An Examination of the Nursing Shortage & its Relationship to Recruitment & Retention

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Introduction

Although there have been intermittent periods of reprieve from the shortage of registered nurses in the U.S., this lack of availability has more often than not repeated itself. These shortages are manifested in a myriad of ways and reveal a complex web of interconnected and often uncontrollable factors for potential employers.

Historical Perspective

We have experienced some interesting patterns from the post-WWII and industrial era to today. Over 60 years ago, Roberta Spohn, Assistant Executive Secretary of the American Nurses Association, stated, “Although there are recurring reports of manpower shortages in many other professional fields, nursing seems to enjoy the dubious distinction of continually suffering from this condition.” (Spohn, 1954 p.865). Despite episodic periods of adequate supply these past six decades, the complex causes of these shortages occurring have persisted. From 1930 to 1950, the number of hospitals in the U.S. remained relatively stable. What did change, however, was the number of beds within these hospitals. There was a 52% growth in beds between 1932 and 1952. On the surface, this would appear to explain the shortage; however, length of stay continued to decrease, and although more patients were being seen, this alone did not explain what was happening with the nursing shortage.

Spohn was truly ahead of her time in suggesting that the problem was much more complicated than just hospital statistics. Early research suggested that a number of societal factors had contributed to nurses entering and exiting the marketplace as well as educational institutions. These included family constellation, childbearing and growth in male-dominated work opportunities. In these early years of hospital-based nursing,

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there was no childbirth leave, limited healthcare benefits and no real incentive to keep women in the workplace.

Jumping ahead to 1987, Linda Aiken highlighted healthcare structural factors such as the prospective payment system that had taken effect in the 1970s. This legislation had a dampening effect on hospital-based nursing salaries, leading many nurses to leave the profession in pursuit of other opportunities. At the same time, government funding that previously subsidized hospital-based nursing schools was decreased and eventually removed, although medical school education remains subsidized by Medicare today. The elimination of government-supported funding for hospital-based nursing programs shifted education dollars to community colleges and state universities. Although this move was supported by nursing thought leaders of the time, it has had a dramatic and lasting impact on the self-selection process for those considering nursing, and it has also changed the character and nature of nursing education, which is still being felt today. In many instances, prospective nursing students applying to community college programs are completing 2-3 years of prerequisite education before being accepted to 2-year programs, and are thus essentially committing to their education the same number of years, or more, as those accepted to 4-year universities, but are leaving with only associate degrees. This has further disadvantaged these graduates in the current workforce, which often gives employment preference to those with a BSN degree. The reasons for this will be discussed further.

Aiken further argued that these 1970s hospital cost containment strategies negatively impacted the attractiveness of nursing as a career. During this same time, the women's movement and increasing opportunities in other fields were dipping into the pool of traditional nursing school candidates. Those who were scientifically and mathematically minded had broader options, such as medicine, engineering, and law. This ultimately changed the profile of nursing students and changed the educational pathways, creating greater divides between traditional 4-year college programs and 2-year associate

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degree programs. These divisions remain contentious and have splintered the profession over the past 40-plus years.

The Complexity of the Shortage

During the 1990s, hospitals experienced two registered nurse shortages. The first began in 1990, with an 11% vacancy rate for full-time RN positions. (Buerhaus, Donelan, Ulrich, Norman & Dittus, 2005). By 1992, the shortage appeared to have lifted and many were feeling optimistic. However, in 1997, hospitals again began to feel the pressure. By 2001, the national average RN vacancy rate was at 13%. (AHA Workforce Survey). Unlike the previous shortages, this one has not abated and is unchanged nearly 15 years later. Shortages are greater in some specialties and geographic regions and are negatively impacting timely access to services and growth potential. Although there have been attempts to isolate a single causative factor, it is just not that simple. Shortages in other skilled professions tend to be much shorter lived, with supply catching up to demand as soon as potential employees receive information about incentive efforts to attain market equilibrium. (Goldfarb, Goldfarb & Long, 2008). The fact that this has not happened in nursing suggests that further examination is needed. The most frequently cited reason for labor shortages in other professions is typically the lack of qualified potential applicants. Surprisingly, this is not the case with nursing. (Aiken 2007). In fact, nursing schools are turning away qualified applicants because of a lack of faculty and resources. According to Buerhaus and Aiken, America has the ability to independently staff its healthcare institutions without reliance on international manpower, but it has not been able to effectuate the interventions needed to ensure this. Salaries for nursing faculty are woefully lower than those for hospital-based work. It can be argued that hospital-based work, with its 24/7 responsibilities, should hold some financial sway, as organizations are seeking PhD and DNP-prepared leaders to manage their complex environments. Individuals with these degrees are therefore reluctant to move to academia. Additionally, advanced practice options for nurses,

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including nurse anesthesia and nurse practitioner roles that permit a greater degree of independence and improved work-life balance, are drawing talent from the bedside nursing roles.

At the same time, hundreds of thousands of RNs have removed themselves from the active nursing workforce, while an inadequate number of younger nurses are entering the market. The societal and occupational factors that are discouraging people from choosing to practice nursing must also be examined.

Demographic Factors

Members of the baby boomer generation (those born between 1946 and 1964) are now the fastest growing users of healthcare services. The U.S. birthrate declined dramatically in the 11 years following 1964. For example, in 1990 there were 77 million baby boomers, compared with 44 million in the following generation, sometimes referred to as “Generation X.” We are now into the Millennial Generation (those currently in their 20s), expected to also slow the total manpower pool in the active workplace.

The nursing profession is composed of a large percentage of baby boomers, which was reflected in projections that nearly 50% of nurses would be over age 50 by 2010, with the average age to be greater than 45 (Buerhaus et al, 2003). Historically, nurses have not worked as many years as are worked in male-dominated professions. Many nurses worked prior to marriage or until children were born. Many nurses had sought part-time work while children were young and then returned to full-time work later, but many never returned at all. The demographics and generational perspectives have now placed us in a difficult circumstance.

In 2015, the average age is 44. This is only a moderate decline from earlier projections, and is higher than many other professions. This is because many who are choosing

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nursing are in their second career, which is keeping the average age high as these persons who enter the profession are in their 30s and beyond.

Retiring nurses are not being replaced in adequate numbers with newly trained, younger nurses. This occurs in conjunction with a delayed retirement phenomenon that occurred in 2008 following the severe financial crisis in the US. This financial decline caused many nurses to stay in the marketplace longer than they had intended. This factor, coupled with the extreme financial hardships endured by many hospital organizations, resulted in decreased or frozen hiring and also further stagnated wages. This in turn created a circumstance in which in some communities, newly graduated nurses could not find hospital work near home, causing migration away from local marketplaces. These phenomena may subsequently impact nursing school enrollments. Of course, where access to nursing education programs is highly competitive, students from more populated communities are enrolling in out-of-state programs, with no intention of remaining in that area post-graduation. These wildly differing conditions are creating substantial confusion.

In the 2005-06 academic year, at least 41,683 qualified applicants were turned away from baccalaureate, master's and doctoral nursing programs (Fang, Wolsey-Wisniewski & Bednash, 2006). Of the schools that turned students away, 74% stated that the lack of faculty was the primary reason (Fang et al, 2006). At the same time, a larger percentage of students are obtaining their advanced degrees using the online format, which changes the context of geography.

A recent survey of adult Americans indicated that 83% of respondents would encourage a loved one to pursue nursing as a profession, but only 21% would consider this career for themselves, and only 1 in 10 male respondents would consider nursing.

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Actual Nursing Work

Turnover of hospital nurses is costly both in economic terms as well as in quality of care measures. Nurses who have left the profession have repeatedly cited the lack of availability of counterparts, poor work environment and compensation as the primary motivations to leave nursing.

The strain of shift work also impacts nurses' longevity in the profession. The physical, cognitive and emotional challenges of growing older while the profession continues to demand more are notable. The need to work nights, weekends and holidays, and the disruption to family schedules, are significant quality of life factors. These factors have caused many to migrate away from hospital-based work settings. The growing number of options for nurses to work in office settings, sales and other non-traditional roles is enticing.

In addition to the physical demands, the constant introduction of new technologies and pressures to increase efficiency and productivity are stressors. The phenomenon of complexity-compression (Kirchbaum, et al, 2007) has created a dimension of distress for nurses who experience an erosion of their time for relationship-based interactions. The increasing patient to nurse ratios, the acuity of patients and the focus on constant monitoring of individual performance has created additional pressures.

The focus on patient satisfaction and public reporting of organizational performance has also ratcheted up the pressure on nurses. As information about care and care expectations has become popularized, hospital-based nurses are confronted with a more demanding public, and intensified scrutiny from employers. As the primary 24-hour workforce, nurses are confronting circumstances around the clock that others may have reprieve from. This includes negotiating the system of the hospital after hours, which often defaults to the nurse filling in for roles that are staffed by others during the

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day. Certainly it is understood when volumes do not justify increased manpower, but often there is a presumption that nurses will fulfill these roles as a matter of convenience to others.

Nurse Wages

Inflation-adjusted RN hourly wages rose 3% each year from 1983 to 1991. By 1994 however, nurses' wages began to decrease (Buerhaus, 1998). The hospital focus on marketing budgets, managed care impacts and the overall recessive economy were all factors.

In 2003, hourly nurse wages increased by 1.8% to a national average of $24.22 per hour, followed by a national increase of 10% the following year (Windham, 2004). Much of this increase was represented by shift bonuses and other incentives. One would expect nursing wages to continue to increase given the shortages; however, according to the National Institutes for Women's Policy Research, wages began to fall in 2004 (Lovell, 2006).

At the same time, dollars previously available to assist with funding nursing education were being decreased, leaving nurses with growing tuition repayment debt. Lower starting wages have been explained by programs that require nurses to work for a certain number of years to pay back debt to employers for tuition support, but this too is different from what occurs with other skilled professions. These trends have resulted in an overall depression of wages for nurses. This wage compression and stagnation may likely be adding to frustration and making some prone to exit the field or leave an organization for only a minor change in wage or improved working conditions. Contemporary literature shows that nurses' salaries are stagnant and in many instances have lost pace with where they were in the late 90s.

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It is important to be completely aware of the wage circumstances in your immediate market. This includes shift differentials and other premium pay allocations. Small variations in these compensations can be highly meaningful to nurses, many of whom will flee for only a modest change in wages. Loyalty to an employer is less likely with nurses who have been in a workplace for less than 5 years, and with those who are not active in financial investment programs. Many employers are agreeing to meet financial investment into retirement programs, so even these benefits are not going to sustain staff. The ability to roll over funds and immediate access to healthcare benefits are other benefits routinely offered.

Some Interventions May Have Worsened the Shortage

Government intervention designed to alleviate the shortage may have actually aggravated the situation. Interventions such as vouchers and incentives to stay within a certain market or organization have often interfered with free market forces artificially suppressing supply and demand factors that are in play within other professions. Other issues such as state mandated nurse to patient ratios further complicate matters. Although on the surface this appears to be desirable, if there are too few available nurses, more pressure is placed on the organizations, increasing the stress on those who remain in the system. This can manifest itself in reductions in support staff who are essential to reduce unnecessary burdens on staff nurses. Roles such as unlicensed technicians, unit secretaries, housekeeping and food services manpower can be reduced to pay for the increase in the RNs required. These outcomes have been reported in California, yet this mandate remains popular in concept and is being actively pursued in other states.

Past solutions, which have included importing more foreign-born nurses and reducing the educational requirements have been proven to increase stress and burden at the point of care. For the past 14 years, after the Patriot Act, international recruitment of

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nurses has become more restricted. The nursing shortage is an international phenomenon, and other countries have also imposed restrictions to the number of nurses who may emigrate or obtain visas for work purposes.

Nurse Hiring

Organizations in many marketplaces are confronted with intense competition among employers. A reputation as a good place for nurses to work is ultimately the best status to own. This includes overall working conditions such as location, nurse to patient ratios, pay and benefits, the perceptions of the Chief Nursing Officer and other nursing leaders, reputation of physicians, number of support personnel and even things like parking, all of which contribute to a nurse's selection. As the intensity around publicly reported hospital performance has escalated, some employers have started using standardized testing to help identify prospective employees who already possess characteristics that are a strong match with the desired organizational culture. At face value this appears logical, however, there are flaws in the evidence of the effectiveness of standardized testing. When the word is out in a community that this type of testing is in place, it can deter some applicants. It is significant to note that more than 180 U.S. universities have suspended use of standardized testing due to evidence of bias against minorities (NPR, 2015). Many argue that better results on these tests can be achieved through coaching, and others believe that they have become irrelevant and ultimately damaging to schools and others who use them. They may be useful as an adjunctive tool, but standardized tests should not be considered a primary source of nurse selection criteria.

The issue of sign-on bonuses is also controversial. These enticements may work in the short run, which may be the only motivation for some employers, but this type of enticement is often viewed negatively by long-term employees, further driving wedges

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between management and line staff. Experience would suggest that a high percentage of those accepting sign-on bonuses leave organizations for another similar bonus.

What Are Effective Interventions That Will Work?

- The principles of the ANCC Magnet Recognition Program®. Strong, professional practice environments that give staff nurses a voice in their own work.
- NEVER stop hiring nurses. Know your annual turnover and stay in front of it. Hire in anticipation of losses. Don't wait for the turnover to occur.
- Modify internal processes to speed up the hiring and onboarding process. Delays result in lost hires.
- Work with local schools to develop strong relationships. Former students will already be comfortable.
- Pay your preceptors and give them a lighter load to compensate for what they are doing. (Hourly rate, bonus lump sum or extra vacation time).
- Offer paid Nurse Extern roles.
- Offer a substantial orientation program. New graduates do not come to the hospital ready to practice. The mission of educational institutions is to teach concepts that allow students to demonstrate this knowledge and to pass the NCLEX exam. Students have limited clinical practice hours that are inadequate to practice safely. There is a presumption that employers will acquire the burden of making new nurses functional in the workplace.
- Keep your nursing education department strong. This applies to new and current employees.
- Nurse Residency programs that create learning and social support are the most effective.
- Ensure that your nursing leaders are tolerant and understanding of these premises.
- Routinely monitor your wages and adjust accordingly.

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- Offer tuition reimbursement.
- Develop roles for nurses to aspire to.
- Treat nurses the same way you treat doctors. Be grateful and deferential. They too are generating revenue for you. Monitor nurse–physician relationships.
- Monitor your nurse to patient ratios. Too many patients increases the risk of error and will decrease your patient satisfaction scores and ultimately lead to increased nurse turnover. How many things can any one person do simultaneously?
- Meet with and survey your nurses often. Ask for their suggestions.
- Offer flexible scheduling. Consider shorter shifts to keep experienced nurses working longer.
- Ensure the availability of support equipment that assists nursing staff including lower cost items such as vein finders and hand-held Dopplers.
- Have an adequate number of computers for nurses to access quickly.
- Consider over-head lifts in all patient rooms so patients can be moved safely with as few staff as possible.
- Create an efficient supply management system. Stock supplies to match demand. Using nursing staff to search and call for missing supplies is a dissatisfier, and costly.
- Keep an adequate support system around the nursing staff, such as patient care technicians and unit secretaries. This will keep nurses efficient and satisfied.
- Offer discounts on local services for your staff.
- Help unlicensed staff who aspire to advance their education.
- Have fun at work.

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As is clearly evident at this juncture, there are no magic solutions to resolving the nursing shortage, but there are small interventions that can be taken to ease it, and sometimes circumstances are self-imposed by organizations.

Your Partners at HealthLinx are Poised to Assist You in Understanding Your Marketplace and Sharing Our Expertise to Position You For Your Greatest Success.

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