In September 2015, the emergency department (ED) at Medway Foundation Trust (MFT) was identified as being in crisis and placed in special measures (Care Quality Commission, 2016). CQC inspections conducted between 2013 and 2015, which had been prompted by higher-than-expected mortality rates, identified serious patient safety concerns. The ED did not have enough nurses to maintain safety, was over-relying on agency nurses, and was not offering effective continuing professional development to staff nurses. Local universities had withdrawn their student nurses from placements at the ED. Working conditions, with routinely overcrowded corridors, were challenging for nurses. The heavy reliance on agency staff and ineffective administration of temporary shifts had resulted in most shifts starting with several positions unfilled and inadequate nurse-patient ratios. Many experienced nurses had left the ED and had not been replaced; reports consistently highlighted a lack of nursing leadership (CQC, 2016). This had led to multiple inefficiencies, including outdated nursing workforce records and a lack of supervision for junior staff. In November 2015, the nurse vacancy rate had risen to 65%.

UK-wide issues

In the UK, there is a shortage of experienced specialist emergency nurses: the average ED consistently runs with a 10-20% deficit (Royal College of Nursing, 2015). This is worsened by the annual turnaround rate, which is also, on average, 10-20% (RCN, 2012). EDs are experiencing extreme pressures, with demand regularly exceeding capacity. The challenges arising from overcrowding result in stress for staff and have been blamed for the high turnaround (Royal College of Emergency Medicine, 2015).

Nurse shortages are not only in the ED. Ninety-three per cent of trusts that responded to NHS Employers’ (2015) supply and demand survey (137/147) reported shortages of registered nurses;
63% (92/147) had had to recruit from overseas in the preceding 12 months. This is not a new phenomenon: evidence suggests that, in recent decades, there have been insufficient numbers of student nurses to replace those retiring and counter the effect of an ageing nursing population (RCN, 2015). As well as replacing nurses who leave or retire, the NHS must keep pace with the increasing demand for healthcare, which grows by 2.8% per year (National Audit Office, 2016).

Regional variations in nurse recruitment and retention can be large, partly because of pay scales and cost of living, and partly because of limited workforce mobility. Addicott et al (2015) have shown that organisations close to London face particular challenges.

Smith and Baltruks (2015) noted that challenges include an ageing workforce, over-reliance on agency and overseas nurses, and worsening morale leading to high attrition rates; they stated that employers need to do more to ensure both their new starters and existing workforce are happy, supported and engaged.

Poor government planning has contributed to a variability in the numbers of student nurse places in universities (Christie and Co, 2016; Smith and Baltruks, 2015). Despite assurances to the contrary, the recent Department of Health reform of financial support offered to students (DH, 2016) could exacerbate existing shortages. To counteract this risk, plans to train 1,000 associate nurses have recently been put in place (Health Education England, 2016).

Even if this new initiative has a positive effect, the national and global competition for experienced nurses, combined with the increasing need to fill gaps in specialist roles left by a failure to recruit doctors, will likely precipitate the need to increase nurse recruitment in the NHS over the next 4–5 years (NHS Employers, 2015). There is, in particular, a large international demand for specialist nurses, which has left critical and emergency care struggling to recruit and retain experienced staff. This is compounded by the fact that departments are unable to replace experienced nurses with sufficient numbers of newly qualified nurses (NQNs), which has resulted in some EDs having to close at night and consolidate nurses during normal working hours to provide a safe service (Illman, 2016).

**A new strategy**

With the above in mind, we knew that trying to rectify our 63% vacancy rate by attracting nurses from other EDs would not be constructive in the long term, as many departments were probably experiencing similar staff shortages. By combining key information from a literature review with the competences and experience of the senior ED team, we developed a recruitment and retention strategy. Its underpinning principles and rationales are detailed in Box 1.

### Learning from the literature

The innovative multidimensional support programme described by Valente and Wright (2007), implemented by a US hospital to attract new graduate nurses to work in mental health, included a specialist mental health curriculum, clinical preceptorship and a new graduate programme. In the first four years, 37 new graduates had been recruited and a 90% retention rate had been achieved. Protecting nurses’ continuing professional development time and delivering training in house were considered essential.

Dawoud and Maben (2008) identified similar themes, with protected time for training and training delivery in the workplace seen as important components of successful recruitment and retention.

Although providing CPD and multidimensional support may entice nurses, Smith and Baltruks (2015) noted that individual nurses being unprepared for the realities of modern nursing accounts for attrition rates as high as 20% during the early years of their careers. This comes after 20–50% of student nurses have left training before completion.

### Employing newly qualified nurses

For employers, filling vacancies with NQNs carries a risk due to their novice status, limited scope of practice, lack of experience and unfamiliarity with policies and procedures (DH, 2010). NQNs require ongoing clinical support, particularly in the ED, where patients will need interventions such as cannulation, blood tests and intravenous drugs.

The knowledge and skills of NQNs have been a long-standing concern (Council of Deans of Health, 2016); although NQNs are expected to acquire and practise preset competences during training, some are still unable to undertake essential nursing tasks on qualification (Whitehead et al, 2013; Nursing and Midwifery Council, 2010). This is particularly an issue in emergency care, where the ability to manage undiagnosed patients and to build on existing skills is paramount.

Healthcare organisations often start by getting NQNs to practise many of the competences they have already acquired, such as basic drug administration and essential care skills. As a consequence, they focus their resources on this and on achieving mandatory training objectives (Jones et al, 2014). Many have introduced short, often unstructured, support programmes for NQNs – referred to as preceptorship programmes (Morgan et al, 2012) – but there is little national guidance on the content, length and associated competences for these (Hardacre and Hayes, 2016).

There are several definitions of preceptorship; in the present context it refers to a period of guided practice helping NQNs to
move from novice to competent practitioner (Benner, 1984).

Despite the complications inherent in employing NQNs, investing in them is one of the keys to successful recruitment in the long term because these new nurses will want to continue training and expanding their knowledge (Marks-Maran et al, 2013). There is also evidence that professionals tend to stay in the geographical region where they trained (Addicott et al, 2015).

The preceptorship programme

We thought a preceptorship programme for NQNs would provide a sustainable answer to our high vacancy rate. A fundamental aim was to rapidly improve NQNs’ understanding of the complexities of presentations in acute patients. For that purpose, a two-day, ED-specific training programme on emergency care essentials was designed, which NQNs undergo within their first three months. This allows any major gaps in their skills and knowledge base to be addressed quickly, ensuring they are able to provide safe care and escalate issues effectively.

Each NQN is allocated an experienced nurse who becomes their preceptor and supports them during the transition period. After having completed the trust’s mandatory two-week induction, NQNs work in a supernumerary capacity for three more weeks. During that period, they gain familiarity with local processes and systems, and undertake basic tasks. The period can be lengthened depending on each individual nurse’s needs.

There is a lack of evidence on the optimal length of preceptorship programmes but current ones last for 3-12 months (DH, 2010). We created a training pathway for NQNs recruited to our ED (Fig 1); it includes all the basic training elements needed for them to:

- Fulfil the requirements of the job description for an ED band 5 nurse;
- Work with indirect supervision only, once completed.

While designing the pathway, it became obvious that the training would not be achieved within a year as originally planned; as a result, the preceptorship programme was extended to 18 months.

Retaining experienced nurses

Nurses have a greater choice than ever of employment opportunities (ward-based or community nursing, roles in private industries or specialist areas such as coronary and intensive care) so retaining and attracting experienced nurses to work in emergency care – an area renowned for high stress levels – was always going to be challenging. In MFT’s case, the issue was compounded by the department being placed in special measures and having repeatedly received negative publicity.

In an effort to retain experienced nurses and attract new ones, the senior ED team developed two specialist higher education courses to be delivered as work-based learning initiatives:

- Bachelor level for nurses who had not yet completed a first degree;
Nursing Practice

Innovation

Table 1. New nursing staff

<table>
<thead>
<tr>
<th>Role</th>
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<tbody>
<tr>
<td>Clinical support worker</td>
<td>8</td>
</tr>
<tr>
<td>Associate practitioner</td>
<td>12</td>
</tr>
<tr>
<td>Band 5 newly qualified nurse</td>
<td>18</td>
</tr>
<tr>
<td>Band 5 experienced nurse</td>
<td>4</td>
</tr>
<tr>
<td>Band 6 clinical sister/charge nurse/trauma practitioner</td>
<td>5</td>
</tr>
<tr>
<td>Band 7 senior sister/charge nurse/trauma practitioner</td>
<td>7</td>
</tr>
<tr>
<td>Band 8 or above: matron, consultant nurse, lead emergency nurse practitioner/practice development nurse</td>
<td>4</td>
</tr>
</tbody>
</table>

- Master’s level for nurses with a degree (and eventually for postgraduate nurses after completion of the 18-month preceptorship programme).
- These courses are an integral part of CPD, accredited by a local university and meet national requirements for quality assurance.

Introducing new roles

The senior ED team undertook a problem-solving session led by the consultant nurse to examine whether patients’ experiences could be improved by introducing the associate practitioner role to support and complement existing roles. The AP role has been recognised as appropriate to fulfil several aspects of care traditionally done by nurses (Skills for Health, 2009) and is supported by core standards that can be built on to structure ongoing training.

Several areas of practice were identified as suitable for APs, including the promotion of patient pathways; these included the hip fracture pathway, minor injury filtering and trauma care. Two things we wanted to avoid were diluting or replacing nursing roles with unregistered staff and creating roles that were purely task oriented.

Another role was introduced – that of trauma practitioner – to give additional support to junior nurses working in the resuscitation room and deliver technical skills workshops. The trauma practitioner is an Agenda for Change band 7 role; it is supported by competences published by the RCN (2012), which provides a framework for skills and knowledge development.

Educational collaboration

A multidisciplinary learning and development board was created to oversee all educational initiatives, ensuring a unified approach to workforce development and a sharing of resources and know-how. The board developed close working relationships with local stakeholders, including two universities. Recruitment open days held in September 2015 had revealed students’ misconceptions about working in an ED. The ED’s consultant nurse designed and delivered a two-hour session for students to challenge these misconceptions. The session comprised:

- A presentation of how an ED functions and the variety of nursing roles it offers;
- A teaching session portraying the complexities of conditions nurses encounter in the ED;
- A question and answer session, which allows participants to discuss working in an ED after graduation.

The student sessions have been held every year for the last three years and attract up to 30 students.

Outcomes

The recruitment and retention strategy has proved a success. Since it was put in place in November 2015, 58 new nursing staff have been recruited, including 12 APs and two trauma practitioners (Table 1). The vacancy rate has dropped from 65% in November 2015 to 14% in January 2017.

Many vacant posts were filled with student nurses who had yet to complete their training; although this delayed the start of NQNs in their new roles, it did allow time for planning preceptorships. The educational programmes are now well established and are repeated periodically for new starters.

Conclusion

Filling vacant nursing posts is an inevitable part of running a department. It becomes overwhelming when nurse managers are confronted daily with more urgent priorities. What happened at our ED shows that the vacancy rate can spiral out of control. The challenge was overcome by simultaneously dealing with the short-term issues and investing in long-term solutions. Even in extremis, a well-constructed plan can quickly improve a department’s ability to attract new nurses and retain existing ones.

Our initiative also shows the benefits of empowering nurse leaders to set up their own strategy, specific to the needs of their area of expertise. We believe the principles underpinning our strategy can be transferred to, and similar outcomes achieved in, other healthcare areas and environments. NT

References

Nursing and Midwifery Council (2010) Standards for Pre-Registration Nursing Education. Bit.ly/NMCNurseEdStandards  