BC Healthy Connections Project
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BCHCP Process Evaluation Communiqué #12 | March 31, 2017

Nurse-Family Partnership Supervisor and Public Health Nurse Interviews: Part 2 - Factors Contributing to Attrition

One objective of the BCHCP process evaluation is to explore contributing factors, existing strategies and recommendations to increase nurse (including supervisors) retention in the Nurse-Family Partnership (NFP) program. Information about perceived successes and challenges of delivering NFP, insight into decisions to leave the program, and staff recommendations for retention of future NFP PHNs were explored. Findings have been summarized into three communiques based on the following main themes: 1) Factors contributing to nurse retention; 2) Factors contributing to nurse attrition; and 3) Recommendations to increase retention. Findings summarized in these three Communiqué are derived from interviews with 11 NFP Supervisors and 28 NFP PHNs (n=39). Of these 39 participants, 22 had left their NFP role; the remaining 17 were still employed in NFP.

This Communiqué focuses on factors that contribute to supervisor and PHN attrition in the NFP program.
Note: Since the data was collected prior to open NFP enrolment, some identified issues may have been resolved.

Theme	BCHCP PE Supervisor and PHN Perspectives
1. Supervisor/PHN related factors	• Individuals chose to leave the program for both addressable and non-addressable (e.g. moving, retirement, restructuring of NFP program) reasons. In some situations, multiple factors over time contributed to final decision to leave NFP. **Personal factors:** • For some PHNs the decision to leave the NFP program was primarily influenced by non-program related factors such as: employee moved away from Health Authority and sought employment in another geographic area, need to secure employment closer to place of residence to allow employee flexibility to meet both work and family demands, or early retirement. For a small number of NFP staff, the personal decision to leave was related to either opportunities for career growth in an alternate public health program or a personal need to decrease stress related to delivery of NFP (described more below). **Compassion fatigue/vicarious trauma/burnout:** • For some PHNs, the experience of compassion fatigue and vicarious trauma was related to working within a long-term therapeutic relationship with women experiencing multiple and chronic health and social issues. For some, the nature of this work was identified as challenging and was a factor in seeking an alternate public health assignment. • Observing the complex lives of many NFP clients, as well as witnessing clients' levels of vulnerability and marginalization within society, including structural barriers to accessing supports and services, was mentally exhausting and emotionally challenging for some PHNs. Some felt the work left little time for self-care and their family. • For some PHNs, exhaustion and fatigue was experienced related to regularly managing cancelled visits, "no shows" or clients who "disappear" from the program without explanation.

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	Maintaining professional boundaries with clients: • While the long-term therapeutic relationship with clients was generally highly valued, some PHNs experienced challenges in establishing and maintaining therapeutic boundaries with clients. For example, many PHNs receive text messages (often related to client safety) from clients outside of business hours yet feel compelled to respond in a timely fashion. **Interpersonal Relationships:** • Across a small number of participant interviews, it was also noted that the development of some negative interpersonal relationships, either between nurses and supervisors; or between nurses on the teams became a challenge, limiting a desire to continue with the program.
" I think nurses would potentially not stay in the[NFP] role because of that stress. Like the amount of stories that you hear and things that you witness takes its toll in trying to cope and stay positive. And very few other nursing positions relate to working with a particular client for such an extended period of time. And so that's hard on one aspect because you just … you know, you know you're kind of in it for a chunk of time." – NFP PHN	
Theme	**BCHCP PE Supervisor and PHN Perspectives**
2. NFP program related factors	**NFP service requirements:** • For some PHNs, the decision to leave was related to: education and training that required travel and time away from home and family and the perceived lack of sensitivity among senior NFP leaders to this issue; or limited capacity of program to offer sustainable education and training via distance technologies. **Caseload management:** • For some PHNs, challenges arose related to: securing caseload coverage while on leave/vacation for those working in single NFP PHN offices, managing referral source frustration when new clients could not be taken on (due to close to or full caseloads) and a lack of internal strategies to develop a NFP waitlist management process. For some NFP PHNs, caseload numbers were lower in NFP to what was anticipated (in part explained by the BCHCP RCT eligibility criteria and recruitment challenges) compared to general PHN home visiting programs. NFP PHNs expressed that this unintentionally creates internal tension between different home visiting programs, with NFP PHNs feeling pressure to take on generalist PHN work. • Additionally, some PHNs perceived that time spent at their desks, preparing for a visit or documentation, was negatively perceived by other non-NFP colleagues and ultimately contributed to the development of a toxic work environment.
"If you don't have a full load and other people know that a full load for a full-time NFP which is 20, should be 20, which at this point we're talking to now I can't imagine that ever would be feasible, but you, you want to maybe then work on that in building those skills even though that you have other people that are looking and seeing, oh you only have two clients, like what are you doing with your time and here we are over here in public health doing all of these 10 babies or 20 babies…that's 10 babies in a day and you're just chipping away with these two clients. There's that pressure as well."- NFP PHN	
Theme	**BCHCP PE Supervisor and PHN Perspectives**
3. **Client Related Factors**	• **Client engagement:** Some NFP PHNs expressed that "getting your foot in the door" with some clients, being able to consistently physically and emotionally engage with the client, and deliver the program content was often difficult. In particular, building trust, cancelled visits, "no shows" or working with clients who did not regularly respond to PHN communication were situations specifically mentioned. • **Communication with clients:** Many NFP clients experience a lack of stable housing and thus can be a highly mobile population. Most clients have cellphones but due to limited financial resources, have limited or no data plans and are limited to text messaging only. These two situations make it difficult for PHNs to regularly communicate with their clients

	and at times, to maintain the home visiting relationship. • **Client attrition:** For some NFP PHNs, having the PHN-client relationship end prematurely by the client was challenging, particularly when PHNs did not have an ability to say goodbye to their clients. It was difficult for some nurses to not internalize blame for the client leaving the program and it was difficult for them to frame the client's decision to leave as the woman's choice. • **Complexity and level of vulnerability of clients:** For some PHNs, supporting complex and high acuity vulnerable clients through multiple crises, and witnessing clients making slow progress towards their goals was at times challenging
"It's a very … it could be very rewarding work and to be able to develop a long-term relationship with these clients and support them in making the changes that they're making in their lives. And that it's really rewarding to be able to help them to break a cycle that's happened in their life where they come from abusive or drugs and substances in that being able to for them to make change and not be like past generations. Yeah, just really great learning through the … with all the support you have from the NFP team. But at the same time it's also very challenging and hard to be able to watch a client make some changes and then they take it one step forward and like ten steps backwards." – NFP PHN	
4. Environmental/ Contextual factors	**Geography related factors:** • **High amount of driving/travel time:** Both NFP supervisors and PHNs found the high amount of driving / travel time in Health Authorities with larger geographic areas to cover was challenging as this was time spent away from home and family. In particular, joint home visits for supervisors often required several consecutive days away multiple times per year. Burnout among PHNs was also influenced by geography, as some PHNs were required to undertake large amounts of driving over broad geographic areas to visit clients as well as commuting time to home offices for documentation. In addition, for some PHNs, travel across different districts (which could occur in either rural or urban areas) decreased opportunities to engage on a regular basis with their team as they were largely working outside of their health units. This led to increased feelings of isolation for some PHNs leaving the program. • **Isolation of PHNs in single PHN offices:** Some NFP PHNs felt frustration over being the only NFP PHN within their public health unit. Isolation was mentioned as a challenge in terms of not only being geographically isolated from one's NFP team and colleagues, but also the nature of the program itself requires time outside of the office visiting clients- thus further isolating the NFP PHN from other staff members physically located in the same office. • NFP PHNs expressed that their positions require clinical and program support from colleagues to fully understand how NFP tools are used in practice (example, Partners in Parenting Education- PIPE). In addition, due to the requirements of the Randomized Controlled Trial and the proprietary nature of NFP material, NFP PHNs were not able to share NFP materials with their colleagues and felt thus prohibited and limited in sharing their new knowledge, tools, or expertise with other non-NFP colleagues. This along with the additional NFP education received created a sense of secrecy and perceived elitism which contributed to environments within some agencies where NFP PHNs faced additional feelings of isolation within their workplace environment. **BCHCP RCT Study related factors:** • Active engagement in supporting the BCHCP RCT, in parallel with delivering a clinical program, was a challenging experience and partially contributed to the decision to leave the program for some participants. Specific frustrations identified were related to: the delay in ethics approval which limited a timely expansion of PHN caseload beyond guiding clients; a perceived lack of communication about study timeline and extension of NFP beyond BCHCP; and the additional workload for supervisors to address study related processes or issues. • Some PHNs were morally and ethically challenged by the inherent nature of a RCT in that they experienced high levels of distress in seeing highly vulnerable women be randomized

	to the control arm of the study, while women they perceived as "less vulnerable" be randomized to receive NFP. Many PHNs expressed dissatisfaction with the RCT eligibility criteria – identifying that in practice there were many other women who they could have referred who met general program criteria – but who did not meet all study criteria.
"I was also just, just feeling like I was done with the role, feeling burned out on it. Not being able to just … expected to do a lot of driving and not being supported with having different worksites and just feeling unable to properly get my charting done and properly have time to prep for the visits. So it's hard to have like job satisfaction." – NFP PHN	
5. Organizational Factors	**Caseload management:** • **Single PHN offices problematic:** Some NFP PHNs expressed frustration as well as an ethical and moral dilemma over having full caseloads in single NFP PHN offices where no waitlist could exist and there was no other NFP PHN to take on additional referrals or share the caseload. • **Dual role (NFP/generalist PHN) largely problematic:** Attempts to schedule work related to different roles on distinct days was attempted but rarely realized. NFP PHNs will small caseloads often then asked to assume more generalist PHN work, which became challenging when caseloads began to increase. Working within a dual role, limited NFP PHNs capacity to be flexible in scheduling home visits to reflect client needs and priorities. • **Low caseload:** During the BCHCP RCT, some PHNs maintained caseloads with < 20 clients. In some offices, PHNs identified that this created a situation where they were "fighting over clients" to be assigned to them. Some PHNs felt pressured, when caseloads were low, to take on additional generalist PHN work. **Recruitment and Hiring of NFP Staff:** • **Not hiring a "good fit" for the program:** Some supervisors expressed that it is important to have criteria to ensure that PHNs hired into the role are a "good fit" for the NFP program. Concerns were also brought forward regarding hiring supervisors and PHNs based on seniority rather than on relevant experience and being a "good fit" for the positions. • **Performance management concerns:** When there were performance management challenges they were difficult to navigate due to the existing management structure in most Health Authorities where NFP supervisors oversee NFP work but PHNs operationally report to operational supervisors onsite at their locations. • **Supervisory position reclassification**: An additional challenge brought forward by some NFP supervisors in their roles was job classification related, whereby supervisors are classified as CH2 rather than CH3 while all other supervisors provincially have CH3 classification. Therefore NFP supervisors are not included in leadership meetings as CH2s where all other supervisors are. As well, rather than reporting to one manager they need to report to several. • **NFP Role within generalist PHN work environment:** Integration of NFP, as a discrete public health program, into existing public health programming has been a challenge within some offices. In a small number of locations, nurses and supervisors described working in a "toxic" environment as colleagues perceived that the NFP program removed financial and human resources from other programs. The unintended consequence in some areas has been the creation of an "us and them" work environment where some NFP PHNs are unable to harmoniously work with their generalist PHN colleagues. Low NFP caseload numbers have further contributed to this situation, as criticism has come from the client caseload of NFP PHNs compared to their generalist PHN colleagues. **Senior leadership support for program:** • **Perceived lack of organizational acknowledgement or support for work:** For some PHNs, the perceived lack of organizational acknowledgement or support for the nature of the complex work associated with the NFP program created an environment that was no longer tenable to work within. High turnover in senior leadership that occurred in some Health Authorities resulted in what some supervisors perceived to be a lack of new

leadership support for NFP. This contradicted their earlier experiences, where at the onset of BCHCP many health authorities had senior leaders who were NFP "champions" and strongly advocated for adoption and integration of this program.

- **Health Authority restructuring:** In some Health Authorities, the re-structuring of services increased staff perceptions that NFP would not be offered or only in a reduced capacity. To protect their job security or to have some control over their job assignments, some NFP PHNs and Supervisors left the program as other opportunities arose. In other Health Authorities, as part of Health Authority restructuring some NFP PHNs and Supervisors were also asked to leave their roles and reassigned to generalist PHN duties.
- **Planning for future of program:** A lack of awareness or communication about the lack of long term planning for the NFP program was also brought forward as a challenge by both NFP supervisors and PHNs. With no communication regarding the direction of the future of the program, this created an environment of uncertainty around job security which was said to be stressful for some. This led to some PHNs questioning their job security and to begin to plan a future outside of NFP. The lack of transparency and communication from within some health authorities – from senior management to the front-line staff – about future NFP planning was disconcerting for some nurses and contributed to them looking for alternate public health opportunities.
- **Reduced flexibility regarding alternative work locations:** One of the factors, cited by both PHNs and supervisors, was a lack of, or increasingly reduced, flexibility within some Health Authorities to make decisions about strategic locations to work from on an occasional basis – decisions that would allow for reductions in driving and commuting time.

"Unfortunately one of the biggest challenges in the location that I'm in is the other public health nurses. It has taken a very long time to build a relationship there because it's an us and them behaviour, in particular in this health unit, and so it was you know always having that fight and that battle against we took positions from them and so you know it was really hard, we could never work together. And so that was definitely a day-to-day challenge here… And it's just little petty things, right? Like they'd go out for team lunches and kind of walk right by and leave NFP in the pod, or go for coffee, and it's very "cliquey". So that's just minor kind of playground stuff it seems like but it definitely involves the entire health unit when you're not feeling like you're part of the team." – NFP PHN

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