HIGH ATTRITION RATES IN THE NURSING WORKFORCE:

CAUSES AND POSSIBLE CURES

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ABSTRACT

This paper looks at the apparent shortage of nurses in the workforce, discusses why nursing appears to be a career declining in popularity, and puts forward suggestions to help enhance the attractiveness of nursing as a career and assist organisations in increasing retention of trained nursing staff. It identifies what nurses perceive as the main causes of attrition. Issues facing nurses in rural and remote areas are also identified and discussed. Effective solutions to the problems noted will depend on nurses, unions and management working together collaboratively.

INTRODUCTION

This paper looks at the apparent shortage of nurses in the workforce, discusses why nursing appears to be a career declining in popularity, and suggests ways to help increase the attractiveness of nursing as a career as well as assisting organisations to retain trained nursing staff.

Staff turnover in health facilities both adds to labour costs and reduces the effectiveness and productivity of care delivery. High turnover undermines a health care organisation's ability to survive in a turbulent environment and is an indicator of the existence of underlying problems (Sofaer & Myrtle 1991). Health

care managers should identify factors that predispose facilities to high turnover so that they can focus interventions appropriately and increase their ability to provide cost-effective care. Health care institutions have come under growing pressure for cost containment and increasing nurse retention rates helps increase the cost-effectiveness of the institution by keeping costs lower (Fottler, Crawford, Quintana & White 1995).

CURRENT SITUATION

While recruiting expenses form a significant proportion of high turnover costs, they make up only 20% of the total, the remainder being costs of having unfilled positions, training and orientation, actual hiring expenses and decreased new nurse productivity (Bame 1993). Inefficiencies of incoming employees, of the position while vacant and of the departing employee are difficult to quantify, but are undeniably detrimental to quality and effectiveness of delivering care and create an extra burden on remaining staff (Jones 1990, Phillips 1990).

The problem of turnover rates is further compounded by the decline in numbers of nurses entering the profession (Australian Institute of Health and Welfare (AIHW) 2000, 1999). Difficulties in recruiting school-leavers into the nursing profession and in retaining existing staff are problems being faced by health care organisations and governments in countries including Australia, the United Kingdom and the USA (Egan 2001; Shields & Ward 2000; AIHW 2000, 1999,). This has placed issues of recruitment and retention in the profession high on the political agenda, where there are concerns about whether numbers of trained

nurses will be adequate to meet the future health service needs of an ageing population (AIHW 2000; Shields & Ward 2000).

In Australia, nursing registrations declined significantly between 1993 and 1996, and while this has levelled off, the total registrations and enrolments remain below the levels of 1995 and earlier. There is a continuing decline in full-time equivalent (FTE) nurse employment per 100,000 population throughout Australia, so that patient numbers per FTE have been increasing (AIHW 2000, 1999). Interestingly, nursing employment in rural, remote and regional areas per 100,000 population is higher than the national average, but around 30% of these are enrolled nurses, as against 17.5% in capital cities (AIHW 1999). Barriers to recruiting nurses include inappropriate advertising as well as problems in the area of nurse education. These include inadequate levels of preceptor training and preparation of clinicians for student clinical placements, inadequate length of clinical placements to give students sufficient hands-on experience, a gap between university and health service provider expectations, and no funding support for undergraduate nurses to undertake clinical experience in rural and remote locations (Queensland Health 1999).

There is also a significant drain on the Australian nursing workforce from nurses obtaining work overseas. The corresponding influx of overseas nurses is far smaller. A further reduction is also caused by the substantial number of trained nurses leaving nursing, either for other employment, or leaving the workforce altogether (AIHW 1999).

Over the past five years, nursing service delivery has changed markedly. Acute care hospitals are the major employers of nurses in Australia, and patient separations from these facilities rose by 55.6% in the ten years up to 1996 (Nursing & Health Services Research Consortium (NHSRC) 2000). There has not been a corresponding increase in numbers of nurses employed, which partially explains the increase in patient numbers per nurse. In addition, there has been a significant increase in the number of nurses working part-time, with over 44% of the nursing workforce now employed on a part-time basis (AIHW 1999).

The nursing workforce has an older age structure than in the past, and this trend will be accentuated by the change in the age profile of persons commencing undergraduate nursing training. The intake of mature-age students has increased, with the average age of students rising over the last five years from 21.8 to 24.5 years. In 1998, 27% of the student intake was aged over 30 years, with less than 38% being school-leavers aged less than 19 years. At the 1986 census, 23.3% of nurses were aged less than 25 years, and only 17.5% aged over 45 years. This contrasts markedly with the 1996 census, where only 9.9% were under 25 years, and those over 45 years represented more than 28% of the workforce (AIHW 1999). This means training costs of nurses will be spread over fewer years, and implies a reduction in the number of years a nurse will participate in the workforce.

Another reason for the changing age profile of nurses in Australia is that older nurses are not retiring, probably due to relatively poor superannuation, low interest rates and the lifting of the retirement age (Queensland Health 1999). Nursing is a physically demanding profession that is perceived to have little status outside the hospital system. The increase in patient intensity coupled with an ageing nursing workforce means that meeting the physical and emotional needs of the profession, as well as the provision of adequate properly functioning equipment such as lifting devices, will become an increasingly important factor in both retaining and recruiting a workforce (NHSRC 2000).

REASONS FOR HIGH ATTRITION/TURNOVER RATES

The issue of gender is a crucial factor. Nursing is one of the most extreme examples of the influence of gender in occupational choice (Crompton, Gallie & Purcell 1996; Davies 1995). Although there are significant numbers of males in the nursing workforce (AIHW 2000), the construction of nursing as a traditionally female occupation implies that any shifts in the prevailing mind-set of women and work will have significant consequences on the nursing profession. In today's changing social climate, women are taking on roles outside their traditional ones (Johnston 1989), and this, in conjunction with the changing perceptions of what women should and could do, has consequences for the nursing profession, including the devaluing of nursing as a career (Davies 1995). Pringle (1998) states that while female doctors have taken up the model of combining medicine and nursing, nurses are increasingly made to feel like 'failed doctors'. In this era of greater equal opportunity, young career seekers are unlikely to choose fields of employment where they will be treated and paid as second-class employees

(Davies 1995). As more options become available, the traditional 'female' professions such as secretarial, waitressing and nursing undergo a reduction in supply as women choose fields of employment with greater opportunities for advancement, flexibility and salary. Work is no longer regarded as a source of personal identity, but as a means of achieving a lifestyle, resulting in more frequent career shifts, with flexibility being seen as signifying initiative. The impact of technology increases this need for flexibility, as workers made redundant by technological advances search for new career opportunities (Mackay 1999). Consequently, the likelihood of nurses also choosing a change of career has risen.

Despite the numerical predominance of women in nursing, many are concentrated in the lower grades and men hold disproportionately more of the higher-grade posts. For many female nurses, particularly those working part-time, career prospects appear limited (Lane 1999). Most part-time nurses are employed in basic clinical posts. Nurses who had taken a career break were concentrated in the lower grade positions even though they had the same number of years' experience as those who had taken no career break (Seccombe, Ball & Patch 1993). Possibly, managers may perceive part-time workers as being less committed to their careers than full-timers (Jackson & Barber 1993). Lane (1999) also notes that men experience far more rapid rates of career advancement than women. Additionally, she finds that women with children take significantly longer to reach higher-grade posts than those without children. This is confirmed

by Wyatt and Langridge (1996) who note that there are more women without children in higher echelon jobs than there are women with children.

Nurses with dependent children, who make up a significant part of the workforce, cite inflexible working practices, family responsibilities and inadequate child care provision as main reasons for leaving the workforce. In addition, insufficient training provision and unfavourable management attitudes are given as reasons for leaving or not returning after childbirth (NHSRC 2000; Lane 1999). Continuing social conventions around the role of caring for children and aged parents subject women to different job stresses from those faced by men. The nature of nursing, including shift work, rotating rosters and night duty, imposes limitations and affects the ability to balance work and family responsibilities. Nursing fails to offer sufficient flexibility in days or times of work to facilitate childcare or cater for school hours. Although childcare facilities are operating increased numbers of hours, parents must be able to provide them with a set roster of times and days for childcare, and this is a major obstacle to working nurses.

One hypothesis put forward to explain the high rates of attrition is that nursing is a profession characterised by a diminishing supply of labour at a time of increased demand for nursing services, resulting in widespread demoralisation and job dissatisfaction linked to increased workloads, excessive working hours and poor pay and promotion prospects (UNISON 1996; Seccombe, Patch & Stock 1994). An investigation of job satisfaction shows that is a key issue for both individuals and the organisation, as it impacts on a person's emotions, behaviours and job

performance (Chiu & Kosinski 1997). Shields and Ward (2000) note that there is a strong correlation between job satisfaction and labour market behaviour of nurses. Workers who report higher levels of satisfaction will be less likely to quit or have time away from work, and will be more likely to be more productive than those who report lower job satisfaction. Shields and Ward's (2000) study of British NHS nurses provides evidence that job satisfaction is the single most important determinant of intentions to quit among nurses. They find being duly recognised for one's activities, coupled with positive reinforcement and encouragement, an extremely important influence on the overall job satisfaction levels. While level of reward has some influence, their study shows that it is not just absolute income level that is important, but also income relative to some expected level or comparison group. Relatively low pay within the nursing profession, associated with lowered perceptions of professional standing are likely factors promoting the significance of pay comparison. Shields and Ward (2000) also note that having to work a shift pattern that is not the nurse's preferred pattern has a very large negative impact on job satisfaction.

A study performed by Lok and Crawford (1999), confirms that the Australian nursing profession is facing similar conditions to that of their UK counterparts. They find that job satisfaction correlates strongly with degree of commitment felt to the organisation, and consequently the likelihood that the nurse will remain with the organisation. They also note a variety of other variables such as age, pre-employment expectations, perceived job characteristics and leadership style influence commitment to the organisation via their effects on job satisfaction.

Lok and Crawford (1999) use Mueller and McClosky's multidimensional measure of job satisfaction, based on dimensions of Maslow's hierarchy of needs. It includes dimensions representing higher-order needs such as the amount of control in the workplace, praise received from colleagues, and the level of professionalism, as well as lower order needs such as amount of reward, flexibility of work schedule and balance of work and home life. The study shows that the higher order needs show the greatest correlation between level of job satisfaction and consequent commitment to the organisation, although flexibility of work schedule did have a reasonably strong correlation.

Lane (1999) also notes that the proportion of women in the profession decreases as seniority increases, and this may have some implications for policies aimed at increasing nurse retention.

Research showed a strong correlation between job stress and satisfaction, with job satisfaction being influenced by work-related stress and, vice versa, job stress encountered by an employee is reinforced by feelings of dissatisfaction (Jamal & Baba 1992; Chen & Spector 1991). Nursing involves tasks that are distasteful, highly stressful and highly risky, and nurses frequently encounter many sad life experiences such as death and separation (Chiu & Kosinski 1997). Nurses also perceive they have little discretion over how they operate, leading to increased strain, which combines with role problems to aggravate stress levels (Arsenault, Dolan & van Ameringen 1991).

Chiu and Kosinski (1997) show that nurses with relatively less experience are more prone to job dissatisfaction and stress. This is attributed to several factors, including the fact that experience as well as training is needed to reduce injuries and accidents at work, and that inexperienced nurses have unrealistic self-expectations that put them at greater risk of self-abusive behaviour. Another reason for the lack of job satisfaction in younger workers is the nature of the power relationship between medicine and nursing. Nurses are now educated largely outside hospitals, and their education stresses that a team approach to health care is best for optimal patient outcomes. This provides little warning of the traditional hierarchical structures still existing within the health care system. Students come from an education system that teaches them to be responsible, critical thinkers, and team members striving to deliver holistic care. Upon entering the hospital, they are confronted with a task-oriented, hierarchical culture, and this results in a culture clash that causes many to rethink the decision to nurse (Senate Community Affairs Reference Committee (SCARC) 2001).

Additionally, pregnancy is now considered a state of wellness, and the health system treats pregnant and non-pregnant nurses equitably. Pregnant nurses are therefore expected to fulfil their duties without inflicting extra burdens on their colleagues, which can result in more stress on younger, pregnant nurses (Chiu & Kosinski 1997).

Burnout is a serious problem, and has been linked to many negative outcomes such as decreased efficiency, increased turnover and absenteeism and interpersonal problems (Turnipseed & Turnipseed 1997). The aetiology of burnout is found in professions that involve caring for people, where large proportions of time are spent in attempting to resolve or reduce the problems of others. This can be extremely frustrating as solutions are often elusive or indeed nonexistent, potentially resulting in chronic stress and burnout. Results of burnout include dissatisfaction with job accomplishments, negative attitudes towards work and others, perceptions of unsuccessful job performance, chronic fatigue, depression and feelings of hopelessness. Towery (1992) identified burnout as the single greatest cause of turnover. Research has established a link between variables in the work environment and burnout in hospitals, but interestingly, a 1997 study shows that these variables change for individuals from different cultures (Turnipseed & Turnipseed 1997).

Applebaum and Honeggar (1998) advocate empowerment to avoid some problems associated with burnout, and to reduce the incidence of burnout. Empowerment exists when lower level employees expect to exercise initiative to achieve the organisation's mission, even when this may take them outside their normal responsibilities; and that if the initiative should lead to a mistake – even a serious one – employees should not be arbitrarily penalised for taking the initiative. Sources of empowerment for nurses include interactions with patients and their families, nurse-physician interactions where nurses are listened to and regarded as team members, working well within the nursing team, being

recognised and complimented by nurses in higher positions, and adequate access to information (Chandler 1992). Research also shows a positive relationship between nurse empowerment and job satisfaction, thus indicating it is another factor influencing the retention of nurses in the workforce (Radice 1994).

A further reason for the relatively high attrition rate is dissatisfaction with workload and staffing. Surveys in several countries show many respondents feel that quality of nursing care has declined over the past years. Nurses stated that they had experienced an increase in patient care loads, and were not comfortable with using mandatory overtime to cover for lack of staff. Other concerns were the need to rush through patient care activities inappropriately, the inability to report unsafe practices and lack of action if these were reported, and the fact that nurses were not supported by appropriate staffing levels (Blankenheim 2001, NHSRC 2000, Shields & Ward 2000).

A further negative factor identified in a recent survey of Queensland nurses was non-supportive management that did not communicate effectively and failed to seek staff input, coupled with a lack of clear direction from management or a strategic plan. They also cited insensitive patient acuity systems which resulted in constant redeployment, did not allow for training and staff development time, did not accommodate emergency situations or unpredictable workloads and failed to recognise the amount of paperwork some nurses must take home as being significant factors influencing the lack of attractiveness of the profession. Rostering and leave practices which failed to provide the appropriate skill mix and

staffing levels and which did not provide backfill from pool staff, (resulting in the use of agency staff who are less familiar with the hospital environment), were exacerbated by management discouraging time off in lieu, recreation and study leave and payment for overtime. This impacts negatively on family life, forcing many nurses to reconsider remaining in the nursing workforce. Additionally, the need to perform non-nursing duties including administrative tasks, cleaning and moving equipment added to the dissatisfaction felt by the nurses surveyed (Queensland Health 1999).

RURAL AND REMOTE SITUATION

Recruitment and retention of nurses in rural and remote health care in Australia is a significant issue, since nearly 30% of the population lives in these areas. Factors positively influencing a nurse's decision to work in rural areas include friends and family being in the area, being born and raised in a rural area, marriage commitments, career development and diversity of practice (Stephenson, Blue & Petkov 1999). A recent survey shows that approximately 65,000 nurses, or 30% of the nursing workforce are employed in rural and remote areas (AIHW 1999). However, there has been a significant decline in the numbers of nurses in these areas since 1995, and reasons for this include neglect by governments, inadequate professional support and the demise of infrastructure in rural areas. According to Witham (2000) recruitment and retention issues have existed in these areas for many years, and have simply not been addressed. Nurses stated that factors contributing to their leaving included downgrading, privatisation or closure of health facilities, the need to relocate their family, injury or illness, lack of access to educational opportunities and lack of career growth or promotion

prospects. Inability to find relief for time off or study, lack of access to appropriate accommodation (this was perceived as being of a poor standard, or failing to cater for partners or children) and inadequate salary were also cited (Witham 2000). A 1999 survey of rural nurses showed that their average age was 43.5 years, and that this was increasing (Stephenson, Blue & Petkov 1999), so this would imply that rural nursing is not attractive to younger people.

In addition rural nurses felt there was stress in the working environment, due to lack of support and the need to undertake tasks for which they are not legally qualified and trained. These included prescription, administration or alteration of medication, insertion of intravenous lines and suturing wounds. Nurses undertook these tasks because they felt that there was little or no choice – doctors were either unavailable, refused to attend, delegated accountability to nurses or had less experience and confidence than the nurses (Stephenson, Blue & Petkov 1999). Nurses in rural and remote areas are often the sole health practitioners, which raises concerns about security and safety as well as feelings of being inadequately skilled to deal with arising situations. Additionally, communities have unrealistic expectations about the level of service, including expectations that the nurse will be constantly on call (Queensland Health 1999).

The Government spends considerable funds to attract doctors to rural areas. This includes establishment of the rural Workforce Agencies to recruit and train doctors, costing $14.4 million per year, the Medical Undergraduate Scholarship Scheme at $8 million over four years, and the $60 million over four years bonus

scheme providing payments to selected country GPs to recognise the additional pressures these doctors face. However, there is no comparable funding for nurses. The limited funding currently available includes $1 million over three years for the Remote and Rural Nursing Scholarship Scheme, which is inadequate considering the size of the nursing workforce (Witham 2000). This inequity in Commonwealth government funding has resulted in nurses becoming disillusioned and angry, increasing recruitment and retention problems. Nurses also stated that many rural areas are isolated, yet do not qualify for the extra financial reimbursement of the remote area nurse package, to assist with the increased cost of living in these areas.

STRATEGIES TO REDUCE TURNOVER

What strategies can health services employ to reduce the attrition and turnover rates in the nursing workforce? One study investigated hospitals with low nursing turnover rates and identified factors that made these hospitals attractive to nurses. These included having a nurse-patient ratio that ensured quality patient care, flexible staffing to support patient care needs, flexible scheduling and the elimination of rotating shifts, a strong and supportive nursing and hospital administration coupled with participative management, and open communication. In addition, the importance of education and opportunities for career advancement were identified, with the existence of clinical advancement opportunities so nurses can continue to work on the wards while still advancing professionally. Provision of inservices and continuing education opportunities for all shifts was also a strong factor in reducing turnover. Finally, a good nurse-doctor professional relationship was cited as important (Helmer & McKnight 1989).

Nursing needs to be promoted as an attractive profession, so that recruitment levels increase. This should include marketing nursing to high school students as a desirable career, by ensuring that careers advisors have access to information and what is needed for entry into nursing, as well as providing and encouraging work experience placement for students. This can be done both on a local level, and as a government initiative using the resources of both the health and education departments (SCARC 2001; NHSRC 2000; Queensland Health 1999). Queensland Health (1999) also recommended the establishment of a nursing career advisory service to promote nursing as a career.

One of the barriers to undertaking nursing study was identified as being lack of scholarships for undergraduate study. Some scholarships are available for indigenous students only, so there are limited options for other students (Queensland Health 1999). Both government and private sector health care organisations have a vested interest in ensuring an adequate supply of new nursing recruits, so they could consider establishing scholarships in return for a guaranteed term of employment at completion of study. This may assist in recruiting nurses to apparently less popular rural areas, thus addressing the maldistribution of the workforce between urban and remoter areas (SCARC 2001).

A further problem area is lack of congruence between objectives of tertiary institutions and needs of health care organisations. Consequently, nurses entering clinical placements can have unrealistic expectations, resulting in disappointment and sometimes a decision to leave the profession. This indicates a need for better consultation between universities and health service organisations, which could be facilitated by development of partnerships between the two. This would increase the likelihood that nursing education will be relevant and able to meet the needs of the profession and the health care sector (SCARC 2001; Queensland Health 1999).

Health care organisations also need to address issues of inflexible rostering practices and inability of nurses to balance work and family life, and the fact that the nursing profession is seen to be lacking in the area of family-friendly policies. Women and men have different work patterns because of the cultural norm that women remain primary caregivers for children and households. However, it is important that these differences are not misinterpreted and assumed to mean that women are less committed to their careers. Organisations must manage diversity in the form of working patterns, recognising that women require different forms of organisational support, particularly in terms of flexibility and part-time work. Managers need to utilise initiatives that enable women to combine parenthood and paid work, and this involves rethinking the traditional model of a career as being full-time and continuous. Future career paths need to encompass the idea of non-linear careers to provide women with dependant children the opportunity to continue with their careers after childbirth. This will mean opening up

opportunities for part-time work in the higher grade as well as the lower grade positions (Lane 1999).

For effective recruitment and retention, it is vital that workplace management does not impact negatively on family considerations. Nurses with family responsibilities are still valued clinicians and should be retained in the workforce. However, a major impediment to this is the lack of childcare, particularly extended hours childcare (Lane 1999, Queensland Health 1999). Health care organisations must assess the need for childcare so that they can plan strategies to reduce the attrition rate of nurses for this reason. In addition, innovative rostering practices should be developed, with input from those who must work the rosters. There may be a need to move away from traditional shift lengths and investigate other entrenched award conditions to provide nurses with the flexibility they need to balance work and family life. This would need to be undertaken as an ongoing participative process with relevant unions as well as staff and management.

Issues raised about job satisfaction and workload must also be addressed. Management style and culture play an important part in influencing staff health and satisfaction by encouraging control over work and participation in decision making. Strong internal communications, staff support and good employment practices contribute to this. Organisations that genuinely involve staff in planning and delivering services find that this leads to better teamwork and helps break down traditional professional barriers and rigid hierarchies (Applebaum & Honneggar 1998; Sofaer & Myrtle 1991). This cultural change process requires

leaders who are committed to setting the tone and working this way themselves. In a typical health care setting, nurses make up the largest group of employees, work in the organisation around the clock, and interact with patients more frequently than other staff. They are a largely untapped resource of meaningful knowledge of great potential value to the organisation. Staff whose experience and input is used feel valued and an integral part of the decision-making process, and this results in a greater sharing of skills, more efficient, effective use of resources and better clinical and non-clinical decision-making (Lanser 2001).

To remain motivated and satisfied, staff need to feel that their own working conditions are being improved, and that they have input into this process. This may cover strategic areas such as planning and delivering patient services as well as the more personal areas such as how their work is organised, or health and safety. The stress of coping with heavy workloads is a consistent theme in the nursing profession, and health care organisations need to develop a business planning model which will take into account measures relating to workloads, skill mix, patient dependency and the training needs of nurses. Staffing levels must change in response to the changing health care environment of decreased length of stay and increasing activity. Current standardised models such as Hours per Patient Day do not recognise the complexities and variances in clinical practice settings, so it is essential that the health sector develop a model to determine appropriate long-term nursing staffing levels needed to meet specific service requirements (SCARC 2001; NHSRC 2000).

Recruitment and retention of rural and remote nurses is an issue that merits attention in its own right. While nursing in remote and rural Australia appeals to many, there are also negative aspects. To improve access to safe and appropriate health care, nurses who currently are required to provide services outside their scope of practice without adequate training and legal coverage need to be provided with legal, educational and professional support. An exchange program allowing rural nurses to leave their communities and work in a provincial centre or capital city to assist them to upgrade their skills would address some of the education and training problems identified (Witham 2000). The negative impact on communication, access to education and training, telemedicine and management practices experienced by rural and remote locations due to difficulties in accessing information technology must also be addressed. Since access to appropriate information technology provides a more effective and efficient service, health care organisations need to assess the availability of such technology, and supply it where it will improve service provision.

Health care delivery in rural and remote areas can be improved by making better use of the skills and capacity of nurses. The issue of advanced practice nurses and nurse practitioners is already being investigated (Fitzpatrick 2001; Offredy 2000). As mentioned earlier, many rural and remote nurses are already working as advanced practice nurses within their everyday practice, but this role is not clearly defined, recognised or supported. A workshop on rural and remote practice defined such nurses as *"nurses who think critically, analyse, reflect, problem solve, and apply high level knowledge that is evidence and research based to*

clinical interactions with people who need their care", (Fitzpatrick 2001, p. 8). It has been recommended to the Commonwealth Government that a National Framework be developed to describe and benchmark skills needed to work in advanced nurse practice in these areas, and that educational institutions revise their programs to cover all components of the Framework. In this way, the work already being undertaken by nurses in rural and remote areas will be recognised and supported, thus alleviating a major concern in this area (Fitzpatrick 2001).

CONCLUSION

While there are many problems facing the nursing workforce in recruitment and retention of staff, there has been much research undertaken into the causes of these problems, and into measures available to redress them. Australia's nursing shortage is not yet nationwide or critical, but action must be timely as the window of opportunity to alleviate the problem is small. Factors affecting recruitment must be addressed by governments as well as organisations, as they are impinged upon by actions in more than just the health sector. In terms of retention, many surveys have identified similar factors that nurses cited for leaving the workforce, so there is consistency in the available results. Organisations should examine their performance in terms of the areas identified, and take corrective action where necessary. However, it is also important that corrective action to be taken is planned and implemented with extensive consultation between all affected parties. Failure to involve all stakeholders in the consultation process is likely to result in unsuccessful initiatives that fail to solve identified problems, and as a result, Australia will face the same serious shortages of nursing staff currently being experienced by the UK and the USA.

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