICU workforce can be built on in relation to developing retention strategies. In particular, many of the ex-ICU nurses who had considerable experience at senior levels offered a wealth of suggestions about how processes could be improved, and were very interested in contributing to such improvements. They were also gratified that their expertise was being recognised and consulted. Offering more avenues for ICU staff to have a say on, and contribute to, the way in which they and their areas are managed will clearly be beneficial to staff, to health services and the Department. Using social media technologies as a facilitator for both intra- and between hospitals could be of benefit here.

We would also suggest that there is also an opportunity, more broadly, to think about the positioning of the intensive care nurse role. This relates to the way in which the role is positioned as a lifelong career (accommodating life stage, offering a sense of career progression). However, it also requires a more strategic focus in terms of how reward and recognition reflect the elite way in which intensive care nurses see themselves. This is not just a matter of incremental or ad hoc change but a re-think of the way in which the status of ICU nursing is positioned as a whole (for instance, as compared to medical specialists).
The following diagram summarises the key themes in relation to addressing retention.

The remainder of this section sets out possible strategies for retention to be considered as reported by the current and ex-intensive care nurses in our sample. We would note this is a relatively small sample comprised of those who work below Nurse Unit Manager level at present. We would also note that different hospitals and health services obviously make for very different nursing environments – some strategies will already be in place at particular services/hospitals, others may be more difficult because of economies of scale/location. They are therefore not meant as ‘mandatories’ but rather as considerations depending on current circumstance and need.
### Structural Possible Retention Strategies as Suggested by Current and Former ICU Nurses

<table>
<thead>
<tr>
<th>Reducing the Impacts of Shiftwork on Work Life Balance and Physical and Mental Health:</th>
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<tbody>
<tr>
<td><strong>Flexibility/fit with family</strong></td>
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<tr>
<td>• Offer flexibility in shift lengths and consider alternate shift lengths (beyond the standard 8 or 12 hour shifts), including alternate start/finish times and the option of shifts on set days of week to suit different lifestyles and stages and planning (i.e. for child care or study).</td>
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<tr>
<td>• Consider onsite child care (including pre-school and out of school hours care).</td>
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**Managing Rostering Well:**

• Investigate if there is potential to learn from the way in which casual nurse shifts are allocated (why do nurses seek these positions as a desired alternative?).

• Build on previous experience: nurses noted that new hospital management can repeat rostering regimes that have already been tried and failed – they feel that seeking nurse input into new approaches will help prevent this.

• Ensure that flexibility in rostering applies to all (not just the ‘mothers’ or the ‘students’).

• Ensure that the rationale behind rostering is transparently communicated.

**Time to Recover**

• Consider increasing the amount of leave to assist staff to ‘recover’ from shiftwork, particularly for older nurses (this suggestion was based on entitlement that ambulance workers were felt to have).

• Consider the potential to diversify the role to retain senior nurses (i.e. part time nursing, part time educator or quality roles).

<table>
<thead>
<tr>
<th>Remuneration, Reward and Recognition:</th>
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<tr>
<td><strong>Building up the Status of ICU Nurses</strong></td>
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<tr>
<td>• Ensure a focus on the professional and stand-alone nature of the ICU role (i.e. don’t remove nurses from ICU to do ward duty).</td>
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<tr>
<td>• In staff communications recognise and highlight the specialised characteristics of the role, reflecting the pride ICU nurses take in their work.</td>
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Non-financial:
- Addressing the ‘little things’ can make a big difference to a nurse’s sense of feeling valued. For instance, access to computers in the workplace to complete training, sandwiches at lunch meetings, or management popping in, praising and shouting pizza/a cake after a particularly arduous shift.

Financial:
*Note: Whilst many aspects of financial remuneration of intensive care nursing are agreed in the appropriate award, health services could consider altering the terms and conditions of employment that are within their control to increase the financial (and non-financial) rewards of intensive care nursing at their health service.*

Acknowledging this, the following reflects the suggestions of ICU nurses in this research:
- Improve/provide incentives for permanent night duty staff (where not already done so), (suggestions from nurses included additional leave, higher long service leave accruals, higher superannuation contributions.
- Ensure policies on study leave are accessible, understood and promoted. Where paid leave to attend training is not provided, consideration could be given to introducing this.
- Ensure overtime is accessible and overtime policies are understood by managers and clinical staff and that these policies are appropriately implemented.
- Offer discounts to car parking, health care, health insurance, drivers’ licences, public transport (e.g. eligibility for concession), discount schemes (such as that provided to pensioners, CFA volunteers).

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<tr>
<th>Improve career progression opportunities:</th>
<th>Monitor the job design to ensure that the role of the ICU nurse reflects diversity, opportunity to learn new tasks, and opportunity to take on new or alternate roles as the staff member develops (such as mentoring).</th>
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<tbody>
<tr>
<td>Providing emotional support:</td>
<td>Ensure staff are aware of pathways to access emotional support (such as Employee Support Programs), debriefing and mentoring programs, and actively promote such programs.</td>
</tr>
<tr>
<td>Assistance with negotiating patient families</td>
<td>Provide mentoring or training in strategies for how to best work with families experiencing trauma or psychological distress, including cultural considerations.</td>
</tr>
<tr>
<td>HOSPITAL</td>
<td>POSSIBLE RETENTION STRATEGIES AS SUGGESTED BY CURRENT AND FORMER ICU NURSES</td>
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<tr>
<td>Resourcing (staffing):</td>
<td>● Consider how to make best use of casual staff to reduce the pressure permanent staff experience in ICUs during staff shortages, including on weekends.</td>
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</table>
| Resourcing (learning and development): | ● Consider introducing a second nurse educator role in each ICU (depending on the size of the ICU), with a dual focus on junior and senior staff.  
● Introduce formalised mentoring programs to increase the diversity of the ICU nurse role for senior nurses, and provide junior nurses with additional support.  
● Ensure staff are aware of existing policies relating to personal/professional development. (e.g. available number of training days per staff member). As noted above, where paid leave to attend training is not provided, consideration could be given to introducing this.  
● Ensure access to sufficient materials and resources to undertake training and professional development activities (e.g. computers).  
● Ensure that nurses can access formal training upon introduction of new equipment and technology (beyond reading the manual). |
| Resourcing (changing nature of patients): | ● Ensure resourcing keeps up with the changing nature of patients (for example, adequate manual handling equipment, support from the mental health teams). |
| Leadership: | ● Ensure senior ICU nursing staff (Clinical Nurse Specialists, Associate Nurse Unit Managers, Nurse Unit Managers and above) have access to leadership and supervision training or mentoring to strengthen their people-management and communication skills.  
● Ensure opportunities for ICU nurses to communicate with management and with ICUs in other hospitals. |
| Change in life stage: | ● Introduce structured pathways back into the workforce, including re-skilling and up-skilling to build competence with existing and new technologies and techniques\(^4\).  
● Issues to do with work-life balance are dealt with under their chief cause (shiftwork) above. |

\(^4\) Programs such as the ‘Return to Nursing’ program coordinated by the Department of Health could be considered. This program provides resources to health services to assist nurses returning to work.
RESPONSE TO CHANGES IN SKILL MIX: ENROLLED NURSES (DIVISION 2) AND RESPIRATORY TECHNICIANS

As part of this study, the views of these current and ex-intensive care nurses were gauged on two possibilities for redesign of the intensive care nursing workforce. The possibilities discussed were:

- introduction of Enrolled Nurses (Division 2) into the ICU nursing workforce, and
- introduction of a ‘respiratory technician’ role.

Enrolled Nurses (Division 2): When asked to comment on the possible role for Enrolled Nurses (Division 2) in intensive care, initial reactions were extremely negative. This negativity appears to be directed towards Enrolled Nurses (Division 2) having some form of responsibility for their own patient load; current and former intensive care nurses feeling that Enrolled Nurses (Division 2) do not have the requisite skills and training for this, and as such this would be detrimental to patient care. Current nurses discussed this issue in the context of a workforce they see as already lacking in calibre, and perceived introducing Enrolled Nurses (Division 2) as an additional threat:

“When I wash a patient I don’t just wash a patient, I check them for bruising, healing etc.” Current ICU nurse

“This was done in [metro ICU] and it was a disaster…we need to learn from mistakes, not repeat them.” Current ICU nurse

However, respondents were able to see some scope for Enrolled Nurses (Division 2) in intensive care if they were employed in a support role, as a ‘floating’ staff member without allocation to individual patients, as had been implemented in some private settings. Even when explored in this context, some hesitation remained. Given the limited scope for detailed exploration of this issue in the current study, further consultation could take place with nurse unit managers as to the feasibility of this approach and to ensure that past learning or pilots of this approach are explored.

Respiratory technicians: A recent American model of intensive care was also put to respondents. Under this model, ‘respiratory technicians’ (a role that does not currently exist in Australian settings) are responsible for managing the settings of patient ventilation, with one intensive care nurse responsible for the remaining care of two intensive care patients (instead of the current 1:1 ratio in Victoria). The nurses in our sample were unanimously against this
kind of approach. It was felt this model goes against the holistic 1:1 nature of intensive care, one of the core factors that attracts them to and retains them in this setting. A holistic approach to ICU nursing is seen by ICU nurses to lead to closer nurse-patient relationships and is also seen to allow nurses to make autonomous decisions in an instant, when this is required. These nurses spoke with pride of ‘Australia’s holistic approach’ and their skill of being able to care for a patient in this way. As with the Enrolled Nurses (Division 2), this model is seen to reduce the skill set and calibre of the intensive care nursing workforce and also the responsibility and worth of intensive care nurses through breaking-up the patient care into ‘portions’ (the latter seen to lead to risking the quality of patient care).

“In ICU you need holistic approach, this could jeopardise patient care.” Current ICU nurse

“We’re the people who assess the patient, we know the ins and outs, the toenails to the brain, blood results, speaking to a technician would be a waste of time.” Current ICU nurse

“When you start fragmenting the role, you risk losing the holistic picture of the patient. It’s having a holistic understanding of all the patient’s needs that best helps you make an informed decision regarding their care.” Current ICU nurse

“You can’t break a patient’s care up into little bits.” Current ICU nurse

RECRUITMENT: ATTRACTING NURSES TO INTENSIVE CARE

PROMOTING INTENSIVE CARE CAREERS RECRUITMENT

Overall, recruitment was not a top of the mind issue for the nurses in our sample – they say the highly aspirational nature of the role means that there isn’t a lack of staff. However, there are barriers to the take up of the role, as follows:

- Firstly, the cost of completing the critical care diploma is seen as a significant deterrent, particularly for those nurses from lower socioeconomic backgrounds. It was felt that the significant cost and time outlay required to undertake the diploma outweighed any resultant financial and non-financial gains, and may prevent interested nurses from enrolling in the diploma. Further, nurses noted that scholarships appear to be inconsistently available or not available at all.

  “A lot comes down to money. If you don’t have the money you can’t pay for the education.”
Secondly, mature nurses can feel uncertainty and a lack of confidence surrounding their ability to ‘pick up’ the skills of intensive care nursing. For junior nurses, the prospect of developing a solid and comprehensive knowledge base can seem exciting, however, for older nurses this ‘step up’ may be a daunting one.

Thirdly, for the mature nurses who typically find night duty more physically demanding than younger nurses, the increased amount of night duty required in intensive care is seen as a further deterrent.

Fourthly, our intensive care nurses reported that the ICU environment can appear intimidating to those who have never worked in the area, due to the combination of unfamiliar technology and ‘big’ personalities, and can mean that some will not consider it.

Fifthly, re-entry into intensive care nursing can be intimidating for those who have been ‘out of the loop’ for some time if transitions are not managed well.

When considering how to improve the recruitment of nurses to the intensive care setting, it will be important to address the key barriers to entry identified above. Some strategies are outlined below:

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<td>Long term financial cost&lt;sup&gt;5&lt;/sup&gt;</td>
<td>Addressing the initial cost outlay for completing the critical care diploma, and consequently making the education component cheaper, would encourage greater entry into the area.</td>
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<td>It is important to ensure that health service management and staff are aware of the availability of already existing scholarships to assist with the cost of the critical care diploma. However, increased funding for scholarships may make it more affordable for interested nurses, and encourage more nurses, to enrol in the critical care diploma.</td>
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| Fear and uncertainty regarding ICU work     | De-mystifying the intensive care environment will be important to address any fear or uncertainty about undertaking ICU nursing. To those on the outside, the intensive care environment can appear ‘scary’ and ‘technical’, and outside their capacity:

“A couple of times, people from wards come down to relieve us, and there was one girl who said, no way could I do it. The way they talk about it makes it sound technical, and depending on who’s doing it [mentoring] they can play on the fear factor, not the best advocate. So no, there’s not much scope!” Current ICU nurse

“They think it’s a horrible, scary, stressful environment.” Current ICU nurse |

<sup>5</sup> Although many aspects of financial remuneration of intensive care nursing are agreed in the appropriate award, health services could consider altering the terms and conditions of employment that they can control to increase the financial (and non-financial) rewards of intensive care nursing at their health service.
Helping to educate non ICU-nurses about what ICU nursing is really like could assist by allaying some of these fears regarding their ability to perform the role. For instance, an online forum, website or intranet detailing ‘a day in the life’, where existing nurses can share their experiences. Understanding what ICU nursing is really like could also prevent some nurses entering into ICU positions who are perhaps not well-matched to ICU work.

Similarly to the strategies for novice nurses, secondment or supernumerary opportunities for senior nurses could be a way for experienced nurses to ‘try out’ the ICU environment and to see whether it is a good fit for their skills and abilities. However, student clinical placement, supernumerary or secondment opportunities offer potential ICU nurses the opportunity to experience the ICU environment first hand – this will also help to ensure that in the long term the people recruited into the ICU environment are the right people, with the right skills, for the job.

Managing shiftwork and associated physical demands
Shiftwork for mature nurses becomes even more challenging; this becomes a challenge even as nurses enter their 30's: “Our bodies aren’t what they used to be!” Reduced night duty demands on mature nurses, or at the least, working with mature nurses to manage this carefully, will help make ICU nursing more attractive for this group.

Managing transitions back into ICU
Introduce structured pathways back into the workforce for those who have been out for some time, including re-skilling and up-skilling in relation to existing and new technologies and techniques.

THE RIGHT NURSES?

The nurses in our sample tended to believe that attracting sufficient numbers of nurses to intensive care was not an issue (so long as funding was available to pay them). Attracting the right kind of nurse, however, was an issue of concern to them and a hot topic in some groups. The role requires a quite specific type of personality, intellect and skill set – nurses noted that without these attributes it is likely to be difficult to cope with the challenges of an intensive care environment, such as keeping up with the required learning, performing in stressful situations or interacting successfully with patient families.

Among some older nurses, there was debate about whether it is appropriate for novice nurses to work in an intensive care environment (whether or not student and graduate nurses are offered rotations or positions in intensive care appears to differ across different hospital settings). While generally attracting nurses to intensive care appears not to be an issue, attracting experienced and mature nurses can be, within some hospitals. This perhaps reflects
the demanding nature of the intensive care role, but also staffing resource and transition issues as discussed earlier. Ensuring the right mix of skills and experience in each intensive care unit – the right nurses – as well as overall numbers, is perhaps an issue that requires some consideration.

**CASUAL NURSES AS A POTENTIAL POOL OF EXPERIENCED TALENT**

We would suggest investigating casual nurses as a potentially un-tapped pool of experienced talent that can be attracted back into permanent intensive care roles. A potential strategy to encourage casual nurses to return might include mimicking the flexibility it offers – for example, mothers of young children report finding it an easy way to manage motherhood, as they can choose the days they want to work at short notice. Those studying further degrees find casual nursing attractive when also juggling study requirements. (The higher rates of pay also serve to attract some permanent staff who want to ‘boost’ their income.) This and other strategies do merit further investigation.

**TALKING TO NON-INTENSIVE CARE NURSES**

While not part of the current study, seeking the views of non-intensive care nurses regarding their perceptions of intensive care is recommended to clarify the nature of opinions regarding intensive care work, and what might attract this group into intensive care nursing.