Nurses Returning to Practice After an Extended Career Break:

A Narrative Study

A Thesis

Presented to

The Jackson College of Graduate Studies

Department of Nursing

The University of Central Oklahoma

Edmond, OK

In Partial Fulfillment

of the Requirements for the Degree

Master of Science, Nursing Education

---

by

Brandi Bates Stanley, BSN, RN

May, 2018

Keywords: Nurse Returning, Nurse Refresher, Returning to Practice, Inactive Nurse, Return to Practice

COMMITTEE MEMBERS

Committee Chair: Joyce Tow Ph.D., APRN, RNC

Associate Professor, Department of Nursing

University of Central Oklahoma

Committee Member: Linda Rider Ed.D., RNC

Chairperson, Associate Professor, Department of Nursing

University of Central Oklahoma

Committee Member: Karen Vessier, MS, RN

Instructor, Department of Nursing

University of Central Oklahoma

Signature Page for Thesis Defense

A Thesis Approved for the Master of Science, Nursing Education

Student: Brandi Bates Stanley, BSN, RN

Student ID: 20427834

Thesis Title: Nurses Returning to Practice After an Extended Career Break: A Narrative Study

This thesis was submitted by Brandi Bates Stanley to the University of Central Oklahoma, Department of Nursing. It was submitted to the persons listed below in partial fulfillment of the requirements for the degree of Master of Science in Nursing Education at the University of Central Oklahoma.

Dr. Joyce Tow Ph.D., APRN, RNC — Date: 5-3-2018

Dr. Linda Rider Ed.D., RNC — Date: 5-3-2018

Karen Vessier, MS, RN — Date: 5-4-2018

_____ — Date: _____

ABSTRACT

Statement of the Problem: The experience of nurses returning to practice after an extended career break has not been well researched and must be understood to facilitate a safe return.
Literature Summary: The nursing shortage is predicted to worsen over the next several years and nurses not currently practicing are a potential pool of personnel with a lower cost associated with re-education (Stevens, 2014). There are few articles in the literature on returning to practice. The Texas board of nursing identified a high risk of errors if the nurse is out for greater than four years. Refresher courses and medical centers both have a stake and a responsibility in facilitating a safe return. Huggins (2005), examined efforts to develop a program in an organization that would allow nurses to be engaged academically and mentored back into practice. Yancy and Handley (2004) concluded that returning a nurse to practice was a complex process that goes beyond a mere refreshing of skills.
Thesis Statement: Nurses returning to practice after a career break face challenges that must be understood for educators and employers to facilitate a safe and satisfying return to practice.
Research Methodology: A qualitative narrative study was best suited for exploration of this poorly understood topic. A snowball method was used to find subjects who had returned to practice or were in the process of returning after a career break of at least five years. Recruitment was done through a professional nursing organization, social media, and referrals. Five nurses were identified, interviewed, and audio-recorded. The grand tour question was open-ended allowing the nurses to begin, progress, and end the story as they chose. Riessman (2010) discusses the natural impulse of people to narrate experiences of life, so subjects were simply asked to tell their story of returning to practice. Following the interviews, transcripts were generated and examined for commonalities, challenges, and learning needs.
Summary of Findings: Nurses returning to practice face many challenges on the journey back. The unfamiliarity with technology, difficulty finding work, insecurity, and horizontal violence are some of the challenges. Nurses who return will often develop a heightened empathy towards others and a drive to become the expert in their practice area. Returners also report a sense of loyalty toward the employer that took a chance in hiring them which often results in longevity with the organization.
Confirmation of Thesis: The return to practice nurses each have a story to tell that enlightens both educators and hospitals on how to facilitate a safe and satisfying return.
Statement of the Significance of the Findings: Because the Bureau of Labor Statistics is anticipating a growing need for nurses, the returning nurse is a valuable resource to meet the predicted shortage. The critical and mortal nature of the profession makes assuring competency of the returning nurse a vital undertaking,
Suggestions for Further Research: Returners come back to practice with a variety of work experiences and variation in length of time out of nursing. Creating a return to practice program that assures competency while providing for individualization for this diverse group is challenging and poorly researched. The fees associated with operating a return to practice program most often exceeds program charges and is pieced together from online sources. How adept individual instructors are at this process directly affects program quality. Economically standardizing curriculum and creating organizational cultures that can facilitate compassionate preceptorships and individualized extended residencies needs further research.

PREFACE

Throughout our lives, each of us is inextricably connected to our personal story. Sometimes we choose to direct the path of the story deciding the course we will take. At other times, the path is determined for us though twists and turns of fate that are unavoidable.

No matter how the path is determined, our stories define who we are. Our stories connect us to one another in our humanity. In the words of Phil Barker and Poppy Buchanan-Barker (2015), theorists of the Tidal Model of mental health recovery, "As people, all we have is our story. All we can ever be is framed by the story of our lives – the events that have occurred and how we responded to them. This story charts not only the changes that have occurred on our voyage from birth, through childhood and adulthood and eventually into death, but also the growth and development that has taken place within us."

The story of the nurse returning to practice is a personal story of growth and development. While there are similarities that bind these nurses in a common quest, it is a lonely voyage. Few dare to return. For the nurse who has the tenacity to return, the personal narrative has become a part of the identity of the nurse, imparting the self-assurance of one who has stared at fear without shrinking back. In the process of the struggle to return, the challenges have been difficult, the work hard. Obstacles had to be overcome that would have defeated many. Those who have stayed the course have emerged victorious, gaining confidence as the story unfolded.

As one would admire a hero who is courageous in overcoming great adversary with tenacity while virtuously maintaining the quality of nobleness of character, so the returning nurse is to be admired. As we hear the story of one who has overcome, we are strengthened by the telling, connected with the struggle, and given courage to persevere through trials.

ACKNOWLEDGMENTS

First, I would like to thank Dr. Tow and my committee for your mentorship and guidance through the thesis process. Thank you to the faculty of the college of nursing. For the past two years you have inspired, challenged, frightened, and pushed me to finish what I started and become a better nurse in the process. Thank you to my family for your patience and understanding. Finally, thank you to all the nurses who shared their stories.

TABLE OF CONTENTS

CHAPTER 1

Why Study Returning Nurses?

In the field of nursing, it is common to find nurses who previously practiced their profession but have taken an extended break or left the profession. Sometimes these nurses will decide to return. Nurses who return to practice do so for a variety of reasons. The need for more money, children no longer needing care at home, changing family structures, and a love of nursing are just a few of the reasons nurses return (Kent, 2015).

Background

Nurses returning to practice have a different journey into caring for patients than those who enter the profession following a nursing education program. The nurse returning to practice may bring with him or her a wealth of experience, communication abilities, and situational understanding which will take years for the new graduate to develop. However, the new graduate is likely to be more familiar with recent developments, the use of electronic health records, and clinical skills that the nurse returning to practice has never seen or has not utilized for some time. The pathway for a new nurse entering practice is common and better understood. It can be anticipated what assistance most new graduates will need to become fully functioning RNs who successfully transition from novice to expert. Returning nurses are fewer in number than those just beginning practice and the needs of the returning nurse are less understood.

According to Benner (1982), The Dreyfus Model of Skill Acquisition describes the phases of skill development a person passes through on the pathway to developing proficiency. These five levels are linear as there is movement from abstract principles, which can be taught, to concrete experience that the nurse draws upon to define actions. When the nurse achieves the final level of the five phases of skill development, he or she becomes the expert. A nurse

returning to practice may need assistance with performing even the most basic of skills much like the new graduate in the novice stage of practice, yet he or she may have characteristics of the competent nurse, already in stage three of skill development, who is capable of prioritizing need and seeing his or her actions in terms of long-range goals for the patient. The nurse returning to practice may already perceive as an expert nurse, intuitively understanding the patient's condition without being able to describe his or her gut feelings, yet be entirely unfamiliar with the technology used to chart patient status. (Benner, 1982)

The journey for the nurse returning to practice is not a linear journey like that of the new nurse. Because the journey is not linear in nature, it is harder to understand the progression necessary to ensure a safe and satisfying return to practice. Benner drew upon the work of Dewey who described the principle that people learn more from experience than from didactic teaching, but it is difficult to describe the learning of those who contain the experience but have not utilized it in some time. It is also difficult to know what needs to be reclaimed in those whose didactic teaching is out of date or has been relegated to the cobwebs of longer term memory.

Purpose

The journey, experiences, challenges, and concerns of nurses who return to practice are relevant topics for study. By understanding the phenomenon of what these nurses fear, need, and experience, educators can hope to adequately prepare nurses for a return to practice. Hospitals may also find this information helpful in structuring residencies for nurses desiring to return to practice after an extended hiatus. There exists no theory of model for learning that addresses the needs of the strange and non-linear journey of someone who used to be competent, still perceives as a competent individual, but lacks even the most basic of information. Only through

understanding the obstacles of this special population of nurses can educators and hospitals hope to return them to a satisfying and safe practice as the primary provider of patient care within the health system.

Significance

The Bureau of Labor Statistics anticipates a growing need for more nurses over the next few years due to medical advances which have led to longer life expectancies and a large population of older adults now needing medical care. Large numbers of nurses currently in the workforce are also approaching retirement age making less personnel available to provide patient care. (Nurse.org, 2016). At the same time, qualified applicants are being turned away from nursing schools due to an insufficient number of nurse faculty, preceptors, and clinical sites. In 2008, a survey found that more than 15% of licensed RNs were not actively employed in nursing and many more were contemplating stepping out of the profession (Gellasch, 2015).

Stevens (2014) discussed the benefits of pulling the inactive RNs back to practice. It is likely that when a nurse returns to practice, he or she will stay until retirement age. Re-education of the returning nurse is less costly and faster than educating new nurses. Using a cost analysis approach, Stevens points out that a three-year program can cost up to 100,000 pounds in the U.K. to educate a nurse. Retraining a nurse will cost about 2,000 pounds and be complete in about six months. Stevens discusses the lack of research about the returning nurses and proposes the need for greater understanding of why nurses leave the profession, how to entice them to stay, and how to draw those who have left back into active practice.

With a nursing shortage, an inability to produce new nurses at the rate necessary to keep up with the shortage, and large numbers of nurses who used to practice, recruitment and reeducation of the already trained individuals would be an appropriate priority. Returning

nurses are a large and mostly untapped resource that can be a means to meet the need of the projected shortage. If educators are to prepare these nurses, however, the educational needs of the nurse must first be understood.

Unlike other professions where education and training prepare an individual to provide a service or meet a need, nursing is a profession where the service and needs deal with the struggle between life and death. The critical and mortal nature of the profession makes assuring competency a vitally important undertaking, To return a nurse to practice without competency is a perilous action with likely consequences of a price paid in human welfare or even human life. Educators must understand the journey of nurses returning to practice due to the vital role that nurses play in patient care and the consequential and perilous actions that a poorly prepared nurse may enact if incompetent in job performance.

Summary

The returning nurse has the potential to be a large untapped resource to meet the needs of a healthcare system that is facing a critical shortage over the next few years. These nurses must be provided with a safe and satisfying method of returning to practice if they are to complete the process and stay actively employed in nursing. The educational needs of the returning nurse have not been studied and are poorly understood. The model described by Benner of the progression of the nurse from novice to expert is not an applicable theoretical model for progression in this population of nurses and there exists no theoretical model that adequately describes the process. Beginning with narrating the experience of the returning nurse can shed light on the process of returning so educators and hospital administrators can structure preceptorships and educational objectives to assure a return that optimizes safe patient care and retains a valuable resource of personnel.

CHAPTER 2

Current Literature

Definitions

Return to practice RNs are nurses who have undergone academic coursework in preparation for licensure as a registered nurse and have at one time obtained a license through the NCLEX examination process in the United States or through an equivalent method for the country of licensure. The return to practice RNs have taken a career break by not being employed in a nurse-related field for an unspecified length of time and wish to again obtain licensure and/or employment as a nurse. The term return to practice RN is broad and includes any nurse engaged in the process of returning to active licensure status or having already gone through the process to re-obtained licensure at some point.

A nurse refresher course is a course designed to prepare nurses in the United States for a return to practice through a combination of academic and clinical coursework. In the United Kingdom, this course is called a RTP or Return to Practice course. In some areas of the United States, nurses may not practice, but still maintain licensure through continuing education despite not being actively employed in nursing for several years. No literature could be located specific to this type of nurse. For the purpose of this study, these nurses were included in the definition of return to practice RN.

History of Returning to Practice

Cooper (1973) discusses the history of retuning nurses to practice beginning with the first refresher course offered in the 1930's during the great depression. The refresher courses were provided again, more extensively, during the second world war. During World War II, federal funds were made available to schools for the re-education of nurses. According to Cooper, the

nurse refresher course was represented in literature after World War II, but became more prevalent again around 1967. Cooper, in 1973, discussed how the recent increases in innovation in nursing and health care makes returning a nurse to practice more difficult. The innovation in health care has continued and has accelerated the pace since Cooper's publication.

Due to a shortage of nurses at the end of the 1980's, Healy (1989) authored an article about activating the inactive nurses. In this article, the Nursing Management Group at the University of California at San Diego came up with a plan and sent a letter of recruitment to 1,600 inactive nurses in the county. The letter to the inactive nurses asked them to consider coming back, referring them to a return to practice course.

Although the literature regarding the history of returning nurses to practice was sparse, it was obvious that during times of nursing shortages return to practice RNs were considered a valuable resource of personnel. Recent literature once again addresses the idea of recruiting and reeducating inactive nurses as a way of meeting an ever-increasing nursing shortage.

Current Research

A literature review was conducted using CINAHL, Science Direct, and a Midwestern university's library database. The terms returning nurse, return to practice, nurse refresher, nurse returning to practice, and experience returning nurse were used to explore available literature.

In the United Kingdom, there has been a large nursing shortage partially fueled by the reduction in the number of places available to train new nurses and the aging nurse population. Additionally, nurses have been leaving the profession due to stress, job dissatisfaction, childbearing, and other factors. The nursing shortage has led to a government effort in the U.K. to staff the health system by enticing nurses who have left the profession to return to work

(Durand, & Randhawa, 2002). The campaign known as the Come Back campaign provides government funding for reeducation of the returning nurse (Dean, 2014).

The United Kingdom is not the only country affected by the shortage. Other countries have also recognized the value of returning nurses to practice after a career break due to the lower cost associated with re-education. It is far less costly in time and money to re-educate a nurse than to educate a nurse from the beginning (Stevens 2014). Several articles in the literature address specific courses for returning nurses to practice, and make suggestions for structuring and inclusion (Robinson, 2015, Nottingham & Foreman, 2000, Hydes-Greenwood & Leach, 2002). Elwin (2007) describes a scarcity in the literature regarding outcomes and processes of return to practice programs. While there are multiple programs published in the literature that seek to address the re-education of nurses worldwide, it seems that there is a lack of any consistency in the didactic and clinical components from one program to the next. Despite the useful information and suggestions in the literature on re-educating the returning nurse, there is almost nothing in the literature on the experience of the nurses returning to practice and how effective these programs are in meeting the needs or addressing the challenges the nurses face when returning. Hobbs (2011) authored one of the only attempts in the literature to document the journey of the return to practice nurses in her dissertation that focuses on the barriers and successes. Hobbs writes “What is lacking are studies that investigate inactive registered nurses’ experiences when they return to practice. Their voices have not yet been heard. Written surveys fail to capture the essence of the experiences of the nurse returning to practice” (p. 7)

Cited by Borgfeld (2014) as a basis for a nurse refresher course development by a local college, the Texas board of nursing conducted a study in 2006 that identified a high risk of committing errors in practice if the nurse had been out of active practice for greater than four

years, or was now beginning practice in a different care area. The study called for nurses returning to practice to have close supervision and an educational update. This study points to the critical nature of understanding how educators and hospitals can facilitate a return to practice because failure to do so can have a direct impact on patient safety.

Huggins (2005) discusses the efforts of a medical center in developing a nurse refresher course that allows for nurses to be engaged academically and mentored back into practice. Yancy and Handley (2004) examined the success of nurses returning to practice and concluded that it was a complex process that goes beyond a mere refreshing of skills but must also address issues such as lifestyle, children, technology and patient acuity to facilitate nurses successfully returned to practice.

Summary

Inactive nurses have been identified historically and currently as a potential source of personnel to meet the nursing shortage that is predicted to continue to worsen. Many of the articles on nurse refresher courses and returning to practice identify that this group of nurses have a different set of educational and emotional needs as well as different support needs from their employing entities. If the returning nurses are to have a safe and satisfying return, the journey back to practice with its perils and pitfalls must be understood. Only when this topic is researched can the needs of this unique group be fully understood and met.

CHAPTER 3

Study Design

Purpose

A narrative study of nurses who have returned or are returning to practice may most effectively serve to answer relevant questions such as: How well did the nurse refresher course prepare you to return to practice? Where do you feel you need more education? What skills do you need more practice doing to feel confident? What challenges did you face coming back to practice? What life challenges do you need your employer to accommodate?

A narrative study may also serve to give a voice not previously given to this group of nurses. By listening to their experiences, we will better understand barriers to success, special challenges, bias of fellow providers, and other social/group phenomena associated with their unique position. Most importantly, understanding the experiences of nurses who have returned or are returning to practice can provide the necessary information of how to structure educational programs to ensure that nurses who return are educationally prepared and competent to provide patient care.

Conceptual Framework

Narrative inquiry can be beneficial in exploring the lived experiences of students and teachers as progression is made in the educational process. The narrative use of stories can attune educators to themes of understanding and experience that are universal to learners and perpetuate the development of curriculum unique to the individual learner (Kim, 2016) Riessman (2010) discusses the natural impulse of human beings to narrate experiences of life, especially ones where “there has been a breach between ideal and real, self and society” (p. 3). This natural

tendency to narrate will propel individuals with a minimal of prompting to describe their stories in great detail and length. Instead of asking interview questions which would fracture the details of the story, the natural progression of the story is the truest reflection of the personal world of meaning for narrators.

Rhizomatic thinking in narrative inquiry is most applicable for the exploration of the story of nurses returning to practice. A rhizome is a root system that has a network of branches which may sprout off in multiple directions with no real order while still being engaged into the same main system. A rhizomatic narrative form of inquiry may not follow the prescribed logical sequence of having a definite beginning point with a linear progression and an ending. Instead the rhizomatic narrative may have elements that do not fit into a traditional story structure, and the beginning point is not fixed. (Sermijn, Devlieger, & Loots, 2008). The nurses returning to practice have stories much like the rhizome. There is no one reason a nurse returns and no one way in which he or she enters the path, yet the returning nurses are universally and inextricably linked in a common goal that requires a journey with the same end-point. Despite the commonality of endpoint, the journey for each is not necessarily parallel in nature. This linking to a universal theme with differences of story makes the rhizome a fit analogy for this narrative structure.

Kim (2016) discusses the term bildungsroman. Bildungsroman is a German term that references a story which not only explores a person's educational progression, but also the personal story of growth and development of identity in the process of education. The returning nurse develops an identify on this journey that few venture. They will forever be known as a nurse who returned, and this new identity may instill pride and confidence in the overcomers who make it back. The narrative of the nurse returning to practice must be a bildungsroman

rhizomatic narrative due to its complex and educational nature and its focus on the challenges and triumphs of personal growth and identity development. As Kim describes the analysis of a person's bildungsroman, she proposes that the analysis be based upon the focus of person growth as the tensions inherent to the story between the ideal versus the reality of the situation are explored. The context of the journey and the ability of the story to impart meaning to the reader as it questions the dialogue and doubts of the journey are also important and help to show the "striving, uncertainty, complexity, and transformation" inherent to the story (Kim, 2016, p. 210).

Research Question

The term *grand tour question* refers to an event that an ethnographer might experience when studying a geographic area as he or she is given an actual tour of a location or scene. In this case, the experience of returning to practice is explored as participants are asked to give an account of their experience of returning to practice taking the researcher on a tour of the process (Spradley, 1979).

By necessity, questions in narrative inquiry must be open-ended in nature with freedom given to the research subject to tell the story in his or her own progression. How the subject chooses to tell the story may be as important as the tale that is told. The researcher acts as a listener who is fully attentive to the story being told. (Kim, 2016) The question: Would you please tell me your story of returning to nursing practice, I would very much like to hear it? would be an appropriate beginning to a narrative inquiry of nurses returning to practice. The simplicity and the open-endedness of the question allows the nurse to have the freedom to begin, progress, and end the narrative as he or she wishes without bias from the interviewer. There is no fragmentation in this type of question as the narrator is free to allow the story to flow from himself or herself in completeness.

IRB Approval

Prior to beginning this study, for the protection of the subjects, permission to conduct this study was obtained through the Institutional Review Board (IRB) of the University of Central Oklahoma (See Appendix A). The design of the study, consent letter, and recruitment materials were all approved before any recruitment of subjects began (See Appendix A, C, & B).

Selection of Participants

Subjects for this study were obtained through a snowball method which included referrals from professors, recruitment through a script posted on the discussion board of a professional nursing organization, and through a script posted on social media (see Appendix B). Subjects were intentionally recruited who were in different phases of the process of returning to practice to gain perspectives that might have been forgotten by those already fully returned to practice. There was little risk to subjects in the research process, but there existed the potential for emotional trauma in the voluntary narrative retelling of traumatic events. The subjects were notified before beginning the study that this was a possibility and appropriate referrals to counseling were made available. The telling of the story provided an emotional release rather than emotional trauma for many of the subjects. The local nature of the population from a mid-western city metropolitan area, and the small sample size are factors that are limiting in the applicability of the study but is a necessity in this type of inquiry. Attempts at generalizability of this study are addressed in the validation section. The sample size was limited to 5 interviews and an autobiographical interview.

Data Generation

Reissman (2010), identifies the importance of the process of taping and transcribing of interviews and calls this process “absolutely essential to narrative analysis” (p. 56). Due to the

essential nature of this element of the narrative process, interviews were recorded and a transcript produced from the recording. Following the recording and transcription, common themes were identified, explored, and recounted to provide structure to the formatting of presentation of the narratives.

Subjects were kept anonymous with only the researcher knowing the identity of any of the subjects. The recording of the narratives, and the transcripts generated were deleted after the narratives were written. The words of the individuals interviewed were used to tell the story whenever possible. Names and some details of the stories were slightly altered while keeping the wording and intent of the narration as close to the original source as possible. It was necessary to de-identify the individuals interviewed by de-constructing the stories from their original form because some of the individuals expressed concern that if the stories were left in the original narrative form, the identify might be clear to others and result in repercussions from co-workers in their places of employment. Following the narrative inquiry, recommendations have been made about how hospitals, educators and nursing leadership can better facilitate nurses returning to practice.

Validation

While the first-hand accounts of nurses returning to practice have merit as a rendition of the personal experiences of five unique individuals, establishing generalizability of the conclusions does benefit educators and hospital organizations interested in this topic. Attempts were made to establish the generalizability of findings through several methods.

In qualitative research design, it is impossible for researchers to fully remove themselves from the study and self-reflexivity is important in the process of being able to be critically subjective. Potter (1996) talks about this self-reflexivity as he quotes the work of Reason saying

that critical subjectivity "means that we do not suppress our primary subjective experience, that we accept that our knowing is from a perspective; it also means that we are aware of that perspective and of its bias and we articulate it in our communications. Critical subjectivity involves a self-reflexive attention to the ground on which one is standing. (p. 187)"

My own experience as a nurse returning to practice is impossible to separate from my interactions with study participants. I was careful not to disclose my experience with the subject matter prior to interactions so I would not influence the telling of the narrative. My experiences on the journey from being out of nursing for 24 years to a fully licensed and practicing RN shared many commonalities with the nurses interviewed. As part of the self-reflexive process, I conducted my own autobiographical interview and present my story as an autobiographical voice added to the structure of the narratives as a means of comparison.

In many ways, because of my familiarity with the topic as an emic observer, I had insight into the stories of the nurses returning and was acutely aware of my own bias of the return to practice journey. At the same time, I could retain an etic perspective as a non-participant in five individual stories that were as unique to each as a fingerprint. The qualitative researcher can never entirely remove themselves from the story, and an autobiographical narrative can "reveal new understandings that are useful for practice and offer novel contextualized insights." (Holloway & Galvin, 2017)

Another method used to establish validity was to discuss the results with hospital educators and nurse managers who have had experience with facilitating nurses returning to practice. Many of their observations of the challenges, barriers, dysfunction, and system failures of returning the nurse to practice were closely mirrored in the narratives of the nurses interviewed. Through these discussions, they expressed their frustrations as guides to the

returning nurses and discussions ensued of how to make the transition smoother. The difficulty of facilitating these nurses was obvious and they were grateful for any perspective I could bring through this narrative study.

I worked with the nurse refresher course instructors, examining the coursework, and attending some of the clinical experiences of the return to practice nurses. Through conversations with the instructors, I could establish the universality of the technological challenges, the insecurities, fears, and other barriers faced by returning nurses. Through observations of the nurse refresher students, I observed their fear and trepidation at attempting even the most basic of nursing tasks. I was also able to review their care plans and writings to evaluate the knowledge base and ability of the nurse to perceive, prioritize, and intervene in patient care. I purposefully chose nurses at various stages on the return to practice journey to elicit perspectives that would be fresh on the mind of those at different stages in the process.

Finally, I made a trip to the U.K. and interviewed a local Return-to-Practice (RTP) course instructor. Through my conversations with the instructor, I established that many of the identified challenges were shared by students in the U.K. The shared challenges illustrate the generalizability of the results even at the international level.

Summary

While qualitative research design has merit in the ability to describe the experiences of humanity, sometimes it is beneficial to describe commonality in those experiences. There is no authoritative establishment of validity in qualitative research design, but every effort was made to see that the results were represented accurately. Whenever possible, individual interviews were quoted directly so that the nurses' thoughts, feelings, and struggles were represented in the voice of the narrator. Combined with validation from others involved in the process of

facilitating returners to practice, such as hospital administrators, course instructors, international course instructors, and my own personal journey, the information obtained can be trusted to be an accurate representation of the journey back to practice. The generalizability of the information also can be trusted based upon interviews with international instructors.

CHAPTER 4

Presentation of Data

The stories of nurses returning to practice are as unique to the individual as a finger print, yet all share commonality. Many have embarked upon this journey never to complete the nurse refresher course. Many nurses have started, only to stop short as they been defeated by the challenges of finding a job, re-acclimating to the physical demands, or the overwhelming feeling of inadequacy. The narratives told herein are of the finishers. These are the stories of those who have undertaken the journey, successfully finished the nurse refresher course, and re-attained licensure. Each begins in a different way for the nurses interviewed. For many of the nurses, the question of why return came up early in the narrative. The topic of the educational requirement for returning was at the beginning for each of the nurses. Even the nurse who had not taken a nurse refresher course spoke about the need for taking it.

Beginnings – Returning to Work

Gail was a nurse who had been referred to me by an acquaintance after I posted a request for subjects on a professional nursing organization's discussion board. Like many of the nurses I spoke with, she was kind enough to meet with me at a local coffee shop and expressed the sentiment of doing "anything to help out a fellow nurse." We agreed to meet for the interview at a coffee shop near Gail's place of employment. It was after work one day when we sat down on a comfortable couch and shared a cup of coffee while soft music played in the background on this lazy spring afternoon. Awkward at first, two strangers who had never met exchanged pleasantries and the customary small talk of nurses. Where do you work? How long have you been there? Do you like that area of nursing? What else have you done?

Before long, however, I suggested we get started. I began to explain the necessities of the

informed consent form, her voluntary participation, and her right to end the interaction at any time. I didn't want to reveal too much of myself at the beginning. While I had told Gail that I returned to practice, I didn't want to begin with the details of my story. To tell my story would have influenced how she told hers and I wanted this to be her story told as she would tell it. We entered as strangers and left as friends as I heard her story, I told her mine, and we shared the bond of two nurses who had undergone a similar journey.

Gail started with "I guess we will start with the fact that I graduated from nursing school way back in the early 80s and worked for 7 years. I then got married and started having children right away. When I got married, I moved to a different state and I didn't even get my license. I moved to Oklahoma at one point, and didn't get my license in Oklahoma either. I was a stay at home mom with several children and was just happy being at home. Then my husband lost his job and it was time for me to go back to work."

"Most of the kids were older," Gail continued, "so I decided to go back into nursing after 22 years of being a stay at home mom. I was living in Texas at that time, and my license was on inactive status in Alabama. To get my license in Texas, I had to take a refresher course and that was all I needed to do - prove that I had taken the refresher course to get reciprocity."

The second interview started much the same way as I spoke with Val a few days later, same couch, same shop, same pleasantries. She began her story with where she graduated, her early work life, marriage, children, a move, and being a stay at home mom. Then she told me of having an active license in another state but moving to the state. "We move here, we build a house, I get four kids settled in school, and then I'm thinking of working again. Again, just to have a little bit…I'm thinking cars, braces… I'm not thinking full time. But, I'm thinking, I've kept my license active so let's see what's out there. So I look up (this state), and it's not a

compact state. So I was dying that it wasn't a compact state. That was my first hurdle. Then when I started looking into transferring my license, if you haven't had so many physical hours working in so many years, and it was like one or two - I mean it was a very small window - you had to take the refresher. I had been out three at that time, so it was just hoop after hoop."

Sarah and I met at a restaurant. I arrived first and asked the hostess to seat us at a private booth somewhere out of the way and in a quiet location because I knew we would be audiotaping. She arrived shortly after me, and we sat down. We exchanged pleasantries, looked at our menu, and ordered lunch. After going through the consent, I began audiotaping and informed her it was now recording. She began. "I had worked my entire life and in 2007, my husband, who was a physician, said 'why don't we retire?' He wanted to move to Florida. He grew up in Florida and wanted to return there so we wound up moving, I did go ahead and get my license in Florida in preparation for working and, however, just one thing happened after another. At first it was moving, and then my husband became ill. I spent most of the time that I was in Florida taking care of my husband. He died in early 2014. At that point, I basically was just adjusting to that and ended up moving back to (this state) where I had some family. I eventually became, you know, bored, and really wanted to do something, but it became imminently clear that I needed to get my license in (this state). Then I found out that since I had not practiced since 2007, I was going to have to either take boards or take an RN refresher course, which is ultimately what I did. "

My next interview was with Julie. She lives in a small town about thirty minutes south of my location. I offered to drive to meet her, but she said she had a very busy life and did not want to meet in person. Instead, we met over a video connection. I obtained her consent by reading her the consent form over the video connection and I signed for her based on her verbal consent.

She had seen my post on social media when a fellow nurse had reposted my request for nurses returning to practice after a 5 year or more career break. We started our meeting by discussing the mutual friend we shared.

She began her story with "I guess it was about 2010 or 11 that I decided I was going to stay home with my kiddos. They were 6 and 3 at the time. I just returned 1 year ago. It definitely was a challenge. I didn't do a nurse refresher, I simply called my old boss back up and said I would like to come back to work and could you use me? Of course, there is a shortage. I had a little longer than normal orientation, but it still wasn't long enough. After going through all that, I recommend anyone that has been out that long do a refresher because when you graduate nursing school you're nervous because you haven't done IV's much, you just haven't had the experience, but you're nervous, but the knowledge is pretty fresh on your brain. Well, then you lose it, it diminishes, even dosage calculations and things like that, even medicines. It was like I had to relearn the different medicines and things. I had a strong background, but coming back was hard, very very hard."

Julie went on to tell me that she had maintained her license in her state of residence which was what allowed her to return to practice even though it had been more than five years since she last practiced. Although she had an active license and did not have to take the nurse refresher to return to practice, the challenges she faced were much the same with the only difference being that she was still licensed and wasn't required to take the refresher.

My final interview was with Margaret. It began in much the same way as the others, coffee shop, pleasantries, consent forms, now recording. She began by talking about the nurse refresher. She had just finished the course and it was on her mind. She did eventually identify her reasons for wanting to go back. "I have been out 11 years now. I went on inactive status

when I had my second child. In Texas, where I was licensed, you had 4 years you could be on an inactive status without penalty. But we moved, and I called (the local office) and Texas state boards, and they said if I wasn't going back to work in the next year or two then a nurse refresher was my only option. Some of the red tape I had to go through. Money and insurance are why I went back. I am getting to that phase in life where I love being a wife and a mom, that's my first priority, but you kind of look to the future and want to leave your mark somewhere else. I'm a fairly religious person, and I feel like this is a calling, works of mercy type. It's not about just getting a paycheck, it is more of a life commitment. I'd rather do it now then in a few years when I am like 50-55, and maybe even have the experience to get into something I would really like to do in nursing."

While these nurses all returned to practice for different reason, loss of a husband, job loss, needing a little extra, insurance, and a calling, for each of them it was a difficult journey. My own journey back into practice began because of a divorce. Despite the different reasons for returning, the interviews began to reveal several themes that were common to the stories.

Re-education – Nurse Refresher

Interestingly, although five different nurses were represented from the state, there were four pathways of educational preparation utilized by these nurses as they returned to practice. One of the nurses went through the nurse refresher course that consisted of a partnership between the vocational-technical school and the university. The other nurse went through a vocational-technical only program. One of the nurses went through a similar nurse refresher in another state, and another just went back to work since she had already been licensed and had maintained licensure. I had personally maintained my license through continuing education courses, but took the nurse refresher course because I felt it was the responsible thing to do to assure I was

practicing safely. The new inter-state compact licensure agreement was just completed by the state while the interviews were being conducted. This agreement would have resulted in some of these nurses not needing to take the refresher to attain licensure since they were already licensed in compact agreement states. Although some of these nurses may not have had to take the coursework, each of them reported difficulty with returning to practice even after completion of the refresher course.

Margaret, having just completed the nurse refresher course, was the most vocal about her experiences as she recounted "I think there are some problems with the nurse refresher program. I think there should be something easier in this state. I like the idea of hospitals taking that on and getting nurses who have been out for a while back into shape, and in return we say we will give this amount of years or pay back this amount of money. I feel like this is so important with so many nurses being female, stopping to have families. I would guess plenty come back. There are those who never do return, but for those of us who do want to return, and there is a shortage, and they do need us, don't make it such a hassle and then charge us an arm and a leg. There is a disconnect for the university. It is low on the totem pole for importance for them and for the vo-tech school it is the same way. "

Julie's was a different journey than the other nurses since she chose not to do the nurse refresher course. She had maintained her license and did not move across state lines. Had she been licensed in another state and gone more than two to three years without working, she would have been required to take the class to be approved for state licensure. It was an easier transition for her to return to work because she went back to her former hospital in a location where she was already familiar with the staff and workflow. She reports that "there were a lot of new faces, a few old ones, and they remembered me as a nurse prior. When I came in I said 'I have been a

nurse for a while, but I'm coming back into this, so treat me like a new nurse. Just have those expectations of me.' They were really good, I was pleasantly surprised with that."

A move from Texas prompted Sarah to seek licensure only to discover that she had been out about ten years and would not qualify for licensure in the state unless she first took the nurse refresher course. "It became imminently clear that I needed to get my (state) license and then I found out that I had not practiced since 07 and so, therefore, I was going to have to take boards, or take an RN refresher course which is what I ultimately did. I ended up doing that fairly quickly, and I finished up the online portion, which is pretty extensive. I enjoyed the clinical experience that I had and enjoyed the mentor."

Val also moved in from another state. She was actively licensed in the previous states where she lived, but when she began looking into licensure in this state, she quickly realized that a nurse refresher was her only option if she wanted to continue in the practice of nursing. "It was 2000 dollars, I mean 1800, to do the nurse refresher course at this vo-tech making it 1000 dollars cheaper than the one affiliated with the university. So, I just went with the cheaper because they aren't that different. It just killed me because I had an active nursing license. So, I went ahead and just bit the bullet, signed up, and did my refresher. I mean you do so many clinical hours, I think 180, so many skills labs, and then 12 hour shifts. All for free. You are a nursing student, but you pay, even though you have an active license in multiple states. It was just a lot. You are doing tests, and online courses. I passed it all just fine.

When Gail decided to go back to active nursing, she was living in another state. "My license was on inactive status in Alabama. So, to get licensed in Texas, I had to take a refresher course. Then all I needed to do was prove that I had taken the course to get reciprocity. I lived in a small town at the time that was about 45 minutes away from a junior college. That was in

2009, and I can't remember how long the program was, but it went on for a couple of months. We started out with skills practice in the nursing school itself, and we finished up with a preceptorship on the floor of a local hospital. In the school part, the academic and the skills lab were combined so there was a test as well as demonstrating skills. It was a long time ago and I don't remember much. It all went by so fast. I feel like it minimally prepared me to go back into nursing."

The statement made by Gail, "I feel like it minimally prepared me to go back into nursing," echoes the sentiments of all the nurses interviewed. The idea that there must be something better, what was done was inadequate, and needing something more, was common no matter what route of re-entry into nursing practice was ventured.

The Technology Challenge

Before I began conducting interviews with nurses returning to practice, I was working to complete hours for my nursing education practicum. I contacted one of the instructors for the nurse refresher course and asked if I could examine the coursework and see if I could make any recommendations. During one of our discussions about the coursework, she remarked that many students begin the nurse refresher course but not many of them complete the academic portion of the course that is necessary before the clinical portion of the course begins. She postulated that the technology may be the greatest obstacle to be overcome. Even the act of adding content into a drop-box or attaching files to email seemed to be a challenge for many of these students.

The internet became wildly popular at the end of the 1990's, and many of the nurses who return to practice were educated well before the advent of the internet. Most people in the United States have probably learned how to navigate web searches, social media, basic email, and online shopping. However, navigating academic online technology, producing word

documents and power point presentations, dropping assignments in drop-boxes, uploading attachments, and installing software needed to run certain files is beyond the comfort level of many adults who were educated before this type of technology was widely used.

Not only is the technology to complete the course challenging, but the use of Electronic Health Records is now common place in nursing. Some of the nurses interviewed spoke of the challenges associated with electronic health records. Julie says, “So much has changed, because when I quit we weren’t scanning medicines, we were getting them out of the Pixis, but we weren’t scanning anything. The computer charting is way more than it was back then.”

Payne (2010), wrote an article based upon her research into why nurses who had completed the midwifery return to practice course did not continue in nursing after completion. She reports finding that nurses returning to practice might not have the necessary computer skills. With computers increasing in practice, nurses returning to practice may need to first take a class that teaches the necessary computer skills before entering the coursework.

Gail talks about her return to a small hospital after completing her nurse refresher. “It was rough, it was very rough, It was so different. I had left in 1987 so it was so different. Thankfully, they were still doing paper charting at that hospital so I was glad I didn’t have to learn that in addition to being re-acclimated to the floor. Charting I could do”

The issue with technology was a problem for Sarah in taking the nurse refresher course. She says “That was one of the hardest things because I had never dealt with power point. Even in the online portion of the course. I had to grab my niece to help me figure out some of that. But you know, I did figure it out. I could work my way around word, but when you got into power point, I was done for.“ She went on to suggest “the older they are, the more computer skills they need, and some kind of introduction to that based on a needs assessment would

probably be good because almost all of the facilities are doing some kind of computer record. The fact that most of the girls in the nurse refresher are younger than me, I think they would pick that up pretty quickly. Or at least, they would probably have more of a back-ground in it than I did. The longer they have been away, the older they are, that makes a big, big, difference in if they complete the course or not. Sometimes, it is just the psyche of the individual who is never going to be confident. Unless they have a big commitment to doing it, when it gets hard they are going to quit."

While working on my thesis, I had the opportunity to go to England and talk with a Return-to-Practice (RTP) instructor. She expressed that many nurses in the U.K. find the technology challenging when returning to practice. In the U.K. program, students are asked to have a certain level of proficiency before enrolling in the coursework. If the student is not computer literate to some degree, they are first asked to take a course in computers through the library or online. When the student enters the nurse refresher course, ten days are spent in face-to-face interactions. Some of that time during the face-to-face is focused on how to navigate online distance learning technology and electronic health records.

All the nurses who returned to practice reported challenges with the technology of the course or the use of electronic health records. My experience was different because I had already taken some courses at the university and was familiar with the online learning format. I had college aged children at home that I could ask for help, and I had been educated in school right at the advent of the computer age. I had to wonder if the use of technology was even more challenging than my interviews revealed because I wasn't talking to the nurse refresher failures, I was talking to the finishers.

Difficulty Finding Work

The nurses returning to practice expend considerable time and energy in reclaiming licensure as a Registered Nurse. Most of the nurses have incurred expenses ranging from 2000-4000 dollars by the time that they achieve licensure. Despite the expense and effort put into re-attaining licensure status, some of the nurses report having difficulty finding a job after the educational process is complete.

"What I did was I applied for a job at the local hospital in the town where I lived. I interviewed for 2 positions and I could tell that neither of them was really interested in hiring me. One was a rehab unit and one was an intermediate care unit. My background before I left nursing was in ICU, and I really didn't want to work in rehab., so it didn't really bother me that the nurse manager didn't call me back. But the intermediate care unit was transitioning to becoming a stroke unit for the hospital, so what I did was I actually called her back and said 'I really want the position.' I said, 'I will be the best stroke nurse that you will have, I will do my best.' She told me that she wasn't really thinking about hiring me, 'but because you did that, I will hire you.'"

Val reported that "Even thought I had an active license, I hadn't worked in 5 years, so I started going to career fairs and everything. I still had multiple children at home, so it wasn't going to be a full-time thing. So, of course, you go to the career things and they are like 'Oh, you haven't worked in 5 years,' there is no way they are going to hire you for a hospital job. So, I would get all the way into the interview and people were like 'heck yeah, we will hire you!' Then they go 'Oh my gosh, you haven't worked in 5 years, we would really suggest the refresher course.' So everyone started suggesting that to me, and I looked into it, and researched it, but it is quite a commitment."

My own experience with returning to practice was that I went to interview after

interview, and it seemed like no one wanted to take a chance on me. I was honest with them up front, telling them that I hadn't worked in several years, and even applied to a residency program that was for new graduates. I am not sure if it was because of my age, or how long I had been out of nursing, but no one wanted to hire me. Finally, I found a nurse manager who believed that I could do it. She promised me an extended orientation and I started work. It took a while, a long while, before I felt comfortable, but then it started to get easier.

The U.K. RTP instructor reported that nurses in the area also have difficulty finding employment. The return to practice students in the U.K. get a lot more time in clinical settings than nurses going through the refresher courses in the United States. The instructor for this program tries to place students with clinical placements where they might be able to find employment. She reports that sometimes the locations available to the return to practice students are not the places the students really want to work. When she can place a student at a previous employer where there is already a relationship established, she says that it tends to be much more likely that the nurse will find a job that will be fulfilling.

With a shortage of registered nurse in most acute care settings, it is interesting that the returning nurse has difficulty finding work. Although some hospitals work to provide special orientation for this type of nurse, there exists little in the organizational structure of most hospitals to facilitate a safe return to practice. Often nurses will be expected to be on the floor functioning as a nurse within a couple of months of hire. This is not a realistic expectation for nurses returning to practice, and because they are unproven as nurses, it is possible that hospitals won't take a chance in hiring them. Nurses who have returned report a lack of confidence and the need for longer orientations, strong preceptors, and more education to complete the journey back.

The Return - Unrealistic Expectations

"In this environment, there was a sense of the idea that they wanted me to act like I knew what I was doing. The expected me to. I have no shame in telling you I don't know what I am doing, and if you actually knew my background you would know why I don't."

It is a mystery why most nurses returning to practice seem to encounter a culture where they are expected to have more competency then they possess. It could be due to the graduation date and time since graduation, the self-confidence of the individual attributable to life experience, the pressures of the business of the unit, or some other factor that causes other nurses to think the returning nurse should be more competent sooner. Regardless of the reason, participants in the study almost all report unrealistic expectations of their clinical abilities from other nurses upon return to practice.

One of the course instructors in the nurse refresher course stated, "I told them all that I think they should start at a large hospital. The large hospitals tend to have more resources to have such things as internships where they are a little more sheltered than they would be just getting released on the floor. When I was at one of the hospitals I ran into one of my students who had been in my class as a refresher student. She had gotten hired in an internship in an intensive care unit, which typically happens for new grads but not for people who aren't new grads. She had almost a year of mentoring before she had to function as a full-fledged ICU nurse. I thought that was amazing that they spent that long because this is unrealistic really. "

Gail relates, "I think if the hospital would have initially recognized that someone who is out of nursing for several years needed to be treated as a new grad instead of just assuming that I could pick it up quicker. I think as a new grad I was more confident because I was young and dumb. I didn't know how much I didn't know. Also, I didn't have the negative feedback from

the other nurses like I did coming back. The orientation was a lot smoother as a new grad and I felt like I transitioned better than when I came back. I had been out several years and so much had changed. I didn't even know what a Braeden score was, that was all new. There were just so many terms and things that they assumed I knew, but I just didn't know. I remember sitting in orientation at the hospital where I was hired and one of the nurses was talking about troponins and other cardiac enzymes. They weren't doing those when I left nursing, they weren't doing troponin levels."

The same difficulties with returning were echoed by Julie who reports "I had a diverse background in nursing, too. I've done health department, home health, hospice, ER, all the different floors of the hospital, but I decided I was going to stay home. Coming back and trying to relearn skills like IV's, that was very difficult. Even a year later, I am still not quite comfortable. You still kind of feel like you're flying by the seat of your pants. It takes time. "

Perhaps no story better articulates this struggle then that of Val who relates, "The scariest person is someone who acts like they know what they are doing when they don't. There were certain situations where they wanted me to give a medication IV push really quickly to a kid and I didn't get the calculation and I won't do it. I was on orientation and it was my first day with kids having this procedure done. I needed to write it all out, and I needed to understand before I felt I could give this medication, but my preceptor was gone. This girl, she expected me to just know and be. My patients come first, my license comes first, I told them to treat me like a new grad. Please understand, because we know how scary this can be if we make a mistake, we are even more cautions. Training was so hard for me, I still every day am learning. I have to look up things. I had to get over - the best nurses are the fastest ones - that's never going to be me, probably. I am going to be the one that everyone loves, and I will hesitate before I give you that

med, I will double check with someone."

The U.K. RTP instructor identified similar problems with unrealistic expectations of return to practice nurses in the U.K. She stated that it was almost as if the other staff members understood until the unit got busy. Once the unit got busy, the other nurses suddenly expected the return to practice nurses to be able to function as full-fledged nurses. The RTP instructor makes it a priority when teaching students to warn them not to allow anyone else to push them to do more than they are able and place their newly acquired license into jeopardy.

For the nurse to safely return to practice, employers must make hospital staff aware of the special circumstances of the returning nurses and expectations must be realistic in how long it takes for the nurse to achieve competency. A common trait of all the nurse returning to practice is that they have a keen awareness of the serious consequences that their actions have upon the patient if they make a mistake. They are no longer "young and dumb," and they are not embarrassed to ask questions. In the words of Martha, " I'm over 40, not 20. We have life experience at our age that gives us the hindsight to know it will get better. Now, I am not going to be afraid to ask questions, where before (when I was a new graduate), I was like, 'well I'm just going to do it because I don't want them to think I'm stupid.' Now, I don't care if they think I'm stupid because I know that I'm not. I'm just asking for help. I'll be honest, like 10 years ago, I probably would have been embarrassed. But now, I'm over 40, and I'm a little more brazen. Overall, I'm just as confident as they are, I just don't have the experience."

Horizontal Violence

Many returning nurses report being surprised by the horizontal violence they experience when re-entering practice. Unlike the new graduate nurse who is expected to know nothing, the returning nurse has been out of school for some time and often presents with a self-confidence

that is a product of years of life experience. It is a mystery as to whether the length of time since licensure or the self-confidence of returning nurses is the reason, but the expectation from other nurses that the returning nurse will function much as a seasoned nurse despite years of non-practice sets the situation for horizontal violence to occur. As one nurse recounts: “The other nurses aren’t that sweet, I was not expecting that. When you’re a new grad, everyone knows you’re clueless, but when you’re older, people are like what do you mean you don’t know that? I had to defend myself, and I wasn’t expecting that.”

The new graduate has the benefit of being introduced to the staff as being a recent graduate who just passed boards. This sets the expectation with staff members that he or she will have a limited knowledge base and not be able to adequately perform skills independently. The staff will often not be given the story of the returning nurse, and are unaware that additional supervision may be required before competency is achieved. Having multiple preceptors instead of just one preceptor can be traumatic for the returning nurse because of this unfamiliarity with his or her background.

Experiencing horizontal violence can be a wounding and deeply emotional experience. As Val recounts, “I cried a lot, in the returning days, and part of it was just working again full time and the pressure of the life and death of it all. That was a lot for me. I had no confidence and I really wanted them to encourage me, and no one was encouraging me. I thought who am I, am I cut out for this? It made me cry a lot, but never in front of them. I tried to act like I knew what I was doing and one day I did cry at work. It was because I was with a different preceptor, mine was on vacation. This other lady was just brutal. She was telling me to do things I could not do, and telling me you’ve got to hurry, they are waiting on you. When I cried, she was like, “Val, what’s wrong with you? You’re a mess.” I was thinking “No, you’re the mess.”

Gail describes an instance involving one of many preceptors that worked with her during orientation. "One of the ones they put me with was like a super-nurse. She had been a nurse for 15 years and she was just Speedy Gonzales in everything she did, and I took too long for her. She just did not give me any positive feedback in any way. I walked out of the med room one day to hear her talking about how sorry of a nurse I was going to be. I wrote to administration and said I feel like this nurse is like Michael Phelps, and I'm dog paddling trying to keep up while she keeps saying 'do this, keep up with me' without giving me any help in how to do it. It was subtle, she was never mean to my face, but I could hear her talking about me when I came around the corner or whatever. It was mostly the one and there was some pushback, too, from the secretary and some of the techs who had been there a long time, but they do that with every new nurse. That was kind of the way they were until they knew you."

Gail continued, "One night, I had a patient that needed a shot of Geodon and I had to reconstitute it. It didn't come with the sterile water. I would have had to have known to pull sterile water so I just got a saline syringe and reconstituted it. I came out of the med room and said, 'this just does not look right.' Super-nurse said, 'You reconstituted it with saline! Don't you know that you are supposed to reconstitute it with sterile water? You are dangerous! Actually, what she did was report me or something. Then they had the education nurse come and follow me for a day to see if I was safe. After that they put me with a different nurse on a different unit."

One nurse describes a situation that occurred. "I had a certain charge nurse who would continually bully me, it got to the point that as soon as I walked in the unit and saw she was there, my heart would just drop. One night I had a very sick patient that I took to the ICU, so I had another patient that I had not done an EKG on yet because he seemed stable and I thought it

could wait till I got back. When I got back to the ER, I pulled the EKG and it said possible STEMI. I thought "oh CRAP!" Here this guy is having a heart attack and I didn't pull an EKG right away when he got here. I quickly got the doc and she went in to get another EKG with me because neither of us thought this guy who looked so good could be having a heart attack. When I came out of the room, the doc was calling cardiology to read the EKG and I was trying to get everything entered and take care of my patient. At that point, this charge nurse comes up to me and says, 'you didn't put the chords back on the monitor right.' I replied, 'what cords?' And she repeated 'when you took the patient to ICU you didn't put the cords back neatly onto the monitor when you brought them back down.'

I said that I hadn't even brought them down, the transporter brought the monitors down, that's who always did. I then quickly spewed the information about what I was dealing with and said, 'I'm sorry, but when I got back here my priority was getting this EKG, and it showed a STEMI, and the doc and I are in the middle of this, and the cords really aren't my priority right now.'

She replied, 'well put them back before you leave your shift.'

I told her I would and then continued working. At the end of the night, I went back to put the cords back on the monitor neatly like she told me to do, and the power cord was missing. I told my preceptor about what had happened and he went to the charge nurse asking for the power cord. She had hidden it. These were the kind of things I dealt with every single day for about the first six months. I still don't know how I did it. At that time, I was just trying to survive and I felt so overwhelmed and helpless that it wasn't until after I got out of that place that I realized just how much horizontal violence I was enduring on a daily basis."

Despite being promised a supportive environment and preceptor, many returning nurses

experience horizontal violence that is intense, degrading, and disheartening. One returning nurse reports, “I was told we don’t eat our own, we are going to train you, you’re good. I did have to go to the management, and I did have to say ‘I don’t know if this is the place for me, and here’s why: A. You’ll do kind of eat your own, and B. This hasn’t been that great coming back.’ She assured me that it was the place for me, and I was going to be fine and all of that.”

Shame, Fear, and Self-doubt

Perhaps resulting from the horizontal violence that the returning nurses endures and the unrealistic expectations of other nurses, there is a sense of shame that many returning nurses experience. One nurse states “There’s a sense of shame, like you’re incompetent somehow.” These nurses also report fear that they will lack some essential patient care skill that will result in harm to a patient.

Julie talked about the fear and embarrassment she experienced, “It’s kind of embarrassing to not be where they think I should be, ‘you’ve been a nurse for 20 years, you should know it all.’ I was very on top of my game in the ER, but seriously, it’s like a muscle, you don’t use it you lose it. I’m slowly getting there. I had the knowledge before and if you go into a job and someone has been there, you know that you can lean on them. The codes used to be no big deal, but now it’s kind of scary. My first day on the floor shadowing a nurse, she had a code and the team came and I just kind of stood back. I know my mouth was open like uuuuhhhh and I thought ‘Oh my gosh this should be familiar to me, all this stuff.’ It was a stroke. It was really weird, because she (the patient) was sitting there talking to me, and what was bad was my shadow nurse went to lunch. I was by myself for 10 minutes and I happened to be in this patient’s room when she went down, like not talking or responding, and she was perfectly fine at

the beginning. So that kind of freaked me out. I was like ‘okay, I am seriously rethinking this (coming back).’”

“My mind own mind was the biggest challenge, sitting there and freaking my own self out because once I got up there and started doing things, it started clicking. But you know before you go up there your brain just goes crazy on ‘why do you think you can go back and do this.’ It was about 6 months that I was scared the entire shift. I would think ‘Okay, I got through that, now what is going to come.’ It was just being so unsure, not sure what is going to happen next, just all the new things.”

Although there is this sense of shame at not being competent, most of the nurses don’t have shame that they stepped out of nursing to take care of families. It is interesting that the nurses report fully embracing the decision to stay home and yet at the same time being ashamed of being the nurse who was educated several years ago and now lacks competency. It is almost as if the self-expectation is that somehow there could have existed this simultaneous living of two lives. I also wonder if the nurses on the floor are hard on the returning nurses partially because they are a little jealous of their new co-workers who prioritized family over work by taking time off.

Leadership Preparing the Way

Perhaps some of the self-doubt, shame, and horizontal violence could be precluded if leadership would prepare the way for the returning nurse. When the returning nurse is hired, and no one is aware that he or she has been out of practice for many years, the nurse is often viewed as incompetent rather than someone engaged in an educational process. As one nurse recounts, “Leadership has to lead out in that there was not a lot of prep for me coming. The person precepting me didn’t even know my story. I was told ‘we don’t eat our own, we are going to

train you, you're good,' then the girl precepting me didn't even know that I hadn't worked in a hospital in ten years. Had she known that, she might have had a lot more grace when I told her. Once she knew, she was super sweet, super helpful, but she had to defend me to a lot of other nurses. She had to really go to bat for me."

Returned to Practice – Priorities, Maturity and Returning Confidence

For all the nurses interviewed there was a healthy sense of priorities. Each of these nurses saw the family as taking first place in life. As Val said, "I was honestly not going to take a job if I was missing my kid's games and missing their life because it's just not worth it. So, I said, 'my kids come first, my husband comes first,' but I do want to work, so I'm not sure how it is ever going to work out." She became successfully employed after finding a position that allowed her to both work and be available to her family.

Julie reports that she accepted a PRN position upon returning because "I want to work, but I don't want to do it full time. I am very involved with my kiddos. I still sub at their school. I did that while I was away because it is important to know their teachers and about the other kids, so I am still active with that. If I feel like I want to pick up an extra shift, I can pick up another 1 or 2 per week."

Martha echoed the words of Val and Julie, saying "I don't regret having a family, so if someone has a bias that's their issue." Her desire to take care of her family has delayed her search for a job by a few months. Despite just finishing the refresher course, she plans to settle her children back in school in the fall before searching for a position. She also plans to seek a position that will allow her to take care of her family and work part-time.

One of the most unique characteristics of the returning nurse is the maturity that he or she has in overcoming adversity in the return to practice. Because returning to practice is a difficult

journey, it may be that only those who have the maturity and self-confidence to believe that they can return make it back. This maturity and self-confidence are a necessity to returning nurses. It gives them the ability to persevere. Where a younger nurse or a new graduate might be tempted to give in and perform patient care in areas where they have had little training or do not yet feel confident, the returning nurse is able to set appropriate boundaries.

One nurse describes a point at which she experienced an epiphany about herself and her abilities, "I had no confidence. So, after a while, I finally looked at myself and said 'No, I'm a good nurse. I'm just in a totally different plane than these people. I'm older, I'm new, and I am in a totally different sphere than them, but I put my patients first. So, you can't tell me that I am not a good nurse.' Now I will come in and they will make little comments like 'Oh, Val doesn't know how to do that.' I'll say, 'You're right, I don't know how to do that.' In this place, there are just people out to get me and tell me I can't do it. I'm a good nurse, it just takes me a little longer. Like with starting IV's again, I still pat myself on the back and say, 'I got an IV!' It just takes longer. Guess what? I'm still here. I'm going to fight this, because I worked so hard for these degrees. I'm going to do this."

The Empathetic Expert

The lack of confidence that nurse refresher students initially experience when returning to the field sometimes prompts them to seek further education and become the expert. Gail reports that the lack of confidence she felt prompted her to seek to become a certified nurse in her care area. "After 2 years, I got my certification. So, I kind of became the one that they always gave students to and new nurses to precept."

The difficulties inherent to the experience of returning to the field often imparts compassion for others in similar circumstances. Val reports that the experience of returning has

given her “empathy for students, more especially for people who are returning because I know what they are going through. If I hadn’t had to do it, I doubt I would have stuck it out.”

The experiences of these nurses is consistent with my own experience of coming back. Driven by the fear that I would miss something and a desire to be fully competent, I took the nurse refresher course even though I had an active license. I also began my master’s degree in nursing. Like Val, if I had not had to do it, I doubt I would have stuck it out. The experience has given me more empathy for others who are going through the same thing because I know how hard it is. This empathy for others and drive to become the expert is due to the insecurities I felt coming back. I never wanted to feel that way again.

My own experience was described by one of the nurses I interviewed. This nurse recounts, “If there was something else I could do that that could have made some money, I tried to think of a million other things, so I was like I could be a real estate agent. I made a list of all and I don’t want to work weekends. I might as well do nursing, but I don’t want to. People are like ‘you’re a nurse why don’t you just be a nurse?’ But they don’t understand.”

What people didn’t understand was that it wasn’t that we didn’t want to be a nurse. We knew how hard coming back would be, and we were terrified that we wouldn’t have what it takes and would cause someone harm by our lack of knowledge during the time between when we retuned until we achieved competency. This knowledge prompted some of us to consider any other ways we could have generated an income that would provide what we needed. The difficulties experienced imparted empathy for others who are in that same position because we understand their fear.

Loyalty

As a nurse returns to practice, he or she is painfully aware of the risk the hospital assumes in re-training him or her. This risk tends to inspire a sense of loyalty to the employer willing to take on the challenge of preparing the nurse for re-entry into practice.

Martha has yet to be employed in nursing, but has already begun to express her loyalty to the hospital that gives her a chance. "I would ask for the maximum amount of time with a preceptor. I know that's time maybe lost for them, but I think in the end, if I stick around that long and go through all that trouble being with a preceptor, I will feel like I owe it to them. I'm only asking for it (extended time with a preceptor) because I know the returns will benefit them. I'd even be honest, I think for me I'd need a little more time than a new grad., because a new grad. has been through clinicals on a regular basis over the past year or two. "

Gail expressed the same sentiment as a reflection about her return to practice, "At the time there were four of us that hired on at the same time, and I was the only one who stayed for more than a month. I was her (the nurse manager's) least likely to hire, and I was the only one who stayed. I stayed 9 years."

Val describes something very similar saying, "and I've continued to stay around. Some of the people who started with me have already quit. One of the girls who got hired with me, she said 'I can't handle these people.' I'm still there because I love my patients. I do have friends that I work with now. I love the hours. I love that they hired me. I love that they took a risk on me. I feel loyalty. I'm still here. I'm going to fight this because I worked so hard for these degrees, I'm going to do this."

Loyalty, compassion, empathy for others, a move from no confidence to self-confidence, and a drive for more education are all traits that make the returning nurse a potential asset to healthcare settings. Hospitals and other care settings would do well to consider how recruitment

and retention of these nurses might occur because the finishers show signs of being mature and dedicated individuals who are in it for the long run.

Bringing Caring Back

With the advent of new technology in nursing, it is easy to focus more on the technology of healthcare and less on holistic patient care. It may be that the skills of caring for the human side of the patient as a holistic person is becoming an increasingly lost art. The push in healthcare is a move toward patient centered care. The nurses returning to practice were often educated before the advent of technology and may influence those around them to develop the skills that put caring for the patient back at the center of care.

This idea was echoed in several of the interview with returners. As Julie said, "They want you to have all these things done on there (the computer), they audit all of that, and my thing is that it seems impersonal. The care seems really impersonal. I am struggling with that because I am sort of old school. I want to get in there and get to know them (the patients) and they can talk and that kind of thing. So that's kind of hard. Val expressed frustration with the fast and impersonal pace of healthcare saying, "I had to get over the best nurses are the fastest one, that's never going to be me probably, I am going to be the one that everyone loves - the patients.

I also experienced this when I first started working. After only about four weeks on the job, I was told that I wasn't fast enough because I talked to my patients too much. I was fortunate because I was then given a preceptor who had mastered the art of talking with his patients while providing good and fast care. I learned to sit down with my patient while starting an IV and use that time to get to know him. I began charting in the patient's room instead of at the nurse's station so I could spend more time with the patient but keep on task with the things I had to do.

The returning nurse has the potential to be an influencer of those around him or her. Introduction of the returning nurse to the milieu of a unit may influence improvement in patient-centered care. When nurses start to talk to their patients again and exhibit increased signs of caring, imagine the influence on patient recommendations for the organization. As younger nurses are reintroduced to a culture of holistic care and spending time with the patient, patient care may be greatly improved. It may be that the returning nurse is one of the most valuable assets in personnel to improving patient centered care as he or she becomes an advocate to bring back the caring skills that have been a part of nursing since the beginning of the profession.

CHAPTER 5

Conclusion with Recommendations

For all the nurses returning to practice there was one commonality. Each identified that the journey back was a difficult one. There is no easy way back. Instead the road is perilous and filled with “hurdles,” “red-tape,” obstacles, and “hoops to jump through.” Even in the best-case scenario of a licensed nurse who returned to her old job in a familiar hospital after taking a career break, the challenges of knowledge being out of date and unfamiliarity with newer technologies was still at the forefront of her thoughts.

There is also no easy transition through the re-education portion of the return to practice experience. The technology challenge alone often prevents returners from ever finishing the online portion of the coursework.

Technology

Nurse refresher course instructors were clear about the number of nurses who enter the course with few advancing through the entire process. They believed it could be the technology that prevents the students from making it through.

Return-to-Practice students in the United Kingdom apply for a limited number of spots and must commit to a face-to-face portion of the course that is between five to ten days. Perhaps because of the increased commitment and the competition for spots, there is a much higher finishing rate. The programs in the U.K. also assess the technology skills of returners and excludes those who do not have the necessary skills to finish the coursework. Instructors of the U.K. program will recommend that applicants first complete a basic computer skills class available through the library or other online means before applying to the program.

The state refresher coursework is expensive with an outlay of money between two and four thousand dollars to take the course. Those who begin would seem to have made enough of a commitment to have a desire to finish based on the cost of the program. An introductory computer course may be a necessary requirement before some of the nurses are able to complete the coursework. Basic email, adding attachments to email, the use of a drop box, word documents, power point, and downloading software, are all skills necessary for completion of the course and should be considered for inclusion.

Many schools using an online platform for education begin with an intensive at the start of the educational process. This intensive requires the student to travel and attend a face-to-face session as the initial encounter with coursework. A two-day intensive that includes an assessment of necessary computer skills and introduction to the coursework might be one way that instructors could evaluate the student's ability with computers and tailor interventions specific to the student. The intensive could be structured to occur four times a year to allow students an opportunity to enter the program once every three months and then progress at variable pacing through the remainder of the program.

When I began the nurse refresher course, the technology requirements were not difficult for me. I had taken a course through the local university, taken a computer programming course in high school and college, used word processing programs for letters, and had taught myself how to program and upload websites. I did not need a basic course in how to use technology. However, I was the exception, not the standard of nurses returning. For those without a solid technology background, the intensive class might be exactly what is needed for nurses to have the skills necessary for completion of coursework. A pre-assessment of technology skills could

be created that would identify those needing coaching in the technology and those who already have the necessary skills to complete coursework.

Variability

Nurse refresher courses vary by state, and even within states there may be many courses that enable nurses to return to practice. The U.K instructor identified that even with the government sponsorship of the programs, each provider of the RTP program must create their own curriculum for the course. It is difficult for refresher courses to provide curriculum resources for nurses returning. Fees associated with online textbooks, fees for online presentation platforms, and educator's salaries are all related expenses. While keeping the cost low is important in returning nurses to practice, it is difficult to provide what is needed due to the cost of operating. In interviews with course instructors and refresher students, students expressed how expensive the program was while instructors informed me that the amount allotted for the course barely covered the instructor's salary. Borgfeld (2014) confirmed this problem saying that the cost exceeds the fee associated with the course which is "consistent with the literature regarding RN refresher courses" (p.81).

Education is a business. Universities, colleges, and vocational technical programs must be able to at least break even on program costs. The fact that returning nurses are a small number of students combined with the difficult breaking even on program costs, makes nurse refresher courses a low priority for educational institutions. As one student describes the experience, "So we go into the field lab and a lot of the equipment was older, and some of it wasn't that great. We had to share the room with another class and they were being loud and obnoxious and we spent those two day being annoyed. We all shared one packet to do a trach kit and we all shared a room with another class that had three times as many people, and the

teachers and kids were being unkind about sharing. I felt like it was low on the totem pole of importance for them (the associated schools).” The low priority of importance was also expressed by the U.K. instructor who talked about having to advocate regularly for the RTP students to have what they needed.

Although the instructors of the nurse refresher courses often do a wonderful job of searching out resources for the coursework, it was obvious that it was difficult to find free quality materials that met the needs of the student. Every reference, video, and link had to be painstakingly reviewed for accuracy of content.

The best analogy for the nurse refresher coursework would be that of a patchwork quilt which takes little pieces of fabric from this garment and that, a little here and a little there, to try to piece together a beautiful quilt. How skilled and meticulous the quilt maker is in the production of the masterpiece has a direct impact on the finished product. In like manner, the instructors of nurse refresher courses are forced to take pieces from many places to try to create a masterpiece that has cohesiveness and meets the needs of the students. The skill with which the instructor gathers material for the course directly impacts how well the student will be prepared to return to active licensure as a provider of patient care.

With a large population of nurses who are not practicing nation-wide, the need for more skilled nurse workers, and an increasing elderly population needing care, it would seem prudent for there to be an effort to provide a curriculum for returners to practice. A program developed in an online platform at the national or international level with clinical programs at a more local level would make sense. If a standardized curriculum for the returning nurse was developed at a national level in an online platform, local courses could use the curriculum for students and structure local clinical experiences. Grants could most likely be used to develop the curriculum

with experts in different practice areas contributing. A portion of the fee charged to the students could go to cover the ongoing cost of maintenance. The remainder of fees charged would go to the local entity for covering costs associated with clinical experiences.

If a standardized online platform for the educational portion of the course was created, it would be safer to return nurses to practice. Imagine a setting without a skilled and masterful course instructor. What sort of student would be produced from that course? Nurses returned to practice should be able to have confidence that they have obtained the knowledge necessary to again function as an RN. Patients should also be assured that the nurse caring for them has been educationally prepared to function in the role of the main provider of patient care.

Employing the Returning Nurse

The nurse returning to practice is a valuable resource yet many report difficulty in finding a job after stepping out of nursing. These nurses are very unsure of themselves, timid, and scared. Perhaps because of their fear and lack of confidence in their nursing abilities, nurse managers seem reluctant to hire them. With these nurses, however, there is a sense of loyalty to the entity that does hire them. They realize that the hospital is taking a risk and feel the need to give back because of the chance they were given.

Many new graduates get out of school, start a job, go through a residency, work a year, and then leave to go to another job, move, or have a baby and step out of nursing. The same risk that is taken on the new graduate is associated with the returning nurse, but the new graduate does not have the same sense of loyalty. Hospitals should realize the value of these nurses who are returning as loyal, dependable employees with years of life experience and work ethic. Residencies structured for the returning nurse with an extended orientation and one or two preceptors that work closely with the nurse would be the most effective way to return the nurse

to active practice. If hospitals invest the time to create a positive environment for these nurses, they are likely to see a good return on the investment. Active recruitment of the returning nurse may yield a valuable resource of personnel.

Returning nurses have a need for leadership to prepare the way for them to return and for staffing ratios to be adequate when they are being precepted. They should not be expected to suddenly "know and be." There should be no expectation that they would be able to function as a full-fledged nurse just because the unit gets busy. They should be allowed to stay on orientation until they are ready. Unfortunately, this is not always the case. The returning nurse is often promised an extended orientation and then expected to function as a full-fledged nurse very quickly.

It is important to note that returning nurses come from a variety of different backgrounds, time off from nursing, and experience levels. Some of the returning nurses may work several years before stepping out and others may have only worked one. Some may have been out 5 years and others may have been out 25. Because of this, there must be great flexibility in assessing where the nurse is when beginning a nurse refresher course, and course progression should be individualized.

How Long Should Licensure be Maintained?

Although I do not want to advocate to make this journey harder for the returning nurse, I am concerned about how easy it is to maintain a license without practicing. When I initially went back into practice, I had a license. I had been out 24 years but had done continuing education to maintain my license. I took the refresher course because I recognized my responsibility and I knew that I was not ready. The identity of the nurse, with all the responsibilities for safe practice and the idea of do no harm, had been ingrained in me from my

college days. I didn't have to take the nurse refresher course, but I did. The nurse refresher minimally prepared me to practice, and I then enrolled in a master's program to make sure I was well prepared to practice.

Julie is another nurse who had stepped out for some time, maintained a license, and went back into practice without the nurse refresher course. Her experience was much more recent and she had extensive work experience so it wasn't quite as dangerous for her as it might be for other returners to practice.

My concern is for the nurse who doesn't have recent experience or extensive experience but has maintained licensure. I could afford the 2,600 dollars to pay for the nurse refresher course, but what about the nurse who suddenly finds himself or herself in a life circumstance that requires him or her to go back to work to support the family and he or she still has a license but hasn't worked in 24 years? There would be enormous temptation to skip the refresher and just go back. What about the nurse who wants to save the money? What about the nurse who never fully formed the value system of the nurse that drives him or her to assure professional competence? Are we enabling nurses to go back to practice without adequate preparation? Shouldn't there be more oversight of the criteria for maintenance of licensure when there is no practice for many years?

It would be interesting to see research into the number of nurses this involves and what route they take back into practice. Are there nurses who have been out of practice for 20 plus years who suddenly went back to practice and did not do anything to prepare for the return? There needs to be more research into the demographics of nurses returning to practice, what it takes for them to come back, and how to structure a safe return. This study has only scratched the surface of the issues related to this topic.

Many of the returners still have family obligations such as caring for parents and children at home. Many are older and have more limited physical capabilities than their younger co-workers. More thought and research is needed into how to structure work environments to create a place that is both safe and satisfying for the returning older worker. Hospitals and other employing entities would do well to research ways to structure time scheduling so workers with family responsibilities would be able to work without sacrificing the good of the family.

Summary

Nurses returning to practice may provide a valuable resource of personnel. Despite being out of practice for a while, these nurses bring with them a wealth of situational and life experience that may be of great benefit to their employing entities. Nurses who were educated before the advent of electronic health records may even help to change the healthcare milieu from one that has increasingly focused on the medical model rather than patient centered care models. An infusion of those who would advocate for a return to holistic care may be just what is needed to light the path out of the mire of the medical model.

Nurses that have returned report a sense of loyalty to the organization that hires them and are likely to stay employed for a long while. The fear and trepidation they feel upon reentering practice often prompts these nurses to pursue higher education and become the expert in their practice areas. The difficulty of returning also develops an empathy for others in similar circumstances including new students just entering nursing. Empathetic experts may change the culture of a unit from one that is engaged in a perpetual cycle of horizontal violence to a culture of caring and mutual support.

Care must be taken when hiring returning nurses to make certain that they are safe to practice. This is the responsibility of the individual nurse, the board of nursing, the nurse

refresher or return-to-practice course instructors, and the hiring entity. It would also seem to be the responsibility of professional nursing organizations to create a platform to unify educational requirements for this group of individuals to assure that they have what they need to function.

Hospitals that hire returning nurses may have an initial investment of time that exceeds hiring of a new graduate or someone already practicing, but the returning nurse would seem to be a good return on the investment. As Stephens (2014) found, nurses that return to practice are likely to stay until retirement age. The loyalty and likelihood of staying till retirement make the returning nurse a worthwhile investment that is likely to provide employers with a long-term, expert, empathetic, patient-centered, holistic, mature care-provider with a good work ethic and an ability to train others.

REFERENCES

Benner, P. (1982). From Novice to Expert. *American Journal of Nursing 82*(3), 402-407. Retrieved from: http://www.jstor.org.vortex3.uco.edu/stable/pdf/3462928.pdf.

Borgfeld, J. (2014). A registered nurse refresher course: Serving the community. *Journal of Continuing Education in Nursing 45*(2), 77-82. Doi: 10.3928/00220124-20140123-01.

Buchanan-Barker, P., & Barker, P. (2015). What is the Tidal Model? An overview. Retrieved from http://www.tidal-model.com/what%20is%20the%20tidal%20model.html

Cooper, S. (1973). A brief history of continuing education in nursing in the United States. The *Journal of Continuing Education in Nursing 4*(3), pp. 5-14. https://search-proquest-com.vortex3.uco.edu/docview/915496828?rfr_id=info%3Axri%2Fsid%3Aprimo

Dean, E. (2014). We want you back. *Nursing Standard 29*(12), 24-25. Doi:10.77.48/ns.29.12.24.s27.

Durand, M.A., & Randhawa, G. (2002). Nurses' views about returning to practice after a career break. *British Journal of Nursing 11*(7), 477.

Elwin, C. (2007). Returning a nurse to practice: A learning journey. *Contemporary nurse: A Journal for the Australian Nursing Profession 24*(2), P. 203-211. DOI:10.5172/conu.2007.24.2.203

Gellasch, P. (2015). The driving force behind nurses leaving the profession. *Nurse Leader 13*(5), 63-68. Doi: 10.1016/j.mnl.2015.01.001.

Healey, S.A. (1989) Activating "inactive" registered nurses. *Nursing Economics 7*(2), pp.109-110. Retrieved from: http://web.a.ebscohost.com.vortex3.uco.edu/ehost/pdfviewer/pdfviewer?vid=1&sid=4314353b-c192-4b98-be06-c061d10d911e%40sessionmgr4006

Holloway, I., & Galvin, K. (2017). *Qualitative research in nursing and healthcare* (4th ed.).

West Sussex UK: John Wiley & Sons, Ltd.

Hobbs, D. L. (2011) *Inactive Registered Nurses Returning to Practice: Barriers and Successes.* (Doctoral dissertation). Retrieved from: ProQuest Dissertations Publishing. 3452429.

Huggins, M.E. (2005). Registered nurse refresher course as an adjunct in nurse recruitment. *Journal of Continuing Education in Nursing 36*(5), 213-217. Retrieved from: http://web.a.ebscohost.com.vortex3.uco.edu/ehost/pdfviewer/pdfviewer?vid=5&sid=84c550d8-ae9b-45a8-a599-1725027383a8%40sessionmgr4006

Hydes-Greenwood, J., & Leach, V. (2002). Return to practice. *Nursing Management 9*(5), 28. Retrieved from: https://search-proquestcom.vortex3.uco.edu/docview/57539353?rfr_id=info%3Axri%2Fsid%3Aprimo.

Kent, L.N. (2015). For love or money: Registered nurses who return to hospital practice. *Journal of Nursing Management 23,* 599-603. Doi: 10.1111/jonm.12185.

Kim, J.H. (2016). *Understanding Narrative Inquiry*. Los Angeles, CA: Sage Publications, Inc.

Nottingham, E. & Foreman, K. (2000). Creating the right environment for return-to-practice candidates. *Nursing Standard 14*(32), p. 44-45. Retrieved from: https://search-proquest-com.vortex3.uco.edu/docview/764090415?rfr_id=info%3Axri%2Fsid%3Aprimo

Nursing.org. (2016*). The state of Nursing in 2016-2017*. Retrieved from: https://www.nursing.org/wp-content/uploads/2015/10/Nursing.org_.State-of-Nursing_2016.pdf

Payne, S. (2010). Why midwives fail to stay in practice following a return to practice course. *British Journal of Midwifery 18*(6), 376-381. DOI: http://dx.doi.org/10.12968/bjom.2010.18.6.48311.

Potter, J. W. (1996). *An Analysis of Thinking and Research About Qualitative Methods*.

Mahwah, NJ: Lawrence Erlbaum Associates, Inc.

Reason, P. (1998). Co-operative Inquiry as a Discipline of Professional Practice. *Journal of Inter-professional Care., 12(*4), 419-436.

Reissman, C. K. (2010). *Narrative Analysis*. Newbury Park, CA: Sage Publications, Inc.

Robinson, J. (2014). Reflection, return to practice and revalidation. *Nursing Older People 27*(6), p. 31-37. Doi: 10.7748/NOP.27.6.31.e692.

Sermijn, J., Devlieger, P., & Loots, G., (2008). The narrative construction of the self: Selfhood as a rhizomatic story. *Qualitative Inquiry 14*(4), 632-650. Doi: 10.1177/1077800408314356.

Spraley, J. (1979). Asking descriptive questions. *The Ethnographic Interview (1st ed.).* Retrieved from: http://jan.ucc.nau.edu/~pms/cj355/readings/spradley.pdf

Stevens, J. (2014). Support for nurses returning to practice. *Nursing Times 110*(48), p.12.

Texas Board of Nursing. (2006). *Guidelines for transitioning of the experienced nurse back into clinical practice or into a new practice setting.* Retrieved from: http://www.bon.texas.gov/practice/breakem.Html

Yancy, P., & Handley, A. (2004) Can everyone be refreshed? *Journal of Continuing Education in Nursing 35(*2), 80-83. Retrieved from: http://web.a.ebscohost.com.vortex3.uco.edu/ehost/pdfviewer/pdfviewer?vid=8&sid=84c550d8-ae9b-45a8-a599-1725027383a8%40sessionmgr4006.

APPENDIX A:

IRB APPROVAL

February 26, 2018 IRB Application #: 2018-015 Proposal Title: Nurses returning to practice after an extended career break: A narrative study

Type of Review: Initial Review-Expedited Investigator(s):

Brandi Stanley Joyce Tow, Ph.D.

Dear Ms. Stanley and Dr. Tow:

Re: Application for IRB Review of Research Involving Human Subjects

We have received your materials for your application. The UCO IRB has determined that the above named application is APPROVED BY EXPEDITED REVIEW. The Board has provided expedited review under 45 CFR 46.110, for research involving no more that minimal risk and research Category 7.

Date of Approval: February 23, 2018 Date of Approval Expiration: February 22, 2019

If applicable, informed consent (and HIPAA authorization) must be obtained from subjects or their legally authorized representatives and documented prior to research involvement. A stamped, approved copy of the informed consent form will be made available to you. The IRB-approved consent form and process must be used, where applicable. While this project is approved for the period noted above, any modification to the procedures and/or consent form must be approved prior to incorporation into the study.

It is the responsibility of the investigators to promptly report to the IRB any serious or unexpected adverse events or unanticipated problems that may be a risk to the subjects.

Please let us know if the IRB or Office of Research Integrity and Compliance can be of any further assistance to your research efforts. Never hesitate to contact us.

Sincerely,

Melissa Powers, Ph.D. Chair, Institutional Review Board University of Central Oklahoma 100 N. University Dr. Edmond, OK 73034 405-974-5497 irb@uco.edu

Office of Research Integrity and Compliance

100 North University Drive / Edmond, OK 73034 Phone (405) 974-5497 Fax (405) 974-3818

APPENDIX B:

SCRIPT

Hello, my name is Brandi Stanley. I am a master's student at the University of Central Oklahoma. For my master's thesis, I am conducting a narrative study of nurses who have returned to practice or are in the process of returning to practice after an extended career break of at least 5 years. I need subjects who meet these criteria. I will provide a small Starbuck's gift card as a thank you to those who agree to participate. Please share this information or contact me with any referrals to returning nurses. Bpphillips15@uco.edu, 405-410-1129.

This project has been approved by the University of Central Oklahoma Institutional Review Board (#2018-015)

APPENDIX C:

INFORMED CONSENT

UNIVERSITY OF CENTRAL OKLAHOMA

INFORMED CONSENT FORM

Research Project Title: Nurses returning to Practice After an Extended Career Break: A Narrative Study

Researcher (s): Brandi Stanley RN

A. **Purpose of this research:** Document the experience of nurses who return to practice after a career break and target educational strategies to meet their unique needs

B. **Procedures/treatments involved:** interview

C. **Expected length of participation:** 30 minutes to 1 hour

D. **Potential benefits:** Processing through a personal narrative may have many benefits for the participant such as: Fostering a sense of pride in accomplishment, giving clarity to the journey, helping with goal setting for future events, identifying needs, helping future nurses on the same journey. A Starbuck's gift-card in the amount of $10.00 will be given to participants in the study.

E. **Potential risks or discomforts:** There is a minimal risk of psychological stress as the participant voluntarily recounts experiences which may have been traumatic during the return to practice journey.

F. **Medical/mental health contact information (if required):** Psychologytoday.com – find a therapist

G. **Contact information for researchers:** bphillips15@uco.edu, 405-410-1129

H. **Contact information for UCO IRB:405-974-5497, irb@uco.edu**

I. **Explanation of confidentiality and privacy:** Only the researcher will know the identity of the participant. The Interview will be audio-recorded and a paper transcript will be generated. Following completion of the study, the transcript will be shredded and the recording deleted. Additionally, some stories may be combined in the writing of the narratives and details that are very specific in nature may be altered to de-identify the information (for example, names will be changed, locations changed and specific institutional identifiers will be excluded.)

J. **Assurance of voluntary participation:** Participation in this study is entirely voluntary in nature and the participant may end the interaction at any time and for any reason, no questions asked.

AFFIRMATION BY RESEARCH SUBJECT

I understand that this interview will be audio-recorded and I consent to this audio-recording.

Signature: _____ Date: _____

I hereby voluntarily agree to participate in the above listed research project and further understand the above listed explanations and descriptions of the research project. I also understand that there is no penalty for refusal to participate, and that I am free to withdraw my consent and participation in this project at any time without penalty. I acknowledge that I am at least 18 years old. I have read and fully understand this Informed Consent Form. I sign it freely and voluntarily. I acknowledge that a copy of this Informed Consent Form has been given to me to keep.

Research Subject's Name: _____

Signature: _____ Date _____