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Staff Retention Through Standardized Training Materials in Adult Primary Care Clinic

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Abstract

As non-profits, community health clinics face a unique set of challenges. Primary amongst these is a shortage of financial resources. Staff turnover, including Registered Nurses (RNs) and Medical Assistants (MAs), can result in avoidable increased wage costs related to training of newly-hired RNs/MAs (clinical staff). Retention of experienced RNs/MAs can be directly correlated with job satisfaction, the obverse of which is job frustration. The intent of this RN/MA training and orientation project is to ameliorate frustration related to a lack of informational resources and clear competency expectations. Upon completion and implementation, project efficacy will be assessed via four longitudinal measures: Likert Scale job satisfaction surveys, clinical skill competency assessment, tracking of RN/MA turnover rates, and fiscal analysis. It is anticipated that the clinic will see results including a decrease in job frustration with subsequent decreased RN/MA turnover, improved quality of care and a decrease of avoidable costs. Retaining experienced RNs equates to responsible stewardship of resources and most importantly maintains quality standards of care.

Staff Retention Through Standardized Training Materials in Adult Primary Care Clinic

This topic is of importance due to its potential to positively impact not only the Adult Medicine clinical microsystem but also the facility's mesosystem. Increased microsystem staff turnover, whether it be of unlicensed assistive personnel or licensed clinicians will inevitably lead to increased labor costs with a strong potential to also negatively affect quality of patient care. The mesosystem will benefit through conscientious stewardship of facility-wide resources (Bae, Mark, & Fried, 2010).

Problem Description

Patient care can be negatively impacted by high rates of staff turnover for a number of reasons. Chiefly, clinic staff who are not familiar with the microsystem's standard practices, workflow, patient population, and available resources cannot provide the highest quality of care (O'Brien-Pallas, Murphy, Shamian, Li, & Hayes, 2010). Fiscal responsibility within a non-profit community primary care clinic is of paramount importance for the overall system. Currently, the primary care clinic in question has historically provided patient care with minimal use of standardized clinical policies and procedures (P & P). The clinic employs a RN/Provider co-visit model of care. This does afford the RN the opportunity to function to the fullest extent of her or his scope of practice. RNs perform the first half of a patient visit conducting primary care assessments and developing a SOAP format care plan. A short period of time is spent consulting with the provider after which the provider concludes the visit with the patient; conducting any additional assessments and prescribing treatment. Consequently, the RN must adopt a wide range of clinical responsibilities and function as independently as possible. Use of this model of care without a robust and supportive P & P manual has led to increased RN staff

frustration. There has been a resultant increase in RN staff turnover. Improving RN staff retention has been proven to offer a multitude of benefits for all stakeholders (Doran, Duffield, Rizk, Nahm, & Chu, 2014)

Setting

The microsystem being assessed is the Adult Medicine Clinic, providing primary care for those 18 years-old and above, within a community health center. The health center provides a comprehensive array of services and specialized clinics, billing patients on an income-based sliding scale. Specialty clinics include: a Women's clinic dealing primarily with Obstetrics and Gynecology including family planning, a Pediatric clinic, a Teen clinic handling primary care, age-specific reproductive and behavioral health, a full-service Behavioral Health Clinic, a Podiatry clinic, an Optometry clinic, a Dental clinic, a pharmacy, phlebotomy services with on-site lab, radiology services, and preventive services including yoga, mindfulness, nutrition and diabetes classes. The importance of this health center in the community cannot be overstated.

Current knowledge related to setting

Services are provided to patients from historically underserved populations. The patient base for this clinic is, by and large, either uninsured or significantly underinsured. As a safety-net healthcare organization, levels of reimbursement typically run much lower than other facilities (Baernholdt & Mark, 2009).

Being a sanctuary clinic within a sanctuary city within a sanctuary state, a significant portion of patients are undocumented. Their immigration status plays a marked role in their socioeconomic experience which undoubtedly impacts their overall healthcare.

The clinic strives to provide both culturally and, as the majority of patients are non-English speakers, linguistically competent care. This adds a layer of necessary skills for clinical

staff and can limit the pool of potential new-hire candidates; all the more reason to ensure staff retention. While it is expected for newly hired staff to already possess the aforementioned cultural and linguistic skills, knowledge of clinic specific policies and procedures must be acquired. It is therefore imperative to provide adequate written resources for newly-hired clinical staff (Currie & Carr Hill, 2012).

The situation is further compounded by the co-visit care model utilized by the clinic. RNs perform most assessments and some minor procedures, collect histories, and provide patient education and care coordination. There is a substantial and very high quality Medical Assistant staff. There are also numerous providers, both Medical Doctors and Nurse Practitioners to furnish, provide oversight and finalize patient visits. However, there is typically only one clinical RN on duty at any given time. The co-visit care model does afford the RN the opportunity to function to the fullest extent of her or his scope of practice. However, the staffing model also makes it incumbent upon the RN to work independently. There are no RN peers or Charge Nurses to whom one can refer. Having a written resource manual becomes essential.

Metrics

[In the interests of academic integrity: this writer must utilize hypothetical data in relation to confidential clinic specific information. Data drawn from literature is as stated.] Rates of RN staff turnover are high across the profession. However, the rates are highest in both rural and primary care settings, at times approaching an annual rate of 200% or greater. (Baernholdt & Mark, 2009). It is an unfortunate reality that a majority of RNs are drawn to higher paying positions. These are typically found within large, urban acute care facilities. Primary care facilities, particularly those publicly funded, are most at risk for high levels of turnover.

There are at four metrics involved in this project. The most important metric which matters in this situation is the rate of clinical staff turnover. This figure is easily obtained from Human Resources records. For the sake of this prospectus, a hypothetical assumption is made of two turnovers of clinical staff (two RNs/MAs no longer employed, two new RNs/MA hired) within 18 months' time. Secondly, RN/MA job satisfaction as measured with Likert Scale surveys have significant importance. Also a skill competency assessment is performed to not only ascertain readiness to practice independently but also to determine which skills require remediation and to serve as official documentation. Lastly, measurement of turnover, particularly in the clinical staff, can place a disproportionate level of financial stress on the already limited resources of a non-profit clinic.

PICOT question

The *(P)opulation* involved are community clinic RNs and MAs, requiring an *(I)ntervention* consisting of clinical support documentation to mitigate RN/MA turnover through increased job satisfaction, which will be *(C)ompared* with the existing state of no definitive clinical support documentation, with an expected *(O)utcome* of decreased rates of RN/MA staff turnover related to increased job satisfaction, measured over a prolonged *(T)ime* period needed to effectively evaluate turnover rates, this project would need to be analyzed over a relatively extended period of time [months to years]. See Appendix A.

Synthesis of Existing Literature

The existing literature indicates a number of reasons for RN/MA staff turnover. These include relationships with colleagues and supervisors, levels of remuneration, career development, and personal responsibilities outside of the workplace (Bogaert, Clarke, Vermeyen, Meulemans, & Heyning, 2009). While these factors all play a role in staff retention, job

satisfaction is often cited as the most critical factor impacting not only institutional budgets but also quality of patient care (O'Brien-Pallas, Murphy, Shamian, Li, & Hayes, 2010). While financial prudence is always a necessity, as without such, provision of services would be curtailed; in nursing, quality of patient care must remain the paramount benchmark (Bae, Mark, & Fried, 2010). Retention of experienced RNs and MAs maintains interpersonal relationships and lines of communication, as well as familiarity with facility patients, policies, procedures, and resources (Estryn-Behar, I. J. M. Van Der Heijden, Fry, & Hasselhorn, 2010). Estryn-Behar, Van Der Heijden, Fry, & Hasselhorn (2010) conclude that quality evaluation of efforts to mitigate RN turnover require longitudinal studies over the span of at least a year's time.

Rationale

As an experienced manager in any industry knows, repeated absenteeism is a classic precursor of an individual's intent to leave her or his current employment. Daouk-Öyry, Anouze, Otaki, Dumit, & Osman (2014) developed a model for examining the constellation of variables contributing to clinical staff turnover and its antecedent, absenteeism. Their Job, Organization, Individual, National, and inTerpersonal (JOINT) model amalgamates these variables into a cohesive conceptual framework. This model confirms the multi-level causes of RN/MA turnover, all of which, to varying degrees, contribute to decreased job satisfaction and thus increased RN/MA turnover.

Project Aim

This project aims to improve RN/MA staff retention, which can then have a positive cascade effect throughout the organization. With decreased staff turnover there is, most importantly, an improvement in patient outcomes related to safety, and quality of care (Gess, Manojlovich, & Warner, 2008). Financial goals are more easily met without the burden of

continuous cycles of new-hire training. In addition, with improved access to clinical P & P resources, RN/MA staff job satisfaction rates increase (Doran, Duffield, Rizk, Nahm, & Chu, 2014), which in turn has the circular benefit of promoting staff retention, through increased job satisfaction resulting from provision of a comprehensive clinical resource manual. Upon completion, this manual should provide RNs/MAs performing at the fullest scope of their practice the support needed to maximize independence. This high-functioning independent RN practice is predicated by the community clinic's co-visit model which creates a dyad of relative equals comprised of RN and provider.

Methods

Microsystem Assessment

The assessment of this microsystem as regards this project is predominantly qualitative in nature. The primary quantitative assessments are those of Likert scale job satisfaction and skill competency assessment scores. Due to the proprietary nature of Human Resource and budget data, industry average data gleaned from literature must suffice for any remaining quantitative assessment.

IHI Culture Assessment

The clinic has the essential components of safe practices in place. There is a need for formally codified policies. The areas of critical need include: a policy on patient and family communications, policies on disclosure and documentation, and a written crisis communication plan; this plan is centrally located and easily accessible by all staff. Ongoing training programs are in place for all staff on communication, expectations, policies, procedures, and guidelines; a team to support staff preparing to disclose (coaches); all clinic staff disclosing are trained in their role; procedures are in place and are known to ensure ongoing communications with patients,

families, and staff; and procedures are in place and are known to bring the case to closure respectfully, as viewed by the patient and family.

ROI Plan

The American Organization of Nurse Executives estimates that on-boarding of new RNs (the more expensive of the RN and MA roles) costs $10,000 in 2000. This amount equates to $14,684 in 2018 dollars. Assuming two newly hired RNs, the associated costs would be ~$30,000. Turnover in the clinic environment is compounded by salary differences with acute care and other high-paying RN positions. The Bureau of Labor Statistics' 25th percentile annual wage estimate for RNs in the San Francisco metropolitan area as of May, 2017 was $57,340 (US Department of Labor, 2018).

With a hypothetical staffing of 5 clinic RNs, this wage estimate equates to an annual wage budget of $286,700. The hypothetical figure of ~$30,000 for two newly-hired RNs represents over 10% of the clinic's annual RN wage budget. These costs primarily involve increased time spent by other staff members including:

1. Orientation and provision of additional site-specific training for new RNs including remediation of skill deficiencies.
2. Human Resource staff integrating new RNs into the facility's benefits matrix and payroll system as well as confirming RN licensure and credentials.

The Bureau of Labor Statistics indicate that the job category most closely aligned with the CNL role is that of "Medical and Health Service Managers". 2017 annual mean wage for this category in California was $122,500 or $58.90 per hour (US Department of Labor, 2018). While CNL internships encompass 220 clinical hours, only a percentage of that time is devoted to quality-improvement capstone projects. For the sake of discussion, one could assume

50% of those 220 hours is spent developing these projects. With that in mind, 110 hours @ $58.90 per hour equates to a labor savings for a facility related solely to project development of ~$6,500. If this project is minimally effective, resulting in the retention of two RNs, the clinic will realize a savings of $36,410 (no-cost CNL labor + RN turnover savings).

Communication Plan

Communication of the needs, intent, and content of the intervention would begin with facility executives, senior administrative and clinical staff. Once approved, the plan would be communicated with downstream staff including staff RNs and in the case of this clinic with the substantial number of highly-qualified Medical Assistants.

Intervention

As discussed throughout, the intervention consists of a comprehensive RN and MA training manual complete with competency checklists, and most importantly clinical support documentation. The competency checklists would serve to ensure that incoming (and continuing) RNs possess the requisite nursing skills to function at the high level of independence necessitated by the co-visit model of care; while the clinical support documentation will provide the RNs with the tools to succeed in their independent role.

Study of the intervention measurement strategy

It has been shown that quality improvement projects such as the one being discussed, can be effectively measured using a toolkit collectively referred to as Statistical Process Control (SPC). SPC is perhaps best explained as the incorporation of "…measurement, data collection methods, and planned experimentation [proposed interventions and result analysis]" (Thor et al., 2007, p. 387) In this model, quality improvement projects can typically be well measured through self-analysis, independent of external validation.

Measures – Family of Measures

- Aim – Reduce RN turnover by 50% within 12 months
  - Outcome Measure
    - Number of turnovers (one RN out, one RN in) within 12 months
- Process Measure
  - Implementation of comprehensive RN manual
    - Increase in job satisfaction
    - Decrease in job frustration
- Balancing Measure
  - Is system being disturbed?
    - Is implementation affecting patient care?
    - Is implementation affecting fiscal responsibility?

(Institute of Healthcare Improvement n.d.)

Ethical Considerations

As this project does not include any direct interventions with either patients or staff, there are little if any ethical considerations. The only item of note would be maintaining the confidentiality/anonymity of Likert Scale surveys. The researcher would want to prevent any concern over participant identification in order to elicit the most candid responses. See Appendix F for Institutional Review Board questionnaire.

Results

The initial steps of the intervention could have been scaled down. The late inclusion (for timeline (see Appendix G) of staff competency assessments (see Appendix H) helped to identify more closely the clinical areas in need of training and reference support materials. Attempting to

develop a globally comprehensive training manual for RNs and MAs went far beyond the scope of this project/internship. The effective development of such a manual will take many months to accomplish. The Likert Scales used to assess individual staff strengths and weaknesses will guide the ongoing effort to develop these important support documents.

An unintended but positive benefit of the development of skill assessment surveys allow for supervisory and Human Resources staff to have documentation on file to support any mandated remediation of if necessary, disciplinary actions up to and including termination.

Discussion

Summary

The keystone finding was the lack of comprehensive clinical support documentation. This had a deleterious effect on both the Medical Assistants and the Registered Nurses working in the clinic. Working with my preceptor, the clinic's RN management consultant, we were able to catalogue the existing support documentation located in fragmented locations. Once we knew what documents already existed, we turned our attention to determining the specific operational needs of the Adult Medicine Primary Care Clinic. Of significance was also developing a staff competency assessment tool to determine clinical and individual staff members' areas of greatest need.

Conclusions

When existing support documentation is reconciled with newly ascertained and documented areas in need of clinical improvement this will allow the RN supervisory staff, in concert with the clinic's providers, to compose a focused set of standard practices. These standard practices will provide the RN and MA staff with the practical support needed as both groups strive to function at the highest level of their respective scopes of practice. This will

undoubtedly lead to increased job satisfaction, decreased staff turnover, improved quality of patient care and more responsible financial stewardship.

While the policies and procedures specific to the clinic may not be particularly well suited to extend to other contexts in their current format; the principle of consolidating existing documentation and applying a needs-centric construct based on staff skills assessment could easily be transferred to a different primary care clinical environment.

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Appendix A

PICOT

POPULATION	Community Clinic RNs
INTERVENTION	Clinical support documentation (microsystem reference manual) to mitigate RN turnover through decreased job frustration/increased job satisfaction.
COMPARISON	Clinic currently has no definitive clinical support documentation, only an ad hoc compilation of unrelated documents.
OUTCOME	Decreased rates of RN staff turnover related to increased job satisfaction.
TIME	Due to the prolonged window needed to effectively evaluate turnover rates, this project would need to be analyzed over a relatively extended period of time [months to years].

Appendix B

Budget and Return on Investment chart

Description	Budget	Values
Free Labor of CNL Hourly mean wage = $58.90 Number of hours spent on QI project = 110	Total CNL free labor savings: $58.90 x 110 = $6500	$6500
Cost of producing hard copies of RN manual	100-page document @ $0.15 per page = $15 per complete manual. 6 manuals printed = $15 x 6 = $90 Total printing costs: $90	$90
Cost of onboarding new RN = $15,000	$15,000	
Minimal scenario: Two RNs retained	$15,000 x 2 = $30,000	$30,000
Potential savings realized	$90 - $30,000 - $6500 =	$36,410

Appendix C

IHI Cultural Assessment Tool

IHI Assessment Tool—A Culture of Respect, Communications, and Disclosure	Element**	Y	+-	N
Internal Culture of Safety	The organization is grounded in the core values of compassion and respect and the ethical responsibility to always tell the truth to the patient and family.	✓		
	There is an expectation for ongoing communication, honesty, and transparency that is set from the board and leadership and closely monitored.	✓		
	Error is seen as the failure of systems and not people.	✓		
	All can expect support at the sharp end of unanticipated outcome and near-miss.	✓		
Malpractice Carrier	There is a commitment to rapid disclosure and support.	✓		
	There is a written understanding of how cases will be managed in partnership between patient/family/carrier.		☗	
	Mechanisms are in place for rapid respectful resolution.		☗	
	There is a policy on patient and family communications.			⊗
	There is a policy on patient and family partnerships. Organizational infrastructure for clinician support exists.		☗	

Policies, Guidelines, Procedures	There are policies on disclosure and documentation.			⊗
	Procedures are known and in place for internal and external communication of sentinel events.		☗	
	Guidelines/policies support a fair and just culture (non-punitive) and the reporting of adverse events.	✓		
	There is a written crisis communication plan. This plan is centrally located and easily accessible by all staff.			⊗
Training	Ongoing training programs are in place for all staff on communication, expectations, policies, procedures, guidelines.			⊗
	There is just-in-time coaching (training) for disclosures.		☗	
Disclosure Processes in Place	There is rapid notification of patient/family and activation of support—typically immediately around what is known.	✓		
	There is a team to support staff preparing to disclose (coaches).			⊗
	Root cause analyses commence immediately, are closely managed, and the results are shared, including with the patient and family.	✓		
The Disclosure	The organization is transparent and honest.	✓		
	Responsibility is taken.	✓		
	We apologize/acknowledge.	✓		
	There is a commitment to providing follow-up information.	✓		
	The caregiver is supported throughout the process.	✓		

	The organization provides continuing support for the patient/family.	✓		
	All clinic staff disclosing are trained in their role			⊗
Ongoing Support	Resources are available to assist families experiencing unanticipated outcomes (not limited to error) – support is defined by needs of the patient and family (e.g., emotional support).	✓		
	Resources are available to assist staff at the sharp end of unanticipated outcomes (not limited to error) – based on the needs of the clinician (e.g., emotional support).	✓		
	Procedures are in place and are known to ensure ongoing communications with patients, families, and staff.			⊗
Resolution	Procedures are in place and are known to bring the case to closure respectfully, as viewed by the patient and family.			⊗
Learning	Mechanisms are in place to ensure learning by the board, executive leadership, MSEC, and across the organization.	✓		
	Measurement systems are in place to assess the impact of communication, disclosure, and support (as well as quality and safety) practices on premiums, claims, cases, and payments.	✓		

(Institute for Healthcare Improvement n.d.)

***Adapted from Medically Induced Trauma Support Services (MITSS)*

Appendix D

EVIDENCE-BASED CHANGE OF PRACTICE PROJECT CHECKLIST *

STUDENT NAME: David Smith, RN

DATE: June 30, 2018.

SUPERVISING FACULTY: Dr. Carlee Yetive Stewart Balzaretti.

Instructions: Answer YES or NO to each of the following statements:

Project Title: MNHC RN Training and Policies & Procedures Manual	**YES**	**NO**
The aim of the project is to improve the process or delivery of care with established/ accepted standards, or to implement evidence-based change. There is no intention of using the data for research purposes.	☑	
The specific aim is to improve performance on a specific service or program and **is a part of usual care**. ALL participants will receive	☑	
The project is **NOT** designed to follow a research design, e.g., hypothesis testing or group comparison, randomization, control groups, prospective comparison groups, cross-sectional, case control). The project does **NOT** follow a protocol that overrides clinical decision-making.	☑	
The project involves implementation of established and tested quality standards and/or systematic monitoring, assessment or evaluation of the organization to ensure that existing quality standards are being met. The project does **NOT** develop paradigms or untested methods or new	☑	
The project involves implementation of care practices and interventions that are consensus-based or evidence-based. The project does **NOT** seek to test an intervention that is beyond current science and experience.	☑	
The project is conducted by staff where the project will take place and involves staff who are working at an agency that has an agreement with	☑	
The project has **NO** funding from federal agencies or research-focused organizations and is not receiving funding for	☑	
The agency or clinical practice unit agrees that this is a project that will be implemented to improve the process or delivery of care, i.e., **not** a personal research project that is dependent upon the voluntary participation of colleagues, students and/ or patients.	☑	
If there is an intent to, or possibility of publishing your work, you and supervising faculty and the agency oversight committee are comfortable with the following statement in your methods section: *"This project was undertaken as an Evidence- based change of practice project at X hospital or agency and as such was not formally supervised by the Institutional*	☑	

ANSWER KEY: If the answer to **ALL** of these items is yes, the project can be considered an Evidence-based activity that does NOT meet the definition of research. IRB review is not required. Keep a copy of this checklist in your files. If the answer to ANY of these questions is **NO**, you must submit for IRB approval.

*Adapted with permission of Elizabeth L. Hohmann, MD, Director and Chair, Partners Human Research Committee, Partners Health System, Boston, MA.

Appendix E

Charter

Nature of the Project - Overview of Existing Situation

Currently, the primary care clinic in question has historically provided patient care with minimal use of standardized clinical policies and procedures (P & P). The clinic employs a RN/Provider co-visit model of care. This does afford the RN the opportunity to function to the fullest extent of her or his scope of practice. RNs perform the first half of a patient visit conducting primary care assessments and developing a SOAP format care plan. A short period of time is spent consulting with the provider after which the provider concludes the visit with the patient. Consequently, the RN must adopt a wide range of clinical responsibilities and function as independently as possible. Use of this model of care without a robust and supportive P & P manual has led to increased RN staff frustration. There has been a resultant increase in RN staff turnover. Improving RN staff retention has been proven to offer a multitude of benefits for all stakeholders (Doran, Duffield, Rizk, Nahm, & Chu, 2014)

Data That Shows the Need for Project - Rates of RN Staff Turnover Indicative of Need for Change

Rates of RN staff turnover are high across the profession. However, the rates are highest in both rural and primary care settings, at times approaching an annual rate of 200% or greater. (Baernholdt & Mark, 2009). It is an unfortunate reality that a majority of RNs are drawn to higher paying positions. These are typically found within large, urban acute care facilities. Primary care facilities, particularly those publicly funded, are most at risk for high levels of turnover.

Goal – Benefits of staff retention

The goal of this project is to improve RN staff retention, which can then have a positive cascade effect throughout the organization. With decreased staff turnover there is, most importantly, an improvement in patient outcomes related to safety, and quality of care (Gess, Manojlovich, & Warner, 2008). Financial goals are more easily met without the burden of continuous cycles of new-hire training. In addition, with improved access to clinical P & P resources, RN staff job satisfaction rates increase (Doran, Duffield, Rizk, Nahm, & Chu, 2014), which in turn has the circular benefit of promoting staff retention.

Evidence to Support the Project - Evaluation of Change Efficacy

The effectiveness of providing a thorough yet concise P & P manual will be evaluated by measuring the rates of improvement in the aforementioned categories. Namely, improved patient outcomes and satisfaction, fiscal responsibility, and RN staff retention and job satisfaction.

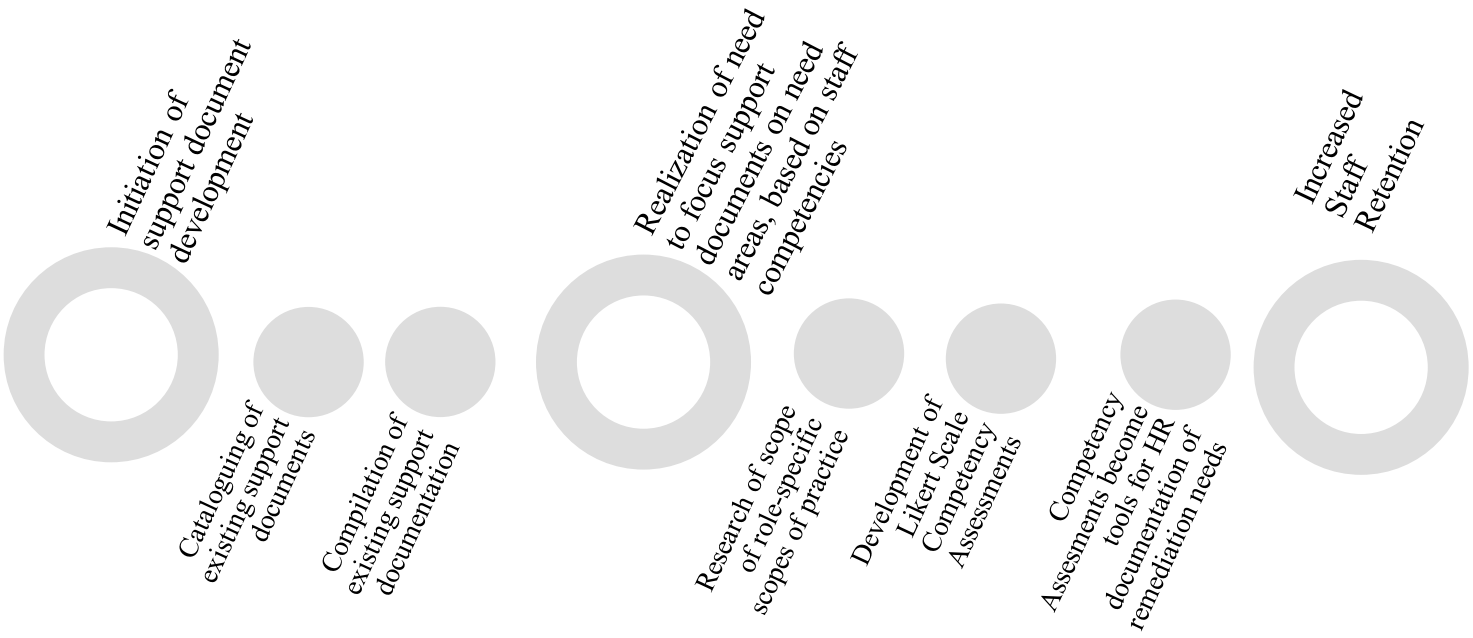
Team

The team consisted of all members of the Adult Medicine Primary Care Clinic. This included Medical Assistants, (Legacy) Licensed Vocational Nurses, Registered Nurses, Clinical Nurse Leaders (Senior RN), Nursing Supervisor/RN Management/Quality Improvement Consultant, Director of Clinical Operations (MPH), Family and Adult Nurse Practitioners, Doctors of Osteopathy, and Medical Doctors including the clinic's Medical Director.

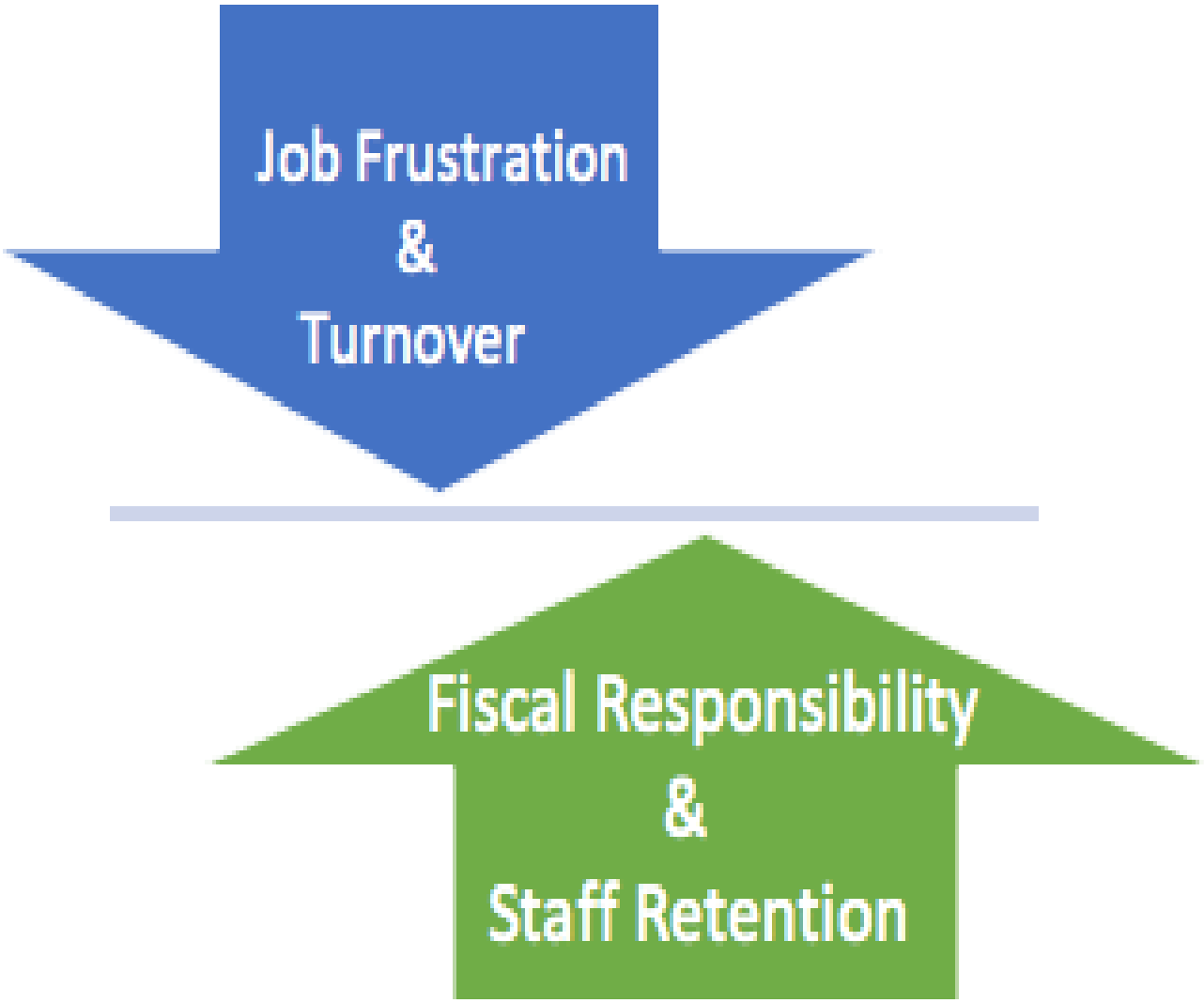
Timeline

The development of comprehensive support documents will take at least 18 months resulting from the layers of review, advisement and revision required for a project of such scale. The competency assessment effort was much more achievable to implement, the benefits of which though will take several additional months to come to fruition.

Timeline – Appendix F

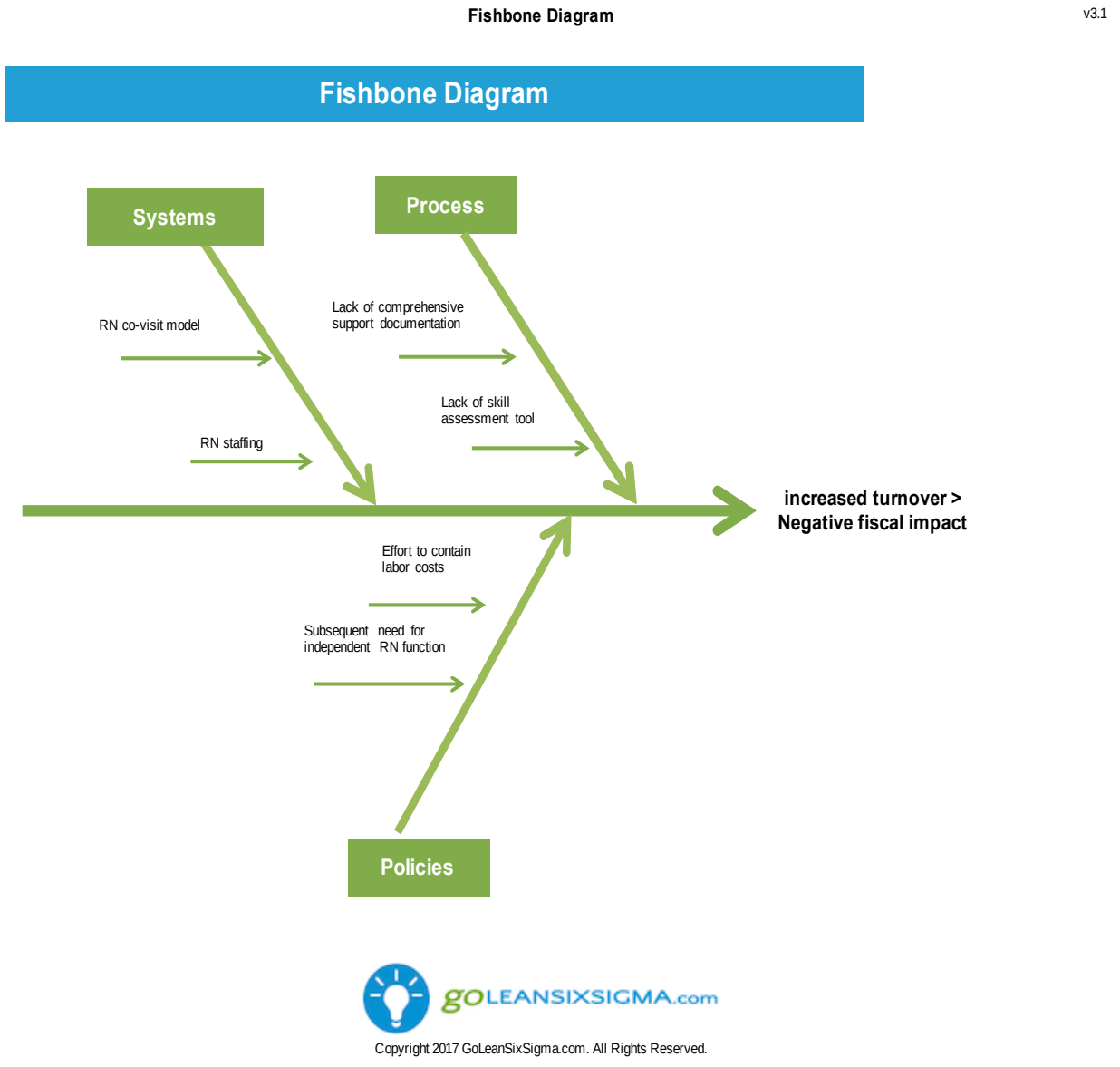


Driver Diagram – Appendix G

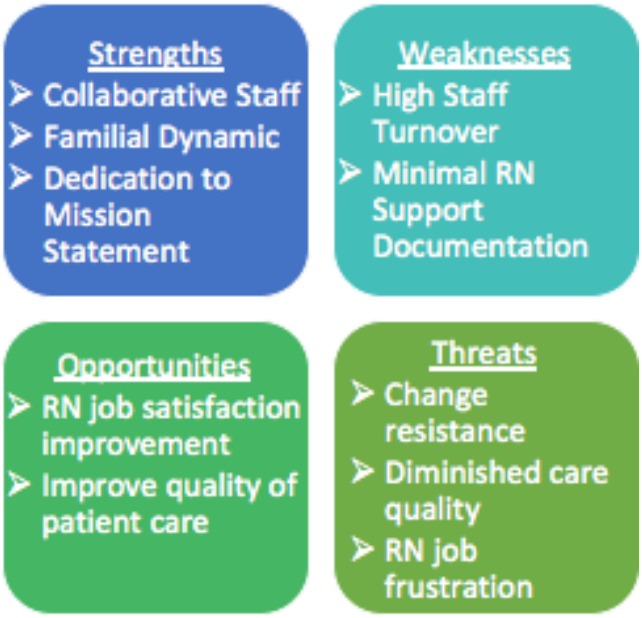


PDSA Cycle – Appendix H

Fishbone Diagram – Appendix I



SWOT – Appendix J



Appendix K

Source Evaluation Table

Study	Design	Sample	Outcome/Feasibility	Evidence Rating
Bae, S., Mark, B., & Fried, B. (2010). Impact of nursing unit turnover on patient outcomes in hospitals. *Journal of Nursing Scholarship*, *42*(1), 40-49. doi:10.1111/j.1547-5069.2009.01319	Secondary Data Analysis	268 nursing units	Controlling nursing staff turnover is a major determinant of quality of patient care	Level III B
Baernholdt, Marianne, and Barbara A. Mark. "The Nurse Work Environment, Job Satisfaction and Turnover Rates in Rural and Urban Nursing Units." *Journal of Nursing Management*, vol. 17, no. 8, 2009, pp. 994–1001., doi:10.1111/j.1365-2834.2009.01027.x	Random sample comparison between rural and urban hospitals	194 nursing units	Nursing work environments can be improved through increased educational opportunities	Level II B
Bogaert, P. V., Clarke, S., Vermeyen, K., Meulemans, H., & Heyning, P. V. (2009). Practice environments and their associations with nurse-reported	Qualitative, non-experimental factor analysis of three sub-scales	155 nurses	Positive correlations of nurse job satisfaction with: 1. Nurse-physician interaction	Level III C (small 'n')

outcomes in Belgian hospitals: Development and preliminary validation of a Dutch adaptation of the Revised Nursing Work Index. *International Journal of Nursing Studies*, *46*(1), 55-65. doi:10.1016/j.ijnurstu.2008.07.009			2. Unit-level nurse management presence 3. Facility-level administration & institutional support frameworks	
Currie, E. J., & Carr Hill, R. A. (2012, September). What are the reasons for high turnover in nursing? A discussion of presumed causal factors and remedies. *International Journal of Nursing Studies,49*(9), 1180-1189. doi:10.1016/j.ijnurstu.2012.01.001	Expert opinion	None	Effective staff retention strategies necessary to maintain adequate nursing workforce	Level IV C (no official organization/agency)
Daouk-Öyry, L., Anouze, A., Otaki, F., Dumit, N. Y., & Osman, I. (2014, January). The JOINT model of nurse absenteeism and turnover: A systematic review. *International*	Quasi-experimental Study	41 out of 7619 potential articles	Job, Organization, Individual, National and inTerpersonal (**JOINT**) is valid for analyzing multilevel relationships and as an overview tool	Level II B

Journal of Nursing Studies, *51*(1), 93-110. doi:10.1016/j.ijnurstu.2013.06.018			for nurse attendance.	
Doran, Diane, et al. "A Descriptive Study of Employment Patterns and Work Environment Outcomes of Specialist Nurses in Canada." *Clinical Nurse Specialist: The Journal for Advanced Nursing Practice*, vol. 28, no. 2, 2014, pp. 105–114., doi:10.1097/NUR.0000000000000031.	Longitudinal analysis	359 nurses	Advance practice nurses including CNSs displayed higher likelihood to exit clinical practice than staff nurses.	Level I B
Estryn-Behar, M., I. J. M. Van Der Heijden, B., Fry, C., & Hasselhorn, H. (2010, May/June). Longitudinal Analysis of Personal and Work-Related Factors Associated With Turnover Among Nurses. *Nursing Research*, 59(3), 166-177. doi:10.1097/nnr.0b013e3181dbb29f	Longitudinal Study	34,587 nurses	Preventive measures including workforce development crucial for nursing staff retention	Level I A
Estryn-Béhar, M., I. J. M. Van Der Heijden,	Randomized control trial	28,561 nurses	Three factors identified to aid in	Level 1 A

B., Ogińska, H., Camerino, D., Nézet, O. L., Conway, P. M., . . . Hasselhorn, H. (2007). The impact of social work environment, teamwork characteristics, burnout, and personal factors upon intent to leave among European nurses. *Medical Care,45*(10), 939-950. doi:10.1097/mlr.0b013e31806728d8			retention of nursing staff at all levels of preparation: 1. Increase individual nurse's expertise 2. Collaborative & interdisciplinary teamwork 3. Team training	
Gess, Ericka, et al. "An Evidence-Based Protocol for Nurse Retention." *JONA: The Journal of Nursing Administration*, vol. 38, no. 10, 2008, pp. 441–447., doi:10.1097/01.nna.0000338152.17977.ca.	Qualitative case report reviews	None given	Encourages autonomy in practice, as well as incentives and recognition to retain nursing staff	Level V B
O'Brien-Pallas, L., Murphy, G. T., Shamian, J., Li, X., & Hayes, L. J. (2010). Impact and determinants of nurse turnover: A pan-Canadian study. *Journal of Nursing*	Quasi-experimental	8,325 nurses	Increased nursing staff turnover correlated with decreased job satisfaction and higher incidence of sentinel events.	Level II B

Management, *18*(8), 1073-1086. doi:10.1111/j.1365-2834.2010.01167				