Avoiding the Critical Care Nursing Brain Drain

By Cindy L. Munro, RN, PhD, ANP, and Richard H. Savel, MD

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eeping highly educated nurses closely involved in direct care at the bedside is imperative for delivering optimal patient outcomes, and is especially important in acute and critical care environments.

Higher educational levels of intensive care unit (ICU) clinical staff nurses not only are associated with better outcomes for critically ill patients and their families, but are vital to sustaining nursing’s contributions to highly functional interdisciplinary teams. Enhancing educational preparation of clinical staff nurses is also essential for moving research forward.

It is clear that technical skill is absolutely necessary, but not sufficient, for nursing practice. In the evolving health care system, nurses must embrace their roles as knowledge workers in order to fully enact their clinical role.

The 2011 Institute of Medicine (IOM) report, The Future of Nursing: Leading Change, Advancing Health, articulates a truth of which critical care providers are well aware: “Care within the hospital continues to grow more complex, with nurses having to make critical decisions associated with care for sicker, frailer patients and having to use more sophisticated, life-saving technology coupled with information management systems that require skills in analysis and synthesis.” Higher educational preparation for nurses is a key to improving patient outcomes and underpins nursing autonomy in health care. This is particularly true in critical care, where information processing and rapid decision making often make the difference between the best outcome for a patient or failure to rescue from avoidable catastrophe.

Two of the key educational recommendations of the IOM report are goals for 2020: (1) to increase the proportion of nurses with a baccalaureate degree to 80% (from the current 50%), and (2) to double the number of nurses with a doctorate (from the current 1%). Unfortunately, the previous pattern in nursing has been that increased educational preparation also increased the nurse’s distance from direct patient care. The baccalaureate degree was too frequently seen as a means to escape the bedside in favor of other roles such as management or clinical education. Instead of being viewed as a way to improve one’s clinical practice at the bedside, a baccalaureate was a ticket to somewhere else.

Attainment of master’s and doctoral degrees tended to lead nurses away from the bedside as well. Expanded scope of practice for advanced practice nurses (APNs) is essential for meeting the many needs of critically ill patients, and is required for the
Critical care nurses must respect and value the contributions of both clinical staff nursing and advanced practice nursing.

About the Authors
Cindy L. Munro is coeditor in chief of the American Journal of Critical Care. She is associate dean for research and innovation at the University of South Florida, College of Nursing, Tampa, Florida. Richard H. Savel is coeditor in chief of the American Journal of Critical Care. He is director, surgical critical care at Maimonides Medical Center and an associate professor of clinical medicine and neurology at the Albert Einstein College of Medicine, both in New York City.

health care system to make the best use of graduate nursing education and expertise. However, health care institutions often align APNs organizationally with medical providers, distancing them from clinical nursing. This may result in APNs being viewed as valuable primarily for their ability to generate revenue for medical services rather than for their advanced nursing expertise. When the nursing aspects of the APN role are undervalued, there is a clear message to clinical staff nurses that nursing skills are not important.

Recognize the Contributions of Nurses
In part, the forces that move nurses away from direct patient care in critical care settings are related to inadequate recognition for the contributions of nurses. Technical competence is highly valued—as it should be. But technical competence is not the only contribution registered nurses (RNs) bring to patient care. Critical thinking, decision making, and communication are what make a difference in patient outcomes, and these abilities are enhanced by additional education.

Douglas and colleagues conducted an interesting behavioral task analysis of adult and pediatric nurses to describe nursing work in the ICU. About half of the nurses’ time was spent on direct patient care, including 17% on physical care, 20% interacting with monitors and devices, and 20% on nursing documentation. Care coordination (defined as conversations with physicians, nurses, other ICU staff, and family members) accounted for another 22% of time spent. Nurses’ work was dynamic, with an average of 125 activities per hour, and a switch between tasks every 29 seconds. The study focused on observable tasks, and thus did not seek to directly document time spent in cognitive activities such as planning. Even when defined as a series of observable tasks, technical aspects of physical care did not dominate the nurses’ time; communication and care coordination did.

There should be recognition and reward for applying the knowledge gained thorough baccalaureate degrees and graduate education to direct patient care. Educational advancement should not require pulling away from direct care or moving to a different role with less patient contact.

Educational achievements, and the enhanced abilities that accompany those achievements, should be recognized. Monetary compensation should follow advanced educational preparation. Clinical ladder programs are important, but they need to be improved to provide meaningful recognition for enriching the caliber of work done at the bedside, rather than preferentially rewarding the expansion of nonclinical duties. Such improvement may require ICU nursing care to be accounted for differently in health care organizations; bundling nursing care as part of “room and board” charges does not facilitate recognition of nursing excellence.

The need for better communication and intraprofessional collaboration among staff nurses, advanced practice nurses, nurse educators, and nurse researchers is critical. For true collaboration among nurses to occur, critical care nurses must respect and value the contributions of both clinical staff nursing and advanced practice nursing. Nurses should be expected to maintain connection with clinical nursing practice throughout their careers, even as they become advanced practice nurses, educators, or nurse researchers.

Appreciate and Respect Staff Nurses
Advanced practice nurses must not divorce themselves from understanding, supporting, and enabling clinical nursing practice. In the excellent report of a Critical Care Medicine Advanced Practice Provider Model published in this issue of AJCC, Paton and colleagues note that tensions exist between nurse practitioners and staff nurses in critical care. Clinical staff nurses express concerns about APNs’ appreciation of and respect for clinical staff nursing. APNs can and should serve as important champions of clinical staff nurses. Papanathanassoglou states, “Acute care nurse practitioners (ACNP) are not a different genre of nurses. They are nurses who because of experience and specialized education have increased accountability for patient outcomes, thus being able to allow room for staff nurses to exercise judgment, share concerns and participate in clinical decision making.”

Nurses in academia must continue to be connected to patient care in order to teach and conduct research. As a practice discipline, nursing cannot afford “ivory towers.” A mutually respectful, synergistic
relationship between clinical staff nurses and nurse researchers is essential to building the knowledge base for nursing practice and to translating that knowledge to the bedside. Baccalaureate, master’s, and doctor of nursing practice educational programs provide skills necessary to apply evidence to practice, and doctor of philosophy programs provide skills to conduct original research. The ability of highly educated nurses at the bedside to identify research questions that can be pursued in collaboration with nurse researchers drives innovation and improvement of care at the bedside.

**Lifelong Learning Is Crucial**

To say that more education improves practice does not devalue those who do not yet have a baccalaureate degree.

A third IOM report recommendation for nursing education was that nurses at all educational levels engage in lifelong learning. As an example, Dr Munro entered nursing as a diploma RN, and continues to value the initial preparation and technical competence that has served as a base for her passion for nursing since then. However, she has personally experienced how the expanded knowledge that came with advancing education expanded her ability to deliver nursing care, to understand the nature of clinical problems, and to improve patient outcomes through research.

The IOM recommendation recognizes that there are many exceptional nurses whose practice would be even further enhanced with additional education. It is incumbent on all nurses to seek additional education as part of lifelong learning, and essential for the educational system to develop articulation pathways to provide educational opportunities. Further, support for opportunities for personal growth, development, and advancement is one of the American Association of Critical-Care Nurses’ Healthy Work Environment indicators.

For higher educational preparation to improve patient outcomes in acute and critical care, nurses prepared at the baccalaureate level and beyond must be able and willing to practice to the full extent of their education and training to provide clinical care in the ICU. We can no longer afford a nursing “brain drain” away from direct patient care. Baccalaureate preparation for clinical staff nurses must be seen by all—nurses at all educational levels, their employers, and their clinical colleagues—as more than a stepping stone to advanced practice and more than a means to move away from direct clinical care of critically ill patients. The future of critical care depends on keeping technically competent and highly educated nurses engaged at the bedside.

The statements and opinions contained in this editorial are solely those of the coeditors.

**FINANCIAL DISCLOSURES**

None reported.

**eLetters**

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**REFERENCES**


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