INACTIVE REGISTERED NURSES RETURNING TO PRACTICE:
BARRIERS AND SUCCESSES

by

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DEDICATION

This is dedicated to God first for reminding me that he has a plan for me and my job is to follow by faith.

To my husband Alan, for his unfailing love and support through these last few years of my dissertation journey. To my children; my son Benjamin for supporting me by being proud of my achievements, my daughter Sarah for her passionate prayers and positive thoughts that helped see me through many moments of fatigue and doubt, and my daughter Rachel for her humor and love that assured me "you can do it mom" no matter what time of the day it was. To my parents, Ralph and Hattie Shanks, who have loved me and prayed for me every day of my life.

ACKNOWLEDGEMENTS

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ABSTRACT

INACTIVE REGISTERED NURSES RETURNING TO PRACTICE: BARRIERS AND SUCCESSES

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George Mason University, 2011

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This qualitative study describes the experiences of inactive registered nurses in their journey returning to nursing practice and the perceived and unexpected barriers and successes they met and overcame on their way. This study focused on the meaning of the situation and experiences of inactive registered nurses returning to practice. The qualitative research design of Dr. Joseph Maxwell was used as the model. Seventeen face-to-face interviews were conducted in March 2010. The purposive sample was of inactive registered nurses who had been inactive for at least five years and had completed a refresher course between 2007 and 2008 at either a community college or university in the metropolitan area of Washington, DC.

In analyzing the context and process of how and why nurses return to practice, seven categories were revealed: the reasons to return, factors that inhibit returning, barriers of a refresher course, rewards of completing a refresher course, roadblocks of employment, rewards of returning to practice, and advice for all registered nurses.

This qualitative study has the potential to pay tribute all nurses who practice the art of nursing by taking time to understand the meaning of the experience. This study provides a voice for the experiences of previously inactive registered nurses and reveals their barriers and successes in returning to practice.

CHAPTER 1. INTRODUCTION TO THE PROBLEM

In 2008, an estimated 466,564 (15.2%) of the 3,063,162 nurses in the United

States were not currently employed in nursing (U.S. Department of Health and Human

Services [DHHS], 2010). Prior to 1994, when there were nursing shortages, inactive

licensed registered nurses (RNs) were used to help relieve those shortages (Cooper, 1967;

Shore, 1990). In the 1940s, people recognized that the process of recruiting inactive

nurses also required updating their skill set so they could return to work. Hospitals

developed mentoring programs and refresher courses to bring these nurses back to active

practice so that they could decrease their nursing vacancies (Cooper, 1967). Inactive

RNs are educated, experienced, and licensed and are an available resource that has not

been adequately tapped to assist in decreasing the nursing shortage (Langan, Tadych, &

Kao, 2007; Williams et al., 2006).

Renewing and updating inactive registered nurses takes less time and substantially

less cost to accomplish than educating new nurses. Educating novice nurses takes 2 to 4

years at an estimated cost for tuition ranging from $6,000 (2008) to $8,483.55 (2011) for

a 2-year associate's nursing degree (Northern Virginia Community College, "RN Return

to Practice Course," n.d., "Tuition and Fees," n.d.), to $150,144 (2008) to 159,072 (2011)

for a 4-year bachelor's of science in nursing degree (Georgetown University, 2011). In

contrast, refresher courses average from 40 to 150 hours for a theory course, and may

require 60 to 160 hours of additional clinical time (George Mason University [GMU], 2009; Oregon State Board of Nursing, n.d.). In 2008, the cost for the refresher program at GMU was $1000; in 2011, the cost has increased to $1350—equal to the cost of a three-credit master level course. Refresher courses vary in cost from $650 for a theory-only course (Consolidated Learning Systems, 2008) to $2,599 for an online course (University of Oklahoma College of Nursing, n.d.). Many states only require continuing education to reactivate an inactive RN license, while others require a refresher course composed of both theory and clinical instruction. Refresher courses can be completed in several different formats: A traditional classroom format, with an accompanying clinical practicum, is still available. Also available are self-study formats such as correspondence courses, or online programs with precepted clinical practicums. Courses are offered in a variety of lengths as well, from 8 weeks of classroom and clinical work to up to one year of independent study and precepted clinical practicums.

Inactive registered nurses are an untapped resource of educated and licensed professionals (Williams et al., 2006). Armed with a review of formal concepts related to nursing theory, nursing practice, pharmacology, and an update of skills and current technologies, these nurses could yield qualified, valuable employees who would immediately help to reduce the nursing shortage (Williams et al., 2006). Although inactive registered nurses may be aware of the national nursing shortage, many may not know how to access the path for returning to nursing practice. Current nursing research supports how to help retain nurses and how to make the work environment more

palatable, but few encourage the active recruitment of inactive registered nurses (Buerhaus, Donelan, Ulrich, Norman, & Dittus, 2006; Goodin, 2003).

Nursing researchers have recently begun to study how healthcare facilities can attract inactive registered nurses to return to active practice; however, research results are limited. Currently, few traditional model refresher courses and correspondence courses are available to help reactivate inactive nurses (Gottlieb, 2002; Hammer, 2005; Huggins, 2005). Goodin (2003) suggests that inactive nurses who return to practice are an important resource. Inactive nurses have many assets such as life experience and maturity, while they may lack current nursing knowledge and skills. Asselin, Osterman, and Cullen (2006) completed a study based on the nursing shortage and the need for hospitals to envision innovative ways to attract registered nurses back to practice. They studied five nurses who completed a reentry program and their experiences of returning to practice in the acute care setting. Asselin et al. validates the importance and successes of these nurses and shares the need for support within the practice area. Successful reentry was related through their experiences as employees in the acute care setting, and how their nursing experiences and skills are assets in patient care delivery.

A limited number of the more creative methods are available, such as online self-paced refresher courses and nurse update courses for inactive registered nurses (Hammer, 2005; Hawley & Foley, 2004; Langan et al., 2007; Roberts, Brannan, & White, 2005; Williams et al., 2006). A study by McIntosh, Palumbo, and Rambur (2006) of all nurses with inactive or lapsed licenses in the state of Vermont was conducted to determine whether there was a shadow workforce of inactive nurses. Survey results showed that

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only 15% of the respondents cited any interest in reentry to practice. A study by Skillman, Palazzo, Hart and Keepnews (2010) of registered nurses whose licensees expired between 2002 and 2003 was conducted in Washington State to determine reasons for leaving nursing, attitudes toward the profession, and any reasons for which they might consider returning to the profession. Survey results showed that 13% of the registered nurses surveyed could potentially return to nursing practice in Washington state.

Significance

The profession of nursing has educated nursing students on how to become a nurse and how to gain entry into practice; however, no clear provision has been established to assist inactive nurses to return to practice. As previously stated, there is a nursing shortage, which is projected to continue through 2020, and more solutions need to be instituted to adequately address the problem (Health Resources and Services Administration [HRSA], 2002). Inactive nurses are not specifically addressed as a solution to decreasing the shortage and are rarely mentioned a few times in the paucity of research literature that exists about the nursing shortage (Langan et al., 2007). Additional information about how to access the inactive nurses, what requirements are needed to achieve active status, and what barriers are faced when returning is imperative to assist in decreasing the current shortage (Buerhaus et al., 2006).

Inactive nurses are an untapped resource for the nursing workforce (Langan et al., 2007). Unfortunately, they are not easy to locate or recruit. There is no national effort to actively search for inactive nurses, nor is there a national database from which to retrieve them. A comprehensive search of the Cumulative Index to Nursing and Allied Health

Literature (CINAHL), Medline, and Dissertation Abstracts databases and an informal survey of state boards of nursing reveal a lack of national or regional databases. McIntosh et al. (2006) reported difficulty attempting to contact inactive registered nurses in Massachusetts because not all inactive RNs reside in their state of licensure.

If an inactive nurse chooses to return to practice, he or she must seek the counsel of the state board of nursing (SBN) for reactivation requirements. Unfortunately, each SBN is different with unique requirements for license reactivation, and navigating the SBN websites can be difficult. Most of the SBNs have no guidelines referencing where and how an inactive nurse can update theory and practice education (for examples, see http://www.bon.state.tx.us, http://www.dhp.virginia.gov/nursing, and http://www.op.nysed.gov). Many inactive registered nurses seek avenues to renew and update their nursing skills before they return to practice (Asselin et al., 2006). Many healthcare facilities have not solicited inactive registered nurses, nor have they investigated how to assist them to return to practice.

In the review of the literature, little research was found that describes the experiences of inactive registered nurses. It is imperative that inactive registered nurses share their experiences on the journey to returning to practice. Their voices need to be heard and their stories told. What was learned from this research could make a huge contribution to removing barriers, designing appropriate recruitment strategies for returning inactive RNs, improving communication and policies, providing better on-the-job transition experiences, and most importantly resurrecting inactive RNs to decrease the nursing shortage.

Quantitative studies cannot describe the experience of these nurses. This qualitative study explored the barriers and successes perceived and experienced by inactive registered nurses when returning to active practice. It also provides information that could be implemented to increase the number of returning nurses by providing a seamless transition for inactive registered nurses.

Purpose

This study explored the experiences of inactive registered nurses and their perceived barriers and successes in returning to nursing practice.

Research Questions

The following three research questions guided this study.

1. What are the experiences of inactive registered nurses returning to nursing practice?

2. What are the barriers to returning to practice that inactive registered nurses experience?

3. How do these nurses overcome the barriers encountered and experienced in returning to practice?

Definition of Terms

In this study the following terms are defined as follows.

Licensed registered professional nurse (RN): a person who has passed the registered nurse licensure exam and is currently registered and licensed by a state board of nursing or other legally empowered body to practice professional nursing within a given state.

Inactive registered nurse: a licensed registered professional nurse presently not employed in nursing.

Nursing review and update course: a continuing education course 8 weeks to 1 year in length, offered to licensed inactive RNs for the purpose of reviewing basic medical-surgical theory and updating clinical skills. Some of these courses require 64 to 160 clinical hours.

Research Design Approach

Current nursing literature has been dominated by descriptive studies that focus on the effectiveness of refresher courses available to inactive nurses (Hawley & Foley, 2004; Huggins, 2005; Langan et al., 2007). 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 experience for the nurse returning to practice.

I selected the qualitative research design of Maxwell (2005) as the model for this study. His model provides an interactive approach to research that encouraged exploring individuals' experiences. Maxwell's interactive design approach provided a framework to discover what it is like to have experienced the return to nursing and allowed the inactive nurses to share their experiences. This model allowed the researcher to explore and discover the experiences, barriers, and successes of inactive nurses on their journey to return to practice.

Maxwell states that "the design is the logic and coherence of your research study—the components of your research and the ways in which these relate to one

another" (p. xii). He presents a model of design with five components that should work harmoniously together. The interconnectedness and flexible structure of his model guided this study in addressing the inactive registered nurses' experiences and meanings of those experiences. Each of the five interconnected parts of Maxwell's model for qualitative design asks a specific question:

1. Goals: Why are you doing the study?

2. Conceptual framework: What do you think is going on?

3. Research questions: What do you want to understand?

4. Methods: What will you actually do?

5. Validity: How might you be wrong? (p. 4)

Each of the questions has guidelines to assist the researcher in the design and application of qualitative research. The first component, goals, is also called purposes by other researchers and is divided into personal, practical, and intellectual goals (Maxwell, 2005).

Maxwell (2005) suggests five intellectual goals can be addressed with a qualitative study:

1. Understanding the *meaning* for participants of the situations and experiences they are involved in.

2. Understanding the particular *context* the participants are in.

3. Identifying *unanticipated* phenomena and influences.

4. Understanding the *process* by which events and actions take place.

5. Developing *causal explanations*. (pp. 22-23)

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This study focused on the meaning of the situation and experiences of inactive registered nurses returning to practice. Through understanding the context and process of how and why nurses return to practice, there can be clarity and insight into barriers and successes encountered. One has to understand the art and science of nursing to understand the *meaning* of the experience.

The second component of Maxwell's model, conceptual framework, is presented as the concepts, assumptions, expectations, beliefs, and theories that support and inform the research. He states it is the actual ideas and beliefs that are held about the phenomena studied, whether written or not. I chose to write the beliefs down throughout the first chapter and included them in Chapter 2, along with the use of the theoretical framework by acclaimed psychologist Kurt Lewin and this researcher's perspective (Maxwell, 2005).

The third component, research questions, is found in Chapter 1 with the background of the problem leading up to the use of process theory. According to Maxwell (2005) process theory asks questions about the meaning of events and activities to the people involved in them, questions about the process by which these events, activities, and outcomes occurred. The fourth component, methods, has four subcomponents, explained in detail in Chapter 3. The final component, validity, is also discussed thoroughly in Chapter 3.

CHAPTER 2. CONCEPTUAL FRAMEWORK

Chapter 1 provided an overview of the research study, the purpose, the research questions, and the significance of this study. This chapter describes the results of a review of existing literature in order to show why this study is important and to determine if the phenomena had been previously addressed. The following review provides a cursory look at the current shortage of registered nurses (RNs) in the United States (U.S.), a theoretical framework, barriers and successes of inactive nurses, refresher courses, roles inactive nurses today have played, and the researcher's perspective. Interactively, it provides a conceptual framework for the study. After data were collected the findings are discussed within the context of what is known about inactive nurses and the barriers and success they experienced in returning to practice.

The worldwide nursing shortage continues to be a problem (Buerhaus, Donelan, Urlich, DesRoches, & Dittus, 2007). Many studies have been conducted in an effort to identify possible solutions. This shortage not only affects patients in hospitals but all other areas in which nurses practice, including doctors' offices, clinics, long-term care, and home healthcare agencies. Buerhaus et al. (2007) reported that there is no one solution to the current shortage, but offered seven strategies and actions to strengthen the nursing workforce that will enable those concerned with healthcare to make changes to

help lessen the nursing shortage. They suggest that there is a continued need to identify more potential solutions to decrease the shortage and its effects on healthcare.

In the midst of creative strategies to recruit nurses, the option of recruiting inactive nurses as a possible solution has begun to be addressed (Langan et al., 2007; Williams et al., 2006). Several studies by Hammer (2005) and McIntosh et al. (2006) focused their evaluations on refresher programs and on the recruitment of inactive nurses as potential volunteers in times of disaster. Skillman et al. (2010) also studied the expired licenses of nurses from 2002 to 2003 in Washington State, examining why nurses left practice and seeking the circumstances under which they would consider returning to nursing practice.

Theoretical Framework

The theoretical framework for this study is derived from Kurt Lewin's force field analysis theory (Lewin, 1951). Lewin has been referred to as the father of social psychology (Neill, 2004). Force field analysis theory is often used for organizational changes of groups. Lewin (1951) expressed that it also can be used on a personal, project, or organizational level to help make changes.

Lewin's most fundamental construct was that of the word "field" (1951). He stated that all behavior (including action, thinking, wishing, striving, valuing, achieving) is conceived of as a change of some state of a field in a given time (Lewin, 1951, p. xi). To determine the properties of the present situation, one may look at history, but it is best to "test the present" (p. 49).

Change issues are held in balance by two opposing sets of forces (Lewin, 1951). One side seeks to promote change, which he calls the "driving forces" (p. 173), and the other side seeks to maintain status quo, called the "restraining forces" (p. 173). Lewin's theory explains that in order for any change to occur, the driving forces must exceed the restraining forces, thus breaking the equilibrium (1951). This theory helps support why inactive nurses must have significant driving forces that compel them to return to nursing practice as opposed to remaining inactive. Identifying what these compelling forces (factors) are could provide potential healthcare employers with new solutions for recruitment and retention.

It is understood that nurses enter and leave nursing practice at different times in their professional lives. Previously, inactive nurses seeking employment would find refresher courses as a means of recruitment utilized by many hospitals (Hammer, 2005). Presently, refresher courses are limited, costly, often online, and not easily accessible to nurses who reside in rural communities or lack technological expertise (Table A1, Appendix A). In a difficult economy many female nurses have returned to work to help support their households. Many of my previous refresher students have shared with me the following reasons to return to practice: divorce, increased need for income to pay for children's college tuition, the feeling of loss experienced after children have left home, and the sense of responsibility after hearing reports of the nursing shortage. One or more of these reasons have stimulated them to take a refresher course and return to practice.

Table A1 (Appendix A) gives a brief overview of recent studies that show specific reasons inactive nurses in this current shortage previously left active practice and

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reasons they would consider returning. The same factors that caused them to leave could also be considered barriers to returning to practice.

Factors such as a better work environment than the one they left, adequate salary, a part-time flexible schedule, and the opportunity to participate in a refresher course are the most common reasons cited by inactive nurses for returning to practice (Goodin, 2003; Hammer, 2005; Langan et al., 2007). Healthcare facilities have been addressing the environment in which nurses practice by implementing phases of Magnet recommendations. Developed by the American Nurses Credentialing Center (ANCC), Magnet certification acknowledges healthcare facilities focus on improving the work environment and providing nurses more voice in their practice. Hospitals that have acquired Magnet status are said to have higher nurse satisfaction and a higher recruitment and retention status (Ulrich, Buerhaus, Donelan, Norman, & Dittus, 2007). Flexibility in scheduling may not be addressed by all hospitals, but is well known as self-scheduling initiatives in hospitals with Magnet designation. If a nurse is allowed to have a voice in his or her schedule that allows flexibility to meet personal and family demands, he or she will be more likely to remain employed. This is one factor that has been addressed for active nurses and might also be appealing to inactive nurses.

At present, only two studies have addressed the barriers in relation to inactive nurses returning to practice. Hammer (2005) discovered barriers in relationship to several difficulties in completing the refresher courses. Durand and Randhawa (2002) studied return to practice (RTP) registered nurses and reported that the fear of technology, demanding administrative responsibilities, and inflexible work schedules

were barriers to returning to practice in Britain. Additionally, barriers mentioned in Skillman et al. (2010) of illness or disability, family care needs, or seeing nursing as too stressful or exhausting, were things RNs perceived as unlikely reasons to return to nursing practice. Lastly, Asselin et al. (2006) reported that returning nurses shared experiences of self-doubt and organizational hindrances in the process of returning within the acute care setting. There is a paucity of literature to date that addresses what inactive nurses express, perceive, or experience as barriers in returning to practice.

Due to the many factors affecting nurses' lives, such as time, family, and finances, there have to be strong incentives during this shortage to encourage nurses to return to practice (Hammer, 2005). The need for increased income can be met with higher paying, less stressful jobs than nursing. Lewin's (1939) force field theory is consistent with this notion, since one set of forces has to outweigh the other for change to occur. This is known as simply choosing to return to practice; this is not necessarily what occurs when a nurse, in fact, does return to practice. These are basic factors that affect a nurse's decision to return.

Many barriers must be overcome to make the decision and then make the journey to return (Hammer, 2005). Goodin (2003) suggests that inactive nurses considering returning to practice are an important resource since inactive nurses have many assets such as life experience and maturity, and what they lack may be current nursing knowledge and skills. Lewin's (1939) force field theory lends an explanation for what inactive nurses need to go through to decide to return to practice.

Consistent with force field theory, there must be strong forces to make one return to practice (Lewin, 1951). Historically, inactive RNs most often returned for financial reasons. Current literature, although limited, suggests that inactive nurses today also return for increased financial need, as well as employment needs due to change in marital status and desire to practice again. Hammer (2005) summarized barriers adults faced that she believed could affect nurses' return to practice. Drawing from the writings of Johnstone and Rivera (1965) and Merriam and Caffarella (1990), Hammer concluded external barriers such as program cost and internal barriers such as personal attitudes (that is, a lack of self-confidence) in being able to return to practice lent an explanation to nurses not returning to practice. Current literature does not address the barriers to returning to practice, but does address the need for refresher courses (Hawley & Foley, 2004) and their effectiveness in returning nurses to practice.

Barriers and Successes of Inactive Nurses

This study addresses an area that has not been a research focus during this current nursing shortage. This study asked inactive registered nurses about their experiences, including their barriers and successes in returning to practice. To date, based on extensive search of CINAHL, Medline, and Digital Dissertations databases, no other study has focused solely on these issues. Inactive registered nurses have not collectively been invited to return to practice nor have they been asked specifically about both their barriers and successes experienced in returning to practice.

My study fills a void in the existing literature by exploring individual barriers that inactive nurses experienced and how they affected each nurse returning to practice.

Hammer (2005) completed a qualitative study focusing on the experiences of nine inactive nurses who had completed a nurse refresher program and the meaning the experience had for them. The participants completed either an online version or correspondence form of the refresher program over a 5-year period. Participants were able to express their reasons for taking the course such as financial benefits, children getting older, fulfilling a purpose in life, and the success of being hired. The reported barriers by Hammer (2005) to the program included obtaining clinical experiences and getting questions answered. Hammer suggests that tracking nurses who become inactive but intend to return to practice could be a solution to future nursing shortages. Participation was limited to nine inactive nurses and focused on their specific course and the benefits for them.

Asselin et al. (2006) conducted a descriptive exploratory analysis of the experiences of RNs who chose to return to acute care. This qualitative study of five nurses queried the meaning for them to return to acute care practice and to what extent the practice environment facilitated or hindered their transition back to practice. Three themes emerged: the nurses' perceptions, which were motivation prior to entry; coping during the process of returning; and the impact of the role of the environment upon the facilitation or hindrance to nurse retention. Limitations of this study were its focus on inactive nurses who returned to only acute care practice as well as the small sample size.

Two other studies completed internationally have also addressed the barriers for inactive nurses who hope to return to practice. Durand and Randhawa (2002) completed a qualitative study of 57 participants that addressed the return to practice of inactive

nurses after a career break. These participants were grouped into three categories: those who took a refresher program and found employment, those who took a refresher program and were not employed, and those who did not take a refresher course. The authors reported that most of the participants would be willing to return to practice. The inactive registered nurses also reported that barriers to returning to practice included fear of technology, demanding administrative responsibilities, and inflexible work schedules.

The British government, in an effort to recruit nurses to decrease its nursing shortage, created additional RTP programs. British statutory regulations require that all nurses desiring to return to work who have practiced fewer than 100 working days or 750 hours in the last 5 years are required to take an RTP program. Barriball, Coopamah, Roberts, and Watts (2007) explored the views and experiences of inactive nurses who completed RTP programs in the National Health System Trusts. Seventeen participants completed self-report questionnaires at the end of the programs and participated in focus-group discussions. Three key findings that addressed nurses' needs were reported: personal and professional incentives to return, challenges of individual support, and flexibility for work and family obligations. There were implied barriers in this study that described RTP nurses' anxiety about being able to cope with the changes in the roles and responsibilities of current nursing. Participants also expressed concern about how they would be viewed by their colleagues, and that there was a lack of mentorship for the RTP nurse. Inactive registered nurses who have chosen to return to practice may experience barriers and successes in their journey that, once reported, will enable future inactive

nurses to return to practice successfully and promote support within the healthcare system.

It should be noted that once a nurse decides to return to practice, he or she must seek out what the board of nursing in his or her state requires. Nineteen states require refresher courses; many others require continuing education requirements in theory only (Appendix B); some, such as Maryland, require clinical practicum hours (Maryland Board of Nursing, n.d.). In my observation of past experiences, inactive nurses are aware that they need to keep their technical skills current, and that many advances in healthcare may have occurred since they left the field. If there are fewer refresher courses available and nurses feel inadequate to practice, especially with the widely publicized nursing shortage, they are less likely to face the idea of resuming practice as easily as they did 15 years ago (Williams et al., 2006). Anecdotally, the more critical the shortage, the more responsible the nurses feel to be adequately prepared to make appropriate decisions and care. For these reasons, inactive nurses contemplate returning to practice.

Most of my students reported that they had actively maintained their license, remained caring and compassionate individuals, and wanted to help address the shortage but did not know exactly what to do and where they could best fit into the healthcare system. I was interested in studying the nurses who had chosen to return to practice and had taken a refresher course, to explore what they experienced in their personal journey and decision to return to nursing. Did they face any barriers personally, financially, professionally, or publicly in returning to practice? Their journey is what is not known; what we do know is that returning to practice is a personal and professional decision. It

requires both a personal and time commitment. In many states returning to practice requires a refresher course, which can be costly.

Refresher Courses

After World War II, refresher courses for nurses as a means of returning to practice appeared more frequently in the literature (Fyfe, 1986). Not only hospitals (Cooper, 1967), but institutions of higher learning, became involved in preparing nurses to reenter the workforce (Shore, 1990). One of the most significant solutions for promoting nurses to return to the workforce began in 1965, when the federal government released funding through the Manpower Development Training Act (MDTA) to reactivate registered nurses.

Targeting inactive RNs was a solution used in many past nursing shortages (Fyfe, 1986), and it should not be overlooked in today's shortage (Burns et al., 2006). During nursing shortages in the 1970s, 1980s, and early 1990s, hospitals developed and conducted refresher courses to recruit inactive nurses (Hammer, 2005). In the early 1990s the demand for nurses decreased, refresher courses became less important, and hospitals focused on the demands of reimbursement protocols with mergers and restructuring (Porta & Pearson, 1997). Since the mid-1980s, state boards of nursing also began to change their practice laws and some state boards required refresher courses for nurses who had been inactive for a specified length of time (Fyfe, 1986). In the past, refresher courses have been addressed in the literature as a means of helping inactive registered nurses update their skills. Since there was a reduced need for nurses in the 1980s through 1990s, less energy went into refresher courses for inactive nurses.

The focus of this review concerns inactive registered nurses within the time frame of the current nursing shortage, 1994-2008. A broad search using the key words *refresher courses*, *return/reentry to practice*, and *inactive nurses*, resulted in 614 citations, 51 of which were research studies. The term *inactive nurse* is often found in the body of these articles but is not the primary subject of the articles. This reviewed literature appears to address inactive nurses but it does not. Many of the articles, under the concept *refresher courses*, refer to refreshing skills such as physical therapy, advanced life support, and occupational therapy. A review of references since 1994, focused on inactive registered nurses yielded 38 articles that made reference to inactive nurses. Most of the articles predated 1994, which was before the current shortage. Thirteen of these articles contained research information, eight of which were within the 1994 to 2008 time frame of this study. The content reported in the eight research articles can be divided into two categories. The first category discussed solutions for the nursing shortages. The second category highlighted refresher courses using a variety of delivery methods and their outcomes..

Inactive Nurses

A study by Williams et al. (2006) focused specifically on inactive nurses as a possible source for alleviating the shortage. In one southern state, 428 nurses under the age of 60 were surveyed to see why nurses chose to become inactive and what they would require to return to nursing. More than a quarter of the participants (27%) reported leaving nursing due to parenting duties and work scheduling requirements. They also reported the factors that would entice them to return to work: flexible shifts and

opportunity for part-time employment. Williams et al. (2006) highlighted that employers have an opportunity to reduce the shortage by offering these enticements for inactive nurses. One limitation of this study was that it included data from only one state.

In 2007, Langan et al. completed a pilot study in the state of Missouri in an effort to investigate solutions to decrease the nursing shortage. They reported that there were few strategies focused on inactive RNs and therefore explored what incentives were needed for nurses to return to practice. After a screening survey to verify inactive status, they mailed 52 questionnaires and received a response from 33 subjects. The questionnaires investigated why inactive nurses left practice, the type of work environment and resources necessary to entice them to return to practice, and the specific skill set required to assure a confident and competent return to practice (Langan et al., 2007). One of the reasons nurses reported leaving practice was due to lack of recognition for their work. Several motivating factors to return to work were reported. These included improved working conditions, refresher courses, and part-time job opportunities. Respondents reported that enticements to return included an acceptable hourly wage and competitive benefits package. A limitation of this study was that it was a pilot study with a small sample size.

An additional study was conducted by Langan, Tadych, Kao, and Israel (2009) that electronically advertised a survey in 13 boards of nursing newsletters between July and November 2006 in an effort to discover why nurses left, what would entice them to return to nursing, and what skill review is essential to competent and confident return to nursing practice. There were 127 respondents to the survey and the greatest reason to

leave nursing emerged as the work environment. These respondents identified four key enticing factors for returning to nursing: improvement in working conditions, recognition of one's work, opportunities for professional growth, and consideration of family needs. A limitation of this study was that it was an online survey, and not accessible to nurses unfamiliar with information technology.

Researcher's Perspective

I have a personal stake in this study. I have been a nurse educator for a refresher course for 8 years. I taught more than 200 inactive registered nurses who wanted to return to practice. In 2004, I was asked to teach the clinical practicum of a refresher course for returning inactive nurses. As adjunct faculty, teaching undergraduates and accelerated students in a bachelor's of science in nursing (BSN) program, I thought this would be an easy course to teach; it was short in length, only 8 weeks long. Since many of these nurses had been out of clinical practice for much of the 22 years I had been in, they were full of questions. It was important to emphasize that many things had changed, but patients were still patients and they still required nursing care.

These nurses began to talk more freely and expressed how afraid they were of coming back, and asked for reassurance from me that they could be successful. I believed that with the help of a refresher course, they would be able to practice. I reassured them, since I had worked with many nurses with less experience in the nursing field than they had. The questions they asked made me keenly aware that they wanted to do their best, but felt very incompetent, especially compared to their practice before inactivity. Many remarked that they were doubtful that anyone would even hire them

once they were finished. We agreed that if they would apply themselves, study, and accept the clinical challenges, I would help them succeed and be ready to return to practice at the end of 8 weeks.

The next 8 weeks would not only change their world but mine as well. I came to appreciate and respect them as they explained all of their previous experiences and knowledge. These were nurses who had practiced in intensive care units, critical care units, trauma units, and emergency departments. They had much more experience than I, so I was somewhat intimidated about what to teach. As the 8 weeks passed, I retaught them many of the basic skills needed to practice in the hospital and helped them revive their assessment, critical thinking, time management, and medication administration skills. They were excited and overwhelmed that nursing quickly came back to them. The equipment and technical skills frustrated them the most, but the hospital nurses were warm, welcoming, and encouraged them to pursue nursing again.

As the clinical practicum was ending, these nurses complained that they were not ready yet; they needed more time and did not want their class or their newfound relationships to end. I was so amazed and proud that nurses who had not been actively practicing for up to 18 years were now ready to get a job and work in the hospitals with me. Their skills were rusty, but their assessments of patients' physical, mental, and emotional needs were great. They did not just complete tasks as many of the newer nurses did, but they stopped to talk with the patients and to address pain and comfort issues without being reminded. I discovered they still could practice the art of nursing. They were just unfamiliar with the newer technologies and equipment. I realized how

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much I wanted to be a part of helping more of them come back to nursing. This is the point at which I recognized what value these nurses could have in decreasing the nursing shortage and began investigating this topic.

After assuming the role of teaching the theory portion of the course, I recognized the challenge and privilege to teach these nurses. That is when I began to see the need for this study. What these nurses needed was a coach to encourage them to read, process the material, and apply it to clinical practice, rather than just getting content in a refresher course. During this time, I began to realize that each nurse's reason(s) for returning, and barriers threatening completion of the course, were different. Some had childcare issues, some were newly divorced and still dealing with personal issues, some were financially strapped and did not buy the textbook, assuming that they would not really need it. Others were overwhelmed and unsure that they could complete the course and succeed. Since I was still clinically practicing and acutely aware of the need for nurses, I was frustrated and knew I needed to do something.

I was an RN of 20 years, and had just completed my BSN and MSN in the past 4 years. I was aware that in nursing education there are still many needs. However, I did not recognize that as I taught new students how to be nurses and go out and practice, there was also a great need to teach nurses how to return to nursing practice. My roles paralleled. So where were all of the guidelines to returning to practice? Where were the refresher courses? The inactive returning nurse's value was not acknowledged and minimally addressed in this shortage, leaving me confused about why. Thus, I decided to

study the unanswered question: What are the barriers experienced by inactive nurses in returning to practice?

CHAPTER 3. METHODS

In Chapter 2, the review of the literature demonstrated that little research has been conducted on the barriers inactive nurses experience in returning to practice. Thus limited knowledge and understanding exists as to why these nurses return to practice and what they experience in their journey to return to practice. The goal of this research was to better understand these barriers and how they affected each nurse's return to practice.

Chapter 3 describes the methods used in this study. The methodological framework (Maxwell, 2005), role of the researcher, research design, selection of participants, method for data collection, and guide for data analysis are found in this chapter.

According to Maxwell (2005, pp. 65-66), in designing a qualitative study the researcher must consider which research methods will best answer the research questions, keeping in mind they influence the value and validity of the conclusions. The first three components of Maxwell's (2005) model for qualitative design—Goals, Conceptual Framework, and Research Questions—were addressed in Chapters 1 and 2. The fourth component, Methods, and the final component, Validity, will be addressed in this chapter. Methods has four subcomponents:

1. The research relationships: The relationships that are established with those studied.

2. Site and participation selection: How settings and individuals are selected to interview and what other sources of information are used.

3. Data collection: How information will be gathered.

4. Data analysis: What will be done with this information in order to make sense of it.

The fifth and final component of Maxwell's model of qualitative research design is Validity, or how might the researcher be wrong.

Participant Selection

Criteria for inclusion in this study were that nurses were out of nursing practice for more than 5 years, had remained actively licensed, had completed a refresher course in the last 3 years in an effort to return to practice, and were willing to participate in face-to-face interviews. All of the nurses who met these criteria were female.

I purposefully selected a panel of 17 inactive registered nurses who had completed refresher courses in fall 2007 through fall 2008. These nurses were drawn from two educational institutions. All participants were volunteers. The justification for this sample was to obtain instances of all important dissimilar representation from inactive nurses (Weiss, 1994). This sample consisted of two groups:

- Group A: participants who had previously taken a refresher course from a university in Virginia.

- Group B: participants who had previously taken a refresher course at a community college in Maryland.

Sample: Group A

Group A consisted of inactive registered nurses who were students I taught in previous refresher courses. Working with them was part of the impetus for this study. In Group A, there were participants from three refresher courses taught by me, one from fall 2007 and two from the spring of 2008. There were a total of 60 potential participants from Group A.

The process of recruiting my participants for Group A began by emailing the three previous groups of students who were in my refresher courses from fall 2007 and spring 2008. All of the students who completed the courses I taught at GMU were sent the invitational letter (Appendix C) asking them to participate in this study if they met the criteria. If they agreed to participate they were placed in Group A.

Sample: Group B

Then, I contacted the instructor of the courses at the community college and asked her to email the invitational letter to her students, offering them a chance to participate in my research study (Appendix D). There were 18 potential participants from this group. Six potential participants from Group B contacted me by phone and email within one week after they had received their letter of invitation, and volunteered to participate in my research study. I responded by phone, thanking them for their willingness to participate. I then asked each participant when we could set up a time at their convenience to conduct the interview. Most of the participants were able to schedule their interview during the phone conversation. Several participants needed to wait a week or so, and then called me back with a convenient time. At the completion of the

phone call, I emailed each of them a copy of the informed consent and explained that I would like them to read the consent form but to wait to sign it just prior to the interview after their questions had been answered. I negotiated with each participant to contact them after their interview. I explained that once I finished transcribing and analyzing each interview I would send a summary of the themes for their review and feedback if they wished to provide some.

These groups represented two of the three different methods available to complete a refresher course in a large metropolitan area that included Virginia, Maryland, and Washington, DC. I also emailed the nursing instructor of a hospital-based refresher course, who had a potential pool of 6 participants from that course. The instructor emailed all 6 potential participants but none responded.

Participant Demographics

Seventeen face-to-face interviews were completed during the month of March, 2010. Eleven participants were from Group A, the university-based program; no participants were obtained from a hospital-based program; and six participants from Group B, the community college-based program (Appendix E). Each of the participants had been inactive for at least 5 years and had completed a refresher course between 2007 and 2008 at either a community college or university in the metropolitan area of Washington, DC. Six of the participants lived in the state of Maryland and the other 11 lived in the commonwealth of Virginia. All 17 were females of White non-Hispanic origin ranging in age from 35 to 57 in 2007/2008 when they returned to nursing practice. Of the 17 nurses, 10 last attended nursing school between 1965 and 1980.

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Their graduation dates from their undergraduate nursing school programs ranged from 1973 to 1995. All participants practiced after graduation, from 3 to 27 years, before becoming inactive. The participants reported being inactive from nursing practice for 5 to 32 years.

The educational nursing preparation level of the 17 participants varied. Seven nurses reported having master's degrees: four in nursing, one in education, one in management, and one in zoology. Six nurses reported having bachelor's degrees: four in nursing, one in zoology, and one in electrical engineering. Two nurses reported having diplomas in nursing and three nurses reported having associate's degrees in nursing.

Researcher Relationships

Relationships are a fundamental part of Maxwell's (2005) model and will be discussed for each group separately. There was an established relationship of trust and respect between the Group A participants and me. I knew these participants from a previous refresher course which they had completed in fall 2007 or spring or fall of 2008; no formal grades were given in the course. I taught all of these students in the classroom setting and some of them in the clinical practicum setting. As the participants of these refresher courses shared their frustrations in returning to practice, I acknowledged their pain and told them that one day I hoped to share their experiences through my research. Many participants volunteered to keep in touch and offered to be a part of the research study. I have had email contact from many previous refresher students asking for references or to report their successes. I have not maintained any regular contact except

for a couple of mass emails with research updates and job offers. For this current study I

negotiated the interview process with each participant individually.

My relationship with the participants in Groups B was new. Group B participants

contacted the researcher through an email sent to them by their instructors describing a

research study in which they could participate. They had been informed that the research

allowed them to share their personal experiences in returning to nursing practice through

an interview process.

As a fellow instructor of a refresher course, I had only professional contact with

the instructors who taught refresher courses at the Group B site. Once I received

approval from their Institutional Review Board to conduct the study, I contacted them

and requested that they inform their previous students, via email, regarding participation

in a research study. All participants contacted me personally via phone or email and

indicated their desire to participate in the study. Only then were they contacted by me to

schedule an interview.

Data Collection

Maxwell (2005) defines data in a qualitative study as virtually anything that is

seen, heard, or that is otherwise communicated while conducting the study. He states that

the researcher is the instrument in a qualitative study and his or her eyes and ears are the

tools used to gather what is occurring. He states this is particularly important prior to the

interviewing process when information collected can provide important connections, a

different perspective from the interview, and a check on interview data often found in

memos and field journals.

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This was a qualitative study, which used qualitative interviewing as the research method for obtaining data. Weiss (1994) describes the value of the qualitative interview process:

> Interviewing gives us access to the observations of others. Through interviewing we can learn about places we have not been and could not go and about settings in which we have not lived. We can learn about the challenges people confront as they lead their lives. We can learn also, through interviewing, about people's interior experiences. (p. 1)

Each participant agreed to an interview place of their choosing and a time that was convenient to both the participant and researcher. The interviews were conducted using an open-ended approach, in relaxed settings agreeable to participants and the researcher; three interviews were conducted in a Starbucks coffee shop, two in local restaurants, and the rest were all conducted in the participants' homes. The majority of the interviews began with food and beverages, either purchased or handmade by the participant and provided as lunch or a dessert. The environments were very relaxed and welcoming for the participants and researcher.

Protection of Human Subjects

Approval for this current study was obtained from the Human Subjects Review Board (HSRB) at GMU prior to recruitment of participants (Appendix F). I gave participants a letter of introduction and an informed consent form (Appendix G) containing the reason for the study and explaining that there were no benefits or risks for participating in the study. Participants were asked to sign two copies of the informed

consent form (one for their records and one for the researcher) and then complete a demographic form prior to being interviewed. A verbal reminder was given to each interviewee prior to the interview questions that participation was voluntary, confidentiality would be maintained, and participants could leave the study at any time for any reason. All participants remained in the study. To facilitate confidentiality, participants were asked to choose a pseudonym for use in the transcribed data. Each interviewee wrote her pseudonym on her demographics sheet at the beginning of the interview.

Each interview began with introductions by me, who I was and why I was conducting research about inactive registered nurses. Each participant was asked to agree to participate in the research, given two official copies of the consent form to sign, and provided an opportunity to ask any questions before the interview began. Once the participant agreed to the interview and tape recording, she was given a demographics form to complete before the recording began (Appendix H).

I then turned on the tape recorder and began asking questions using the interview guide (Appendix I). Interviews were audiotaped for accuracy and lasted from 40 minutes to 2 hours. For the first two interviews, I pilot tested my questions from the interview guide and audio equipment, using two audio recorders for both interviews. During both interviews I was somewhat direct in simply asking the questions from the interview guide and very little prompting of the subjects was necessary. The first interview lasted only 20 minutes, and I turned the tape recorder off at the end of the interview. The participant then began relaying more information that answered several of the questions about

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barriers. I asked if I could turn the audio recorder back on and she said yes and continued

to share. She explained she was nervous, and thought she should answer the questions

directly, and realized a few more things after I turned the audio recorder off. I learned

here that I should let the recording continue even after the interview questions were

completed. Participant 1 was informed at the close of the interview that I would contact

her by email with a one-page summary of the interview for member verification, a part of

the qualitative research process.

After each interview was completed I reviewed the audio recording for clarity and

transcribed the data on my computer. The rest of the 17 interviews were completed in the

same manner, except only one audiotape was used for recording. I took field notes

throughout the interviews to include any nonverbal communication from the participants.

Once the individual interviews were complete, I wrote memos documenting my thoughts

and feelings regarding the interview.

Other forms of data that I collected were from the demographic sheets, written

memos completed after each interview, casual conversations, participant journals, and

incidental observation.

Participants were sent a one- to two-page summary of the interview, by email,

informing them that the summary was part of the qualitative research process. This part

of the process was called a member check and required that they read and acknowledge

the transcription, which summarized their thoughts and intent. They were also asked to

correct any discrepancies. All 17 participants responded, stating the summaries were

correct and no changes needed to be made.

Data Analysis

In keeping with the interactive design of this research, data analysis began at the point of data collection (Maxwell, 2005). As the researcher, I recognized the complexity of barriers that inactive nurses may relate in their interview process. I bracketed my thoughts prior to data collection to inhibit prejudgments of these inactive nurses and allow a less biased analysis of the data. I wrote a memo of my thoughts of potential bias, and brought the memo to each interview with me. I read the memo to myself prior to each interview to help keep these thoughts in mind during each interview. The biases that I was aware of prior to conducting the interviews were that each nurse would be honest and share her feelings in response to the questions, each nurse would explain what barriers she encountered, and she would ask questions of me for clarification without prejudice.

After all the data were collected, confidentiality was maintained by coding the audiotapes and field notes with pseudonyms. I transcribed the audiotaped interviews verbatim. Each transcription, which extended from two to nine pages, was summarized to two pages or less and returned to each participant by email for a member check for accuracy. Two participants returned further comments but none required corrections. Following the research, the data are being kept locked in a cabinet for a minimum of 5 years per university requirements.

Initially, each transcription was reviewed as a whole to allow me to become familiar with the text. The plan for the analysis process was conducted in four phases as suggested by Maxwell and Miller (2008).

1. I read and reread the transcripts, observational notes, and any other collected data, which allowed me to dwell on the data and write memos about significant words, phrases, or themes (Maxwell & Miller, 2008).

2. I proceeded to identify units of data, referred to as "marking what is of interest in the text" by Seidman (1998). Here, I added to my memos the areas of interest.

3. I used categorizing strategies (coding and matrices) following Miller's example (Maxwell & Miller, 2008) by coding the data in elements that seemed to appear as a major category of each interview. I then constructed matrices with each major category and looked across each interview for these concepts. At the same time I constructed narrative summaries with extensive quotes from the data, organizing the data in a form that gave a concise account of the narrative.

4. I then connected the coding and matrices with the narrative summaries in order to achieve an understanding of the interviews and other collected data (Maxwell & Miller, 2008).

Analysis

I uploaded the actual audio recording into my computer and was able to play the audio of the interview sentence by sentence, and transcribed each interview myself. This process allowed me to hear the interview, remember the interview, and note how each participant was relating her story to me. As I transcribed each interview, I was able to recognize certain identifying comments that stood out from each participant. I italicized

and highlighted these sentences with different colored font on the computer as an area of interest. I also read the memos I had written after each interview to help frame the interview atmosphere and any additional comments for thoughts about the interview. Once all interviews were completed I read and reread them to highlight the repeating words or phrases that stood out to me.

As part of the second step of the analysis, I wrote memos that included listing the repeated words or phrases that were shared by many of the participants. I listened to the interviews again and reread the transcriptions to verify the accuracy of my memos of words and repeated phrases. To connect the words and phrases from all interviews, I made a spreadsheet with the repeated words, the related interview, and the significant paragraph. I put the repeated phrases from each interview in a spreadsheet and counted how many times the same thought was stated throughout all 17 interviews. Then I placed the repeated phrases in categories that seemed to explain the phrases on poster boards across my office walls. It was through this process that I discovered the same words or phrases were repeated in many of the interviews, such as the topic of "time constraints," but that they appeared in different times during the interview. Time was mentioned as a problem in the beginning, middle, and the end of the interview questions.

To maintain integrity with the data, I took each interview and began coding each of the data in elements that seemed to appear as major themes from each interview. Four distinct themes began to appear throughout the interviews. To add rigor to this analysis process, I had three additional content experts review four random transcriptions in my presence to determine themes they discovered from each transcript. All three content

experts discovered the same four themes as I did, strengthening the analysis. As a part of phase three of the analysis process, I began constructing matrices grouping the large quotes from all the interviews into themes and categories that appeared to have the same meaningful experiences. To ensure that I understood the meaning of these large quotes, I read and reread them in the context of each interview and then reorganized the matrix into new categories with subthemes to appropriately represent the meanings of the data.

As I began to organize the data into narrative summaries I recognized that I would need to organize the data in a chronological manner of events, since the interview quotes often had many concepts within the paragraphs. I began color-coding the data to ensure it was in the correct category. I then went back to the interviews and memos and reread them to make sure I gave an accurate account of what the nurses said in narrative summaries. Lastly, I began connecting the coded phrases, matrices of narratives, and report and understanding of the interview and the experiences these nurse had in returning to practice. Each one had a journey and, although similar to other nurses', it remained a unique journey and deserved to be shared.

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Validity and Limitations

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Maxwell (2005) addresses "Validity—How might you be wrong?" as the last part of his design model. It is here where he expresses that the researcher must be aware of alternative explanations and must protect from bias and reactivity.

The first validity threat was that I might have misunderstood the perspective or thoughts the participant wanted to express and the meaning of what she said, did, and her perspective on the situation, because of my own biases and assumptions. I needed to

proactively listen to the participants when gathering data and not presume to interpret what they were thinking, but accurately record and report what they said. Since I had previously known some of the participants, even for the limited time of 16 days of the refresher course, the passion and compassion shared by the participants with me during that short time had left me with certain assumptions. These assumptions were that each nurse had a story to tell, and she would tell me what her story was and would also want to be conscientious and ask me follow-up questions to ensure that she had "given" the information I inquired about. I had to diligently recognize these assumptions and keep them in check and try not to influence the data or draw the wrong conclusion. However, I also believe that my experience as a nurse provided a greater ability to listen to the participants, hear what they said, and report their stories with greater accuracy.

The strategy to address this validity threat was to acknowledge it, write the assumption down, reflect on it before data collection, and to keep a journal to document my thoughts so as to not get distracted from the goal. By acknowledging any known biases prior to data collection, I was able to ensure a greater accuracy of data collection and analysis, with less risk of misinterpretation.

Another potential validity threat referred to the possible inaccuracy of the data. This validity threat was addressed by ensuring that the interviews were tape recorded, transcribed verbatim, and summaries of the interviews were reviewed by participants to ensure accuracy of what each participant said and meant. Field notes of what actually took place during the interviews—the nonverbal clues and responses by the participants—were documented to help ensure the accuracy of the data. Direct

quotations from the interviews were also used to ensure accuracy in the written report of the research.

A third validity threat was reactivity: the potential influence I had on the setting or participants. The greatest potential for such influence in this study was that nurses might tell me what they thought I wanted to hear when they were answering my questions. However, the relationships that I established with the nurses minimized this risk, and the interview transcripts provide much evidence that the nurses were expressing their own deeply-held views and reporting actual experiences, rather than simply trying to meet what they thought I wanted.

I aimed to establish rigor and trustworthiness in this study by incorporating member checks, peer briefing of the themes, an audit trail of the research, and direct quotes. First, an audit trail of the entire research process was continuously documented (Appendix J). Member checks were incorporated after the transcription of each interview. A summary of the interview was sent to each participant, allowing her to verify the researcher's transcription of their interview. Peer debriefing had taken place in several areas of the research. It began with peer reviewing of the interview guide questions and the demographics sheet. Contributions and suggestions were incorporated in the final demographics sheet and questions. Peer review took place by three content experts in several phases of analysis. Content experts blindly reviewed interviews for themes, and reviewed the categories and sections of large quotes for appropriateness. Several times they also reviewed the organization of the narrative in chronological order of reporting the findings. They made suggestions on synthesizing the data to accurately

represent the large quotations. Content experts were actively involved in this research

from the beginning development of research questions, the development of the guided

interview, and the entire process through writing the conclusions and suggestions.

Content experts were previous refresher students, nursing educators, and researchers.

One limitation of this study was that I was unable to get participants from the

hospital-based program I sought, and did not seek participants from online courses.

Therefore, this study is limited in the fact that it represents two of the four types (online,

hospital-based, community college–based, or university-based) of refresher programs

available.

CHAPTER 4. FINDINGS

This chapter provides the findings of the study. I have organized these findings in terms of seven main categories: *the reasons to return*, *factors that inhibit returning*, *barriers of a refresher course*, *rewards of completing a refresher course*, *roadblocks of employment*, *rewards of returning to practice*, and *advice for all RNs*. Table 1 summarizes the categories and their subthemes.

Table 1

Summary of Categories and Subthemes

Category	Themes	Subthemes
Reasons to return	Self-fulfillment Financial need	
Factors that inhibit returning	Lack of Confidence	Self-Doubt
Barriers of a refresher course	Locating a refresher course	
	Expense of the course	
	Time obstacles	Hassles to get in the course Time to carve out for my family Time to read
	Barriers of clinical practicum	Fear of harming a patient by having less than competent nursing skills
		Advances in the use of technology in providing nursing care • Changes in equipment • The process of medication administration • Documentation
		High levels of patient acuity
		Increase in patients' physical size
	Family obligations	
Rewards of completing a refresher course	Emotional benefits Unexpected camaraderie	
Roadblocks of employment	Creating resumes Online job applications Rejection Job requirements of shiftwork	
Rewards of returning to practice	Personal satisfaction Job satisfaction	
Advice for all RNs	Advice from returning nurses to all nurses	

All participants in this research chose pseudonyms to replace their names to protect their identity. The pseudonyms were Erin, Katie, Yolanda, Lea, Trixie, Susie, Priscilla, Jesabelle, Nancy, Maryann, Victoria, Christine, Rain, Jeanne, Thelma Lou, Maria, and Denise.

Reasons to Return

There was no one theme that appeared in all of the interviews that explained why these inactive registered nurses returned to nursing practice after being out for so many years. Susie explained,

> I never meant to leave nursing; I was sort of forced to leave nursing because when
> we were in Europe there wasn't a nursing position available. So I knew as soon
> as I came back to the United States or where ever there was I was always looking
> for another job.

Two reasons appeared in the analysis. One reason of returning to nursing practice was *self-fulfillment*; the other theme was *financial need*.

Subtheme *self-fulfillment* is described as the act or fact of fulfilling one's ambitions or desires through one's effort. Thirteen of the 17 nurses shared reasons for returning to practice that had to do with self-fulfillment. Erin said,

> I *really* missed nursing, I missed the intellectual piece of work. I had just a really
> busy life but wasn't completely fulfilled with all that stuff. It took me a couple of
> years to get into the refresher course and come back but it had been on my mind
> for several years, just a piece of it, something was missing in my life.

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Yolanda too describes her reasons to return:

> We have been able to survive on my husband's income, that's not an issue so this would just be for those college bills and things like that.... [I was] not really feeling like I have personally developed in the manner that I would like to have.... So I think I started reflecting on where I wanted to go; also, I was really starting to be concerned about being a role model to my kids.... At times I see my friends successful, and I felt I hadn't really moved on with my life, which started to lay heavy on me so I thought, "You need to go back," I needed personally to go back for that stimulation.

Priscilla said,

> I was a preschool teacher for about nine years and loved it but I have always loved nursing. But what got me deciding to go back to nursing was my son was diagnosed 4 years ago with diabetes and it made me realize how I was not up-to-date on the current treatment and all and I didn't just feel like I was as confident, I wanted to be more confident.

Trixie too, explained that

> I had been home for a long time and I never expected to go back into nursing, and with four children who I stayed home with all of the time. I just reached a point in my life where, I just felt the world was kind of passing me by.

One participant, Thelma Lou, explained that after a lot of praying,

> So for six months or a year I was trying to decide what I would do with my life and I decided to return to nursing rather than engineering or something like that. I

decided nursing would be the way to go. So I prayed and saw signs that this was

the way I was pointed to go.

Denise explained she had several reasons to return:

I had an inner drive and I could really focus on what it was, on the surface, I guess

it was more my brain was turning to mush, and I am not a very self-directed

learner. I need to have material put in front of me and have someone say, "Okay

now, you have to do this".… I wanted to get my mind active again; I just had an

inner drive. It wasn't a financial drive…the inner drive to go back was my

children not respecting that I was a stay-at-home mom.

Of the 17 interviews, 7 nurses explained that their reason to return was primarily

based on financial need. The subtheme *financial need* is described as a need for income

or monetary assistance. Two of the nurses explained divorce was the instigator for

financial needs. Nancy emphatically said,

The decision was based largely on finances; it was the impetus for the timing, but

I always did want to go back to my career, because I always loved nursing. I was

in the middle of a divorce and a mother of four and needed to refinance my house.

I needed to get back in, in the shortest pathway as possible.

Another nurse, Rain, sadly explained as we sat across the table:

I actually thought about giving up nursing and changing into a teaching track. I

was also having some issues that were pushing me toward needing to get back

into a full-time job. I was a stay-at-home mom and had been out of nursing for a

while, but it had to do with my husband saying he wanted a divorce, so that I

would need to be able to support myself.

Two others described the financial need for their children's college tuition. Maria
explains in hindsight,

I suppose in part it was my sons' college tuition and I was looking at those bills

and in part I had just paid my NY state nursing license renewal, and I thought,

"Maybe I should see what it would take to move my license down here in case I

would ever want to go back to work as a nurse."

Helping out with the family's finances is reported by Jesabelle:

Well, as my children got older, I found that I had more time, I was thinking about

nursing. I did not feel comfortable with my knowledge set after having been out

of nursing for such a long time.… Then my husband was going to be retiring

from the military after 30 years and we didn't know what our financial picture

was going to be, so I was also motivated by finances to be able to get back into

the workforce.

In summary, nurses returned to practice for two main reasons: self-fulfillment and
because of financial need. Many nurses recognized that as their children got older or left
home, they needed more stimulation intellectually and desired to see if nursing was still a
fulfilling profession for them. Other nurses simply chose to return to the nursing
profession because they were in need of a job due to financial need.

Inhibiting Factors of Returning to Nursing Practice

The next decision for the returning nurse was how to start the process to return once the decision was made. The main inhibiting factor in returning to nursing practice was lack of confidence. All nurses shared that they needed to "brush up on skills," but some wanted to delve right into skills and others were more anxious about getting back into nursing itself.

All 17 nurses interviewed reported feelings of lack of confidence or self-doubt. Erin explained,

> I was completely rusty and I wasn't sure of what I could do. I didn't know if anyone would hire me. Didn't know probably if the refresher course was the right place for me, based on my background as a clinical specialist and master's-prepared nurse, but my level of anxiety of being in the hospital again, uhh, it looked like a good place for me to start.

Not alone, Yolanda shared,

> I never even went to get a job because I knew I needed a refresher course. I think I started looking at going back to school to pursue different avenues. And I realized it would be doing myself a disservice to change majors since I knew I had an innate desire to help people…. Having been out for 7 years, I was scared and insecure to return.

Maryann, also a nurse educator, explained,

> I didn't feel I was competent to go back and teach again because I hadn't practiced bedside nursing in so long. I probably was competent but I didn't want

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to be that kind of instructor because I had had a couple of instructors like that, and you knew had been away from the bedside forever and they just didn't have the credibility that I wanted to have and used to have an instructor/professor.

Erin recognized, "maybe my only barrier was the lack of confidence that I know enough that I am not safe, I am not good enough to be back yet, but I want to come back."

Victoria said,

That was very difficult because I didn't know what it really was that I needed to be aware of…saw a return-to-practice course by another organization and of course that was all online, and I knew I didn't have skills to do that because I hadn't used a computer in a work capacity ever…. It took me up to a year to get the courage to go, because I was scared I was going to totally blow it.

Rain exclaimed,

My biggest barrier was lack of confidence…as a wife and mother I lost part of my identity. I had a big confidence problem, whether I could handle going back into nursing and whether or not I really wanted to do it.

Prisilla too, explains,

I think that the forgetting a lot was a huge barrier and that scared me…. And then I was wondering, "Is this knowledge going to come back to me?" Or am I going to be able to learn all these new things. To tell you the truth it was a huge challenge, but it was soooo great…. The barriers were mostly education-wise, and know, that, I had a great base education, but forgetting. I remember when

Wendy was saying, and I remember talking about PT/INRs and I am like, "What the heck is a PT/INR"…that was not in the picture when I was in practice. So, that kind of hit home. I think there is more that I don't know than I thought [laughing], and I thought, there can't be that much that has changed, but there was enough.

In summary, the main inhibiting factor to all of the nurses of returning to practice was a lack of confidence in the ability to get a job or regain the skills to return to nursing practice.

Barriers of a Refresher Course

Each of the nurses in this study decided that a refresher course was the best pathway to return to practice. However, this beginning step presented other barriers. Sixteen of the 17 nurses reported barriers with a refresher course, but they were not all the same. Five specific barriers were mentioned for the refresher course: *difficulty locating refresher courses*, *expense of the course*, *time obstacles*, *barriers of clinical practicum*, and *family obligations*.

The difficulty of locating refresher courses was discussed by all nurses, some saying they had more difficulty than others. Four nurses voiced their difficulty in locating a course. Nancy said,

You know I found out completely by trial and error. I went to several interviews and in the process one of the hospital nursing directors told me that "no hospital in the area would accept me without a refresher course" and refresher courses are no longer hospital-based. I would have to find one that was either online or

locally; that [Northern Virginia Community College] had offered one and George

Mason University was offering one as well. So, she gave me some information

that was critical but I did not know of any other resources that were providing that

information.

Rain responded regarding the refresher course:

I returned to Virginia from overseas and then began getting active again. Another

barrier was the hospitals, at least one of them; they didn't help me accomplish

what I needed. I thought the first place to go to find out what you needed was a

hospital, they didn't respond at all. So then I went the route of the Virginia BON

[Board of Nursing] and the university level.

Several nurses looked online for courses; one was Yolanda, who explained,

I found that when I went on websites, such as returning nurse, RN refresher

course things were not popping up as quickly as I thought they would, or I would

be getting umm, websites from Arizona, Texas, not so much from Virginia. It

was other states, California, and then there were the distance learnings, Phoenix,

and then you had some of those things programs. But then I am a person who

learns hands-on, I need to talk to somebody. I knew that the online programs

would not be good for me, because I am, I have some issues with [attention-

deficit disorder] myself. I needed to have somebody hold me accountable for

what I needed to do. And I think that when you are looking at an online program

you have to be very disciplined and that's not me…. But you know, when the

desire came, to go back I became diligent and I was able to find resources, but
you had to put time and effort into it.

Lea said,

I also read the VNA newspapers that came, I've checked them both out, so, I tried
to find refresher courses. Researching online I guess I was surprised that there
weren't more. And I was delighted that GMU had one, it seemed like it would
work better for me, the distance, and the requirements. The [Northern Virginia
Community College] one I looked at was more expensive and it seemed more like
it was critical care. So it didn't seem like it would complement my background,
as well as something that was more, uh, for the med/surg nurse or community
nurse getting back to work. So that was why I chose [George] Mason.

After locating the refresher course, several difficulties occurred in *traveling* to the
refresher course. Trixie explained it was easy to find a course but location was still a
barrier:

Once I found the schools that offered refresher programs it was very easy to find
out what their requirements were to get back into the program…. I just registered,
and the biggest barrier was for me, location, finding a place close by. There was a
community college in…Worcester County, they had an online course and then
Anne Arundel had a course at Glen Burnie? I think…at the time that seemed
terribly far…. I remember thinking, "There is no way I can do that twice a
week." I have to say the only barrier for me was location, how far would I have
to go to take the course? One hour and 15 minutes twice a week is how far I had

to go, so just coordinating the time with the family would be the only other thing I had to do.

Jeanne, too, shared concern about traveling:

I was a little concerned about the refresher course being so far a drive for me, because I would have to commute during rush hour in the morning, and it would take me over an hour.

Victoria shared this about getting to the refresher course:

The biggest barrier I had during the course was driving on to campus [laughing]. Because, I am in my 50s and driving on to a college campus when you have never been on a college campus for 20 years, was my biggest barrier. I practically was having an anxiety attack.

The *expense of the refresher course* is another barrier that 7 of the 17 nurses (41%) mentioned. Nancy said,

Also financial, financial is a huge obstacle. I had four kids, and I needed to come up with $1,000 on a tight budget. And when you are trying to find a job, because you need money, and you are having to come up with $1,000 so that you can make money, it is hard, and then having to wait for a deadline to be re-met. And also, in the interim I got a job knowing it would be an interim job in the doctor's office to help pay the bills. But I needed time off to take the refresher course, and the job that I was working, did not really allow you to do that. I was a full-time nurse, and I literally had to quit my job, to take the course and sort of sell some stock to sort of make it through those months.

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Rain, after being told she needed to prepare for a possible divorce, explains:

> I went so far as to email them, hospitals, and tell them my situation. Having an active license and asking, "What would I have to do to get back into nursing?" I got my answer from VA BON that GMU had this refresher program. It was easy to locate but then there was paying for it, I didn't have the money for it up front and so, umm, the university allowed me to pay $500 at one point and let me pay the $500 later after I had registered…. I was worried about the little things and I still had to worry about child care.

Two nurses revealed that they had each taken refresher courses before. Jesabelle shared,

> I tried to do [the refresher course] before we moved while I was in Alaska, and I was uncomfortable by being sponsored by somebody I didn't know at the community hospital and I had to do it by correspondence for the theory portion. It was a correspondence refresher course through the University of South Dakota. So my first try at a refresher course was time consuming and expensive. So after we moved here I signed up for the course at local community college. I was happy and I felt much more confident in doing it since I could go to a class and have real instructors that you could ask questions of. And it too was expensive but the rationale is you make it all back very quickly. The cost was kind of an issue but we did some stuff and cashed in some bonds.

Having taken the same refresher course before, Thelma Lou remarked,

>The cost of the course went much higher than when I took the course back in
>1995. In 1995 it was $700-something, I can't remember exactly but it was below
>$1,000. It is probably close to $2,000 now by the time you add the books and all.

Another barrier expressed by many was *time obstacles* of the refresher course.
Five of the nurses said that time was an obstacle with the refresher course. Time was
reported as three different forms of barriers: time *hassles* to get in the course, *time to
carve out* for my family, and *time to read*. Jesabelle shared,

>It was a pain in the neck to get my license straightened out and the BON
>rigmarole. You know it's hard to get a real person on the phone, it took a
>while…. I didn't have a Maryland license [and] needed to get my New York
>license transferred to Maryland. I had to turn an active license into an inactive
>license; there was lots of paperwork and took a whole bunch of time. Then it was
>getting your immunizations up-to-date and the making appointments for physicals
>and all the stuff to get into the course…. I started working on this process in
>September 2007, and it took me all 3 months to get it done, costing me time and
>money.

Lea explained,

>I think the process of signing up through the website; I think that was easy to me.
>There was some sort of paperwork that was an obstacle, I think it was to go
>through the safety and security, fingerprinting and background check, and there
>was something about the fingerprinting process that was a challenge. There was

an issue with it, I had to go to the city police and the county, somehow the process of taking my fingerprints left them less readable, anyway it got taken care of but it was frustrating.

A different barrier of *time* was shared by Victoria, who explained,

The other barrier for me was the *time*, for me to carve out the amount of time it took that day, for going for a refresher-slash-clinical and all that went with it, was huge sacrifice for my family and they weren't really excited about it because it was taking away from what they were receiving from me, and that was tough.

Three nurses reported concerns with the final time barrier, *time to read*. Susie explained,

It was intense, the reading was just amazing how much I was reading, constantly. I was just taking my textbook with me everywhere I went, I was constantly trying to keep up with that, because of the amount of reading. But I really enjoyed it.

Maria said,

Barriers during the class was primarily trying to keep up with the reading with concentration, and we had quizzes each week and I wasn't sure if I could pass them so we formed study groups. I did pass them but it was an intense intellectual experience. I admit I thought it would be easy; I had done a refresher class 10 years before, but I was so wrong. It was very intense and very difficult, but I wasn't going to pay all that money and not get my money worth. The previous refresher course I had taken was just sort of a pleasant way to spend a couple of hours a night a couple of nights a week. It wasn't bone-grinding and

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intense. But if you are going to take a refresher course, you want it to be bone-

grinding and intense.

Jesabelle said,

There were huge amounts of information; sometimes we had hundreds of pages

supposedly to cover in 2 days. We had class Mondays and Wednesdays and they

were supposed to be from 6p to 10p at night, sometimes they let out early. We

had this whole big fat med/surg book and it was pretty complicated. It had

electrolyte imbalance and pH imbalances, and things I hadn't dealt with in a lot of

years. So getting it done was the overwhelming volume of material, all I ever did

for 4 months was read. From Monday to Wednesday you could have 200 pages to

try and absorb, understand and fill out this test and hand it in. Things kind of fell

apart around here [home], because I was always saying "I have to read"…. But it

was for a short period of time. So, when you get this age, you understand it and

sacrifice some things for short period of time or longer because you understand

what you will get in the end. So everybody was pretty on board around here for

that and they were pretty helpful.

Another subtheme was the *barriers of clinical practicum*. Seven of the 17 nurses

interviewed explained that some aspect of the clinical practicum was difficult for them.

Nurses take pride in providing the highest quality of *safe* nursing care for their patients.

When the delivery of *safe* nursing care is compromised by the nurse's skill sets,

proficiency, equipment, or things outside of their control, the nurse feels a sense of

responsibility. These nurses explained they had fear, anxiety, and felt intimidated in

returning to the hospital to provide nursing care not knowing what factors would inhibit their delivery of safe nursing care. They were aware that they had the knowledge to care for patients but were concerned about being able to deliver great nursing care since they were unfamiliar with the current patient population and the technological advances in the individual hospital care delivery systems.

The four types of barriers they described in their clinical practicum were *fear of harming a patient by having less than competent nursing skills*, *advances in the use of technology in providing nursing care*, *high levels of patient acuity*, and *increase in patients' physical size*.

For the fear of harming a patient, Erin explained,

I would wake up at 4 a.m., with the fear of my nursing skills not being up to par. Clinical was stressful, probably much more stressful than classroom…. I had never really been a med/surg nurse, so coming back working on a med/surg floor, and not having been a bedside nurse for many, many years having, I had been a clinical specialist. That was I, um, probably scary, umm that was nerve-wracking, I just didn't want to hurt anyone unintentionally.

Victoria said, smiling,

Clinical was really scary, oh my gosh, that first class going back into the hospital, just to walk around was very intimidating, because there was a sense of impending doom [laughing] that I might be called on, to have to really rescue somebody and I, not know what in the heck I was doing. Way scary stuff! You know easing everybody in was very helpful, and once we kind of got our

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bearings, then it was getting past the anxiety of knowing how to function in that

organization.

Jesabelle explained,

Clinical, like, gave me diarrhea; clinical was very anxiety producing to be back on

the floors again. It was difficult, because a couple of things were different than in

my previous experience, but patients are all the same. They are all the same, they

have the same needs: they need to understand, they need to be supported, they

need to be comforted, taken care of, they need to feel safe, all that stuff. Patients

hadn't changed, just the environment they were in.

Many nurses voiced anxiety and feelings of intimidation in providing nursing care

due to the higher acuity level of patients and increased physical size, making the delivery

of nursing care challenging. Thelma Lou said,

People are so acutely sick in the hospital now, than when I did nursing before. So

much sicker, people now in days are sent home too, with their own treatments and

told to give their own care, and they never used to do that when I was nursing in

the 1980s.

Jesabelle said,

[B]ut as anxiety producing as it was it wasn't enough. I would have liked to have

spent a month straight, then I would have been fine. Being able to work 8 hours a

day for a month would be great. It wasn't complete days, then we would go back

and talk about it, how people ran in to situations and how we would handle it.

Patients are much sicker these days, and heavier, than they used to be. There is a

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lot more physically tiring work than there used to be, lifting and turning them and using good body mechanics. Patients are much sicker; people on the floors would have been in the units 30 years ago. So that was more anxiety producing; they are younger and they are sicker and they are older and they are sicker. But clinical was very good, because now I had a very basic understanding of what it was like now in nursing; now, when people talk about something, I understand and I've got it.

Maria said,

But the biggest difference I could see in the 25 years I have been out was how big people had gotten. I am absolutely serious, I think in the 6 years I had been in the [Veterans Administration (VA)] I think there was one guy that we could weigh on the 300-pound scale. One guy! To me that was the real shocking change and how quickly they booted you out when I felt the patient had real needs and they discharge them, and I am like, but, but…. And they would say, "They will come back if they need to."

Due to the advances in the use of technology in providing nursing care, several nurses voiced their frustrations with *changes in equipment*, *the process of medication administration*, and in *documentation*. Susie said,

When we got back into the hospital setting, I discovered how much all of the equipment had changed, it was intimidating. It was just so much. All the beds are now rotating do this, whereas before I cranked up the bed.

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The process of giving medications is different, Susie explained,

[A]nd as I am talking with the other students that were there, they were also commenting on how overwhelming the medications had changed. I remember the days of pouring your pills out of the giant bottle, into the medicine cup, and sitting all your little cups out and walking from room to room. And now, you suddenly, there are dispensaries and you've got to hit codes to get your pills out, and you're *scanning* like you are at the checkout counter to get your medicines. And all medications are practically [intravenous] now, whereas before I was so used to giving [intramuscular injections] and [oral medications] and that's a big, big change.

Five nurses voiced concerns about the difficulties in documentation, a key component of nursing practice. Thelma Lou said,

Even being able to approach a patient [to complete an assessment] when you can't even chart on them is another obstacle. Charting was a big obstacle at clinical. When we went over to the hospital for clinical, we couldn't chart, because everything was all computerized. And in order to chart, the people in the hospital had to take a 6-week computer course. Since we couldn't do that as students in the refresher course, we couldn't chart. We could give medications but we had to take a short course to even be able to document giving the medicines. The whole experience was a little intimidating.

Jesabelle said,

> The computer systems were…it was just like, "Just give me a paper chart," I
> could write this note in 2 minutes and it has taken me 10 minutes to navigate to
> the right screen. I found it was very restrictive to chart, because you could only
> check off this symptom or that symptom, what was on the screen, and if you
> wanted to write anything you had to go to another screen and I found it to be very
> cumbersome and time consuming. After the end of clinical rotation I felt better
> and had a basic understanding of how to chart.

Victoria summarized the clinical experience of returning to the hospital,

> [A]nd not knowing how to function with the medication technology, the computer
> health records, getting past all of those infrastructural organizational things was
> huge. I knew I'd be okay with a real person, but it was everything else that went
> into care delivery that was way scary. So, I had lots of anxieties there, it was very
> nerve-wracking the first couple of days. And thinking "What am I doing here,
> what was I thinking?" And I was thinking "I am too old to be doing this." But
> you got us past that.

In summary, all of these nurses expressed fear, anxiety, and intimidation when
asked to recount their experience about returning to the hospital to perform their clinical
practicum. Nurses take pride in having a strong knowledge base and proficient skills
from which they are able to provide the best nursing care. After being out of nursing
practice they feel anxious and less than confident in providing efficient nursing care with
the change in processes and the use of technological advances, and the barrier of sicker

and/or larger patients than they have cared for before. But they report that the support

and mentoring in the refresher course helped them succeed.

The last barrier of the refresher course, *family obligation*, was shared by 5 of the

17 nurses. Family obligation was something that they could work through but still it was

a barrier. Maryann explained that

The biggest barrier to even taking the refresher course is, how am I going to get a

job that is going to fit into, uh, my family's lifestyle, because of the 12-hour

shifts? That is why I procrastinated for so many years, which I regret now. I

wish I had gone back and taken the refresher 10 years prior.

Susie shared that

[S]till the family does become an issue when you return. If you've been at home

they have certain expectations of what you are going to do and what you are not

going to do. So you can't forget your family and what their wishes are. So that's

something you've got to consider, where do you balance your personal life and

your nursing life?

Denise, too, felt the family pulling:

It was a little difficult to change focus, everyone, in the family, having to share

me with study time, and transportation, and me on the road to class, when

somebody got sick, and my husband having to refocus and say me, maybe I am

the one that has to stay home. And the Navy doesn't look at that kindly. I think

family life was a big hurdle. And my husband especially because there is a lot of

ego involved, especially, you know, in being the full breadwinner and now having

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to make concessions for someone who is still only contributing very little financially.

In summary, five main barriers were listed by participants: *difficulty locating refresher courses*, *expense of the refresher course*, *time obstacles of the refresher course*, *barriers of clinical practicum*, and *family obligations*. Within the theme difficulty locating refresher courses, most nurses reported that access to the refresher course types and locations was the most frustrating, was inconsistent, and varied by state.

Many nurses drove long distances to take the refresher courses. The expense of each refresher course was between $1,000 and $2,000. Several nurses had to cash in stocks and bonds to attend. Time obstacles of the refresher course were reported as different things. Most of the nurses agreed that the time for the course itself took away from the family and made family responsibilities difficult. The time it took to read and absorb as much as was possible in preparations for the refresher classes, quizzes, and clinical practicum was much more than they expected.

Each nurse experienced different barriers to the clinical practicum. Some of the nurses explained that the fear of returning to the hospital, caring for patients again, and not knowing what was going to be demanded of them by the patients was of great concern. Many felt such a great obligation to have their knowledge current and skills at a level of proficiency before they returned that they felt it was a barrier to return less-than-proficient. Others related that the medication technology, computer health records, computer charting, and all of the other organizational changes were a source of huge

anxiety. And finally, the majority of the nurses expressed difficulty with managing family obligations and taking a refresher course.

All of the nurses persevered to complete the refresher course in spite of these barriers. Once the nurses were able to complete refresher courses, four other significant themes were apparent. These themes were *rewards from completing a refresher course*, *roadblocks to employment*, *rewards of returning to practice*, and *advice to all RNs*.

Rewards From Completing a Refresher Course

All 17 nurses had praise in one form or another for the refresher course being a bridge to helping them succeed in returning to nursing practice. These nurses had many comments to share about their experience and the rewards they received. Many described the *emotional benefits* they gained from completing the refresher course; others described the significance of support during the refresher course through the *unexpected camaraderie*.

Katie said,

You know, I think what was good about the refresher course was it made me realize that I have a ways to go before I am going to feel comfortable. But it was a great entry or return because, you know, because with you as the instructor, you always made us feel competent, where most of us felt anything but this, and that was really important. I realized quickly, we weren't there really to deliver patient care on the fourth floor, we were there to get our hands wet, get our feet wet, see what it's all about. Coming through the refresher course gives you a boatload of confidence and opportunities for jobs. So I feel really grounded, starting with the

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refresher course, and the refresher course was the catalyst that did it for me.

That's just it. It gets you in, it's not the be-all end-all in terms of making you feel

like, "I'm good to go." But it gets you there and you realize you can do it; there's

things you need to study and learn further but it gets you back in there and it's a

good feeling.

Christine said,

So the nurse refresher course was a good opportunity to overview a lot of things

again, and the freedom to ask questions again and to have some help to get back

out there. And I think part of the lesson to me is, in medical work anyway, you

have got to be a lifetime learner.

Rain explained,

Being faced with divorce…. I am very pleased with the whole process; I

personally needed the boost in the confidence and I needed people to understand

me and not judge me. Um, just encouraging, I needed encouragement at that time

along with a refreshing of the skills, I would say. It was good. As far as what I

needed to accomplish, I was successful. It was successful at getting me back into

practice and a good stepping stone of helping me advance my career in nursing.

And that you don't have to worry about doing something that you really don't

want to do, that there's plenty; just knowing nurses are needed and that there is

something for everybody.

Maria said,

> I am very pleased, I think I owe my success to the high-caliber refresher course,
> and I do not praise lightly. I realized it gives you a place to start, it gives you the
> confidence again to proceed, you are, like, that stuff you had thought you had
> totally forgotten was just kind of buried under layers of motherhood. I still knew
> what stuff was and how it worked; it made a huge difference. I feel successful in
> returning to practice. The community college refresher course was the best
> money I ever spent, a hard semester but well invested.

In summary several nurses believed that they received more than just a review
from the refresher course. Through unsolicited praise for the course they also explained
that they received emotional benefits of increased confidence and encouragement to help
them continue on the journey of returning to practice.

Camaraderie an Unexpected Benefit

Several nurses expressed that they thought they were on their own in returning to
practice, but once in the refresher course they discovered other women returning to
practice just like them. Katie said,

> What comes to mind immediately was the course, it was just wonderful. The
> content of course was wonderful, but I mean I just remember the group, the other
> women, I remember just looking so forward to going, and just seeing everybody,
> and I didn't really maintain touch afterwards, but for that time I know I could call
> on any of those women in the future and be able to say, "Remember when we
> were together?" That bond, you know, some of them were pretty scared. And I

still so admired that. Everybody seemed to have anxiety, in that returning feeling, and that was really important about the course.

Priscilla also shared:

[P]art of it was the course and part of it was the camaraderie with you and the other students, that they were all in the same place and I was realizing there are a lot of us out there, and I'm not over the hill. There are a lot of us exactly in the same place and doing exactly the same thing. And really there's a huge asset for us being there, there is a lot we can contribute. And that it's, we're really, they're lucky to have us. We've got a great face, we know what we're doing and we have a lot of experience. Like you said, being a mother and living life, is huge and it really gives you so much common sense, and that you're not stepping into it as a new nurse, going, "I don't have a clue what I am doing." We've seen so much, life is a great education. But I think that was part of it, all of us together, it was a great group. We had such fun and came from such varied backgrounds and we were all going the same place, we were all trying to get back into it.

Maryann advises to returning nurses,

It's a huge learning curve and a lot of work. It's good and the support is there. The support was there during the refresher course, especially when, I don't know how anybody else would comment about this but, I needed, but I didn't like at the time, all the discussion we had about "how do you feel about this, about clinical at the beginning of each class," because at the time I was more—thinking! I've got to learn about these drugs, and the Dinamapp, and I've got to learn this and we are

sitting here talking about, "How did you feel," and looking back on it, I needed

that because that gave me the confidence. We bonded as a group, we pushed each

other along. We would get there early, waiting to see where we would go that

day. We would all chat about anxiety, but I didn't really realize that I had the

anxiety, but listening to them it was sort of like, okay, if they can do it I can do it,

so there was a lot of feeding off of each other.

In summary nurses recognized many benefits taking the refresher course, more

than just education and refreshing their skills. They also recognized that all thought they

were going it alone, but that there were many other nurses returning too, doing the same

thing, and they bonded and supported each other through the process. They praised the

stellar education of their refresher courses and had praise and respect for their instructors.

The specific benefits they shared were that they received encouragement, mentoring,

initiative, and knowledge to do nursing again; an increased sense of pride; an increase in

self-image; and a realization that nurses are needed and that there is something for

everybody.

Roadblocks to Employment

Many of the nurses expressed difficulties in finding employment. Of the 17

nurses, 14 (82%) shared things that blocked their progress to getting jobs. Sixteen of the

17 nurses reported success in getting jobs after the refresher course. Many, however,

shared concerns of the roadblocks to employment: *creating resumes*, *online job*

applications, *rejection*, and *job requirements of shiftwork*. These roadblocks are in no

particular order, but were important to the progress of returning to nursing practice.

Two nurses referred to the subtheme *creating resumes*. Erin said,

> I did struggle with my resume and it took a long time for me to put it together
> even though I had been encouraged to work on it in class weekly. But it was
> difficult to know what to put on it since I had been out of practice for a while.

Yolanda explained she too had difficulty

> writing resumes, but when I actually started applying for jobs, it was no longer
> filling out that checklist. It was very, umm, much, much more, narrative umm,
> goal driven, umm, which you know is kind of like that nursing care plan,
> definitely like coming full circle, you had to justify your accomplishments.

Other roadblocks these nurses described were about *job applications*, which 4 of
the 17 nurses reported. Katie explains,

> You know the job barriers seem to be that everything seems to be online and it's
> so impersonal and you can't talk to anyone anymore in person. But seeking a job
> now is just really different from what it was a long time ago, and I find that the
> cyber barrier to be just a little intimidating. Like everybody looks the same on an
> email resume, well not really, maybe that's not an accurate statement. It's just
> hard to get past online, they don't respond to you; you know you send in your
> resume and no one ever called back, it's a little daunting. Whatever happened to
> going in person to apply for a job?

Denise, too, says, "I put an application in online and waited, waited, waited, and
waited, and got a call back a couple of months later and didn't think much about it then."

Nancy also had a problem with online applications:

My divorce was final in February of 2008, and I immediately began to look through the newspaper for opportunities. I immediately began to apply online. And that was another thing that was very new to me, was most applications were submitted online to a very nebulous, nonresponsive audience and many, it took me a while to put my resume together and I had an old computer that a lot of it was stored on and, needless to say, it was difficult and I did have to wing it. I did a really poor job the first time around and not acceptable, but the second time was much better, through the help of the refresher course and you, once I was at GMU's refresher course. But I didn't hear anything back and it was like sending your life out onto the ozone [laughter].

I think not having an agency or a place to really know where to turn. Not knowing how to really direct my path, not really knowing what the requirements were, not knowing where to go to find them. Not having access to directors since they did do everything online was extremely difficult.

Online job applications were difficult for other nurses as well, but for a different reason: This time they couldn't even complete them. Jesabelle explains,

I finished in May, and I didn't look for a job immediately. So I took off the summer and started in September and I wanted to do [obstetrics (OB)], and the obstacles that I found, I could not get into the OB applications systems online because of the prescreening questions that they asked. I didn't have an associate's degree. So I got kicked out immediately. Half of them didn't even have diploma

program listed. So I couldn't even get in the system to fill out an application and

I found that very frustrating. So I thought why I even bothered taking this course,

since I couldn't even get past the first screen.

Six nurses of the 17 voiced frustration in trying to find jobs that would fit into

their lives due to the job requirements of shift work. Yolanda explained,

The economy took a plunge, and there was a hiring freeze in some of the local

hospitals and they were just hiring from within. So I think certainly there were

jobs out there but I have worked so many evenings and taken so much on-call

shifts that coming back, I didn't want those oddball shifts and I didn't want to

take on-call, and when I interviewed that's kind of what they were expecting me

to do, starting back as a new graduate. And I just wasn't going to do that. I am

not in a position that I have to do that.

Jesabelle said, "I would have come back earlier but the thing that kept me from

trying to do it was feeling like I didn't want to work in hospitals and do shift work." Lea

said,

I go online a couple of times a month looking for jobs at hospitals, nursing homes,

and the training center. I have even looked at volunteering as a nurse, because I

can't work full-time with kids, but I want to get my feet wet.

Susie, too, found shift work to be a problem when she inquired about nursing

jobs:

When I started looking out for different jobs and I started seeing what was

available in the hospitals and, of course, everything that was available was the

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night shift again, which my husband wasn't pleased about, they were telling me they wanted 2 to 5 years' experience with pediatrics before they would put you directly into a pediatrics position or you had to already be working. I also had another experience when I applied at ------- [name removed] and they were receptive. It was like, "We will take anybody." Please, oh yes, yes, yes. "We will love to have you, we will make something work," but of course, night shift, which to me, I have done my share of night shifts, and every time I moved I ended up on the night shift, I've done it all. At this point in my life I am just getting tired of that.

Rejection, a subtheme expressed by 3 nurses, began while the nurses were still in their clinical practicum working in the hospital, seeking a job, and up through the interview process. Susie said,

When I did my clinical at ------- [name removed], several of the nurses that I was in clinical with, were applying to ------- [name removed] and they were pretty much told that they [the hospital] prefer new graduates that they could mold and that they didn't particularly care for the returning nurses. Even though when we were there they were very nice to us, very helpful, very cooperative. But what we were getting from [human resources] was very different, "We want younger nurses, we don't want older nurses that have been out. We are able to mold the newer nurses as opposed to the nurses who have been out there for a while and have their own thoughts and ideas."

You keep hearing that *there is such a shortage of nurses* and I would have thought it was like "Oh yes we will gladly take you, you've got experience, we won't have to take as much time training you." But the impression I got was that I was going to be treated like a brand new grad and not being [given] any sort of credit for my past history or anything like that. And they did say that I would have to be in a program that was similar to what a new graduate would be where they have their preceptor—newbie assigned. It might not have been so bad but it was the tone implying that the new graduates would catch on much quicker, you know "You are a little bit slower, and you are up in your age and you are probably not going to be able to keep up with them." That was the tone I got when I was talking with them.

Jesabelle shared a similar experience:

I would say I was very successful but it wasn't without a huge amount of effort, perseverance, and follow-up, door shutting and mostly due to perseverance, not due to any particular, the process was not an easy one, it was not simple and it was not even welcoming. I mean I talked to the recruiters at Anne Arundel and they didn't even want to talk to me even though I had taken the refresher course, and we had done our clinical there; they didn't want to talk to me. As soon as they found out how long I had been out of the hospital they didn't even want to talk to me. They were not even receptive at all, they were pretty snobby. I didn't really want to work there but I was trying to get my feet in the door.

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Maria too, agreed,

> One thing I think is a real barrier to nurses returning to practice or beginning
> practice is the unfriendly attitude of the floor nurses to the student nurses. It
> hasn't changed in 25 years. They were obstructionist, unwelcoming in many
> cases, and downright sabotaging in some cases. And you see that in the hospitals
> where I have been with my relative who was receiving care. And it doesn't
> matter what hospital you go to, the poor students are not getting the support they
> need from the experienced nurses they have the right to expect. There is not
> mentoring going on. There is not backup, no support system, and I think, that that
> happened 25 years ago and I saw it happened as a nursing student for the refresher
> class, and I saw it as the relative of a patient in two hospitals recently over the last
> year and a half. Where current working nurses do not mentor or help the new
> nurses, they ignore them. They sabotage them subtly. They do not support them,
> that hasn't changed in a quarter of a century, there is something wrong with that,
> you know the phrase, they call it eating their young, and if I talk to other nurses I
> know they say, "Yeah, it's always happened and I don't know what we can do
> about it but it's a real shame," and I think nurses should hang their heads in
> shame.

> I have worked in many fields, I have worked in a university, in a graduate
> department, I had done many other things since my initial nursing and before I
> left. It doesn't have to be that way.

Marie also shared the job-description barrier that kept her from returning to work in a hospital setting:

In their job description, it said you have to be able to lift 50 to 100 pounds. That is not very practical place to start for a woman at my age. My husband works in building and trades, and construction workers are not allowed to move that much on their own, adult men who are construction workers. So it's not prudent, as a middle-age woman, to think about it and if they put that in their bylaws, that this is their requirement. What is their level of consideration for your back if construction workers are not allowed to do that legally? How can they expect nurses to do that and most nurses are middle-aged? So, that and the 12-hour days, I just decided that it wouldn't be for me, plus since I could choose, I didn't want to work nights or weekends since my husband travels; I would like to be home with my family. So the hours in the hospital, but the lifting and the moving were too much. But the hospital pays better; there are no two ways about that. But the lifting and the moving was a barrier to my returning to working in a hospital setting.

In summary, the roadblocks to returning to practice were reported as *difficulty with resumes*, *difficulty with the online job applications*, and *rejection*. The difficulty with the resumes was easily overcome. Many nurses, however, expressed great frustration over the lack of personal contact and response from employers when submitting online job applications. Two nurses found it disturbing and humiliating that they were unable to complete a job application online because they had diplomas in

nursing and could not complete the application by checking the box with what type of

degree they had. It made them question their decision to return to nursing practice. Job

requirements of shiftwork was the greatest theme reported by 7 nurses out of 17 since

they had already done shiftwork in their previous nursing experience. Three nurses were

disappointed and frustrated to be rejected as qualified nurses with experience by the staff

they worked with in the clinical practicum area and when inquiring for a job with human

resources department. Although these roadblocks occurred, they did not keep the nurses

from succeeding in returning to nursing practice.

Rewards of Returning to Practice

Sixteen out of 17 inactive registered nurses returned to nursing practice and

obtained jobs in the healthcare field. The goal of these nurses in returning to practice was

to gain employment; however, they found other rewards in returning to practice. The

subthemes of rewards of returning to practice were *personal satisfaction* and *job

satisfaction.*

Eight nurses shared *personal satisfaction* stories with me. Katie, wringing her

hands in excitement, shared

> I think I would have to say I have rediscovered a part of me, that of course I knew
>
> was there, but that I feel that I have rekindled it. I also realize that at my age now
>
> I am not what I was when I was working in my 20s in the critical care, and I loved
>
> that back then. But I don't have any desire for that now. But I feel like I have a
>
> place in nursing, in the community, outpatient sector, and I still need to pursue

that more fully, and I am on my way there. That much I have realized, that I think

that's my comfort level, my area of interest, and what I want to do.

Yolanda agrees: "So I think returning to practice, for me, is stimulating. I am in an area

that is personally rewarding as well as, I guess, I am getting positive feedback, which in

the past I can't say I always got."

Maryann shared,

I enjoyed the refresher course, enough to know, I was ready to do nursing again

[smiling], but I didn't know if I would be successful at it again. But I had

confidence to go and try it again. And, uhh, I got a love of it back again, that I

was like, "Okay, I really, I really like nursing." I picked the right thing. How

many years ago? In 1977 whatever that is, I picked the right career. This is for

me. Nursing is so large though, you, I kind of knew that during the refresher that

I was going to find a place for myself, that it's so big now, that during the

refresher you didn't know what would be the way for me to go now. As opposed

to I used to be critical care and teaching at a university level. So it was like, you

didn't really know, except I did know that I really did want to go back to patient

care. I wasn't going to do anything else but go back to patient care. First, that

was defined in the class. It was defined for me in the class. I didn't know what

area, I didn't know hours, all of that kind of stuff.

Reflecting, Jesabelle explained,

It was a very difficult process. It has kind of opened up a different chapter in my

life, with the kids growing up and leaving; we have four of them out and on their

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own way, and not to have that sense of being needed, even though they do. It has reestablished a different part of me. That I've never really seen myself as a nonprofessional person, I have really grown a lot just doing the refresher course and just completing it. It was really good for my self-image, which wasn't bad before, but it is a little extra sense of pride, persevering through all of these processes, having to interview and all of those things that I haven't had to do for a long time. That was good to overcome those obstacles, growing in a whole other area. I have the feeling like I am doing well at my job and I make a difference.

Victoria said,

When I finished the refresher course, I knew at that point in time that what I really need to do was to pursue my education, and it was very clear to me that if I wanted to be really effective, I needed to have a much broader perspective and pull a lot of the pieces of the puzzle together in my practice. I enrolled in an online master's program and took one course at a time. And, two years later, I will be graduating in May with my master's in nursing education.

Ten nurses shared stories of *professional satisfaction*. Many talked about how they felt valued. Erin said,

I got a job teaching in a refresher course; the transition is still challenging here 18 months later. But returning to practice is definitely worth the effort, it's hard, but the benefits outweighed the negative parts and I feel valuable. I feel like I have had a lot of experience and education in the past and I feel like that is valuable too, people still need me to do that, so I feel like, umm, I am doing a good deed,

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umm, so to speak, I am paid well and my talents are being used or utilized

appropriately, and I think that is a good thing. And it feels good.

Yolanda explained,

I did find a company that was just opening up; the gentleman…he has no medical

background at all. I bring a lot to this company as a nurse. I do a lot of research

to help them but it's a good fit right now. It's a home care company and we help

out with activities of daily living. I feel good when I am there. From my nursing

background I teach these people about care plans, expectations, follow through,

and evaluation.

Jesabele emphasized,

I got the director of the birthing center, her name is Ann, and I told her I was an

RN and I was a Lamaze instructor and I was looking for work in OB. She said,

"Did you see my ad?" and I said, "No, I didn't know anything about an ad but I

would really like to come in and talk to you." And so we talked on the phone, for

a bit, and so I went in and talked to her and she hired me. I work on call, I make

my own shifts and I love it. It's exactly what I always wanted to do. It was

divine intervention that I called her that day, and that she was willing to have me

come in and talk to her. So I have been there for a year and I love it.

Priscilla, who took a job in home health, explains,

It's an ongoing success, because, like I said, I am learning as I go along. I am

learning all the time, really feeling comfortable and confident again. I kind of

always thought I wanted to be a professor, because I love teaching, so this is my

thing. Instead of teaching students, I teach my own little students who are my

patients, and I make them feel that they are empowered by the time I leave, they

know what they are doing and they can call the doctor because they know when

something is wrong, whereas when they first come home from the hospital they

don't have a clue. So that is a lot of what I do, is teach. I've had patients that are

like, "Oh my gosh, I wouldn't have known what to do without you." I do know,

that's the reason for the job.

Nancy explained,

It's been very successful in my career. Umm, it took a while to get back on my

feet and feel comfortable and regain my skills. But I have come to the place, after

just a year, where I feel very much as an asset to the company.

Maryann proudly shared,

I had the interview for two jobs, I was offered both jobs, and was told… "No, you

have this great critical care background and you definitely should be on telemetry,

you know, think about it." I didn't know if I had the confidence to do that but I

did!

In summary these nurses shared many unexpected rewards that they received in

returning to practice: personal satisfaction, job satisfaction, and benefits of the refresher

course. *Personal satisfaction* was shared as a reward that many nurses received in

returning to practice. Some of them reported it as getting a love of nursing back that they

didn't expect; others discovered that they gained self-confidence in returning to nursing

but were additionally stimulated to further their nursing education by taking additional

courses, certifications, and advanced nursing degrees. *Job satisfaction* was not just

acquiring a job but being fulfilled in caring for patients with pride again. These nurses

explained they felt great satisfaction that their nursing skills were back, they were

proficient in their care delivery in a variety of healthcare settings—including community,

home health, hospice, intensive care unit (ICU), emergency departments (ED), pediatric

clinics, birthing centers, and outpatient surgical centers—and that they were given praise

and told they were valuable assets to these healthcare area, which many say they had

never had before.

Advice for All RNs

The final category is *advice from returning nurses to all nurses*. It is something

all 17 nurses shared when asked the last interview guide question of, "Is there anything

else you want to share?" They gave general pieces of advice that are not easily

categorized but are lessons they learned about themselves and the process of returning to

practice. Their hope is that other nurses will benefit from their advice.

Katie said,

I would like to say one thing before we go. If I had to do it over again, I think,

and I would say this to anybody, I wish I had figured out a way to stay in nursing.

Because I was talking to a nurse who has stayed in the [operating room] all these

years and a nice financial nut she is sitting on, but it's not about the money. My

husband's schedule was such that he was always gone. But I think if I was

stronger I could have pushed that a little, I should have figured it out even if I

could have done a weekend a month, and it would have fulfilled a number of

things, like family, not so dependent on you for everything, like you know the
doormat syndrome. And, you know, I think I catered to my husband…. But I
always felt because I wasn't working full-time that my job was to be at home.
But I wish I had been savvy about this, to think, "Wait a minute, we can do this
another way…."

I think it would have gone a long way to cement or at least fortified a
confidence level, and make it easier to segue when you get to the empty nest,
going back, you know. I have to admit, I would counsel a younger person to do
that because I think it can be done. And yet, it might be a little difficult at first,
but you get into the rhythm of it. It's okay that it is kind of a "should of, could
have, would have," and it definitely has been a thought over the last year.

Lea explained what she discovered after being out so long:

I love all my family and all that I do, and it's important work for me what I do.
Um, but I guess I wish that there had been a compromise. Maybe that is the
solution, just finding somehow to be doing something in nursing. Just something!
And so I feel like I just am falling short of having that goal. I feel like I have
fallen short and I am disappointed. I think the other thing for me is, well, the kids
aren't always going to be around and so I don't want to be at this point years from
now and just be looking and thinking, "Oh but now what do I do?" I want to have
something that I am planning for, so I feel like I can still use this experience in the
refresher course to get me to that point, so I am glad I went through this process.

Trixie explains the benefit of having her bachelor's of science in nursing (BSN) when returning to practice:

> To every young person who I talk to that shows the remotest tendency to go into nursing, I'd like to say "Do it, just go through it, get your bachelor's," because I never knew 25 years ago the decision that I made then, to get my bachelor's in nursing I never dreamed how much it would benefit me. Even though I hadn't worked in 17 years, because I had my bachelor's I was able to get a job, as a community health nurse [level] 3 and get a great salary, it was just profound. So I encourage women, "Don't stop at the RN, just go get the bachelor's while you're still in school. You will be so glad you did, it will just benefit you so much. You never know down the road." I never thought I would go back into nursing. I don't know what I thought I would do. But all of the sudden it was just a season in my life where, yeah, I think I will do that and it's been wonderful.

Priscilla said,

> This is my advice: take a refresher course. It is really what helped me and made me feel like I could do this. I think that my biggest barrier was thinking that I've gone to long, I'm kind of over the edge, and I'm not going to be able to do this. The refresher course is what gave me the knowledge that I can do this and that there is not really that much there. The basics are there, you just have to learn those little extras and tweak them and you are good to go.

Victoria tearfully explained,

> There is something to nursing as a specialty, because it's fun, and the great thing
> about it, is that it blesses your whole life, and you learn that nursing has relevance
> to everything. Nursing is a great vocation…you have to get a refresher because
> you don't know what you are missing. So I am a big advocate for those coming
> back to practice to get some formal instruction and mentoring so that you know
> how to jump back in.

Nancy said,

> There is a lack and a need for some way to direct nurses back into the process,
> some method of connecting people. Maybe hospitals need to recognize that that
> is a problem and if they want nurses to come back, then they need to have
> something on their website that says "If you are a nurse returning to the field,
> please," or "This is the link [for] you."

Katie explained,

> The other thing I realized is that you don't have to stop here, with the refresher
> course. It's something to reconsider to keep going and get your master's degree.

In summary, all 17 nurses expressed lessons they learned about themselves in returning to practice. They felt a need to share their experiences with current and future nurses in reference to how to stay in nursing and keep a nursing identity, the value of obtaining a BSN, the benefits of a refresher course in helping to return to practice, and the need for a formal pathway to help return to nursing.

Summary

I asked three research questions in this study. After completing the research and analyzing the data, I discovered that research question 1 was what the data fully addressed. Research questions 2 and 3 appeared to be subquestions to research question 1.

Research question 1 asks, "What are the experiences of inactive registered nurses returning to nursing practice?" Seven categories emerged from the data: *the reasons to return*, *factors that inhibit returning*, *barriers of a refresher course*, *rewards of completing a refresher course*, *roadblocks of employment*, *rewards of returning to practice*, and *advice for all RNs*.

During the interviews all of the nurses shared specific reasons why they returned to practice. From analyzing the data, two specific subthemes emerged. The first subtheme nurses explained they returned to nursing for was for self-fulfillment. The second reason they returned to nursing practice was for financial needs. The rest of the categories will be answered in research question 2 and research question 3.

Research question 2 asks, "What are the barriers to returning to practice that inactive registered nurses perceive?" Inactive registered nurses explained in their interviews that there were several factors that inhibited them from returning to nursing. All 17 nurses shared during their interviews that lack of confidence and self-doubt were their main inhibiting factors in returning to practice. Many nurses expressed specific barriers, most of which had something to do with the process of taking refresher course in an effort to return to practice. This category encompasses the barriers that these nurses

shared but groups them into what was referenced as occurring before, during, and after the refresher course.

There are five subthemes of a refresher course: *difficulty locating refresher courses*, *expense of the refresher course*, *time obstacles of the refresher course*, *barriers of clinical practicum*, and *family obligation as a barrier of the refresher course*. Each of these subthemes had several subthemes of their own that further break down the barriers in detail.

The third and final research question was, "How do these nurses overcome the barriers encountered and experienced in returning to practice?" All the nurses stated that they began by discovering what it is they needed to do to return to practice. Once they recognized the need to take a refresher course, they located the appropriate one for them and then completed the course. Many nurses said that their successes began when they participated in the refresher course. Most of them expressed praise for the course; others wished it could be more practice specific, not just a med/surg review. These nurses expressed surprise and gratefulness for the unexpected benefits and rewards of increased self-confidence and the support they discovered in their newfound friendships. All of them discovered that they were not alone in returning to practice; there were many other nurses just like them also trying to return. Most of them praised the "camaraderie of the group and the instructors" for helping them succeed in returning to practice and advised that they could not have done it without them.

In the midst of their success, these nurses also discovered that they encountered roadblocks to employment that they had not anticipated. They explained that the

refresher course had provided them with many of the skills to succeed in seeking employment but that there were unexpected difficulties in getting a job. The subthemes of "roadblocks of employment" involved *the creation of resumes*, *the process of online job applications*, *unanticipated rejection*, and *the continued job requirements of shift work*. The support of the instructors and comrades from the refresher courses helped the nurses to persevere and succeed through these roadblocks. They felt a bond to help each other succeed and many of them kept in touch after clinical, some for months and some for years. They shared information from their first day in class, family struggles, and their successes and disappointments with job searches and interviews. Emails sharing advice and possible job interviews began in class and have continued for many of the nurses.

The anticipation of a job and the desire to return to nursing was the greatest expectations these nurses had in returning. Since they received much more than they expected, they passionately shared what they learned individually in returning to practice. These rewards were categorized in two subthemes: *personal satisfaction* and *job satisfaction*. When asked at the end of the interview if there was anything else they wanted to share, every nurse shared a little advice from the lessons they learned in returning to practice, to all registered nurses.

Although this chapter relates to what was revealed in the data, chapter 5 will lend support to the data through reflecting on the literature review and implications for practice, education, and policy.

CHAPTER 5. CONCLUSIONS AND RECOMMENDATIONS

The purpose of this study was to discover the experiences of inactive registered nurses and the barriers and successes they encountered in returning to practice. In the first section of this chapter, the results presented in Chapter 4 are discussed in relationship to the current literature. The second section describes implications for education, practice, policy, and further research.

Discussion of Findings and Their Relationship to Existing Literature

Significance

Few studies begin to address the experiences of inactive nurses returning to practice. This current study adds a significant contribution to the nursing literature regarding the nurses, their experiences, and the barriers and successes they encountered in returning to practice. The following discussion presents the significance of returning nurses to active practice and the five main categories of findings that are new to this topic. These nurses explained in great detail what helped them to decide to return and their experiences throughout that journey. Each nurse included the barriers she encountered as well as the additional rewards she gleaned beyond returning to the workforce. It is important to consider all the experiences these nurses shared since only a few studies have recently begun to address nurses' experiences (Asselin et al., 2006; Hammer, 2005; Langan et al., 2009) in the returning process in the United States.

In fact, since the nursing shortage continues, new avenues are needed to attempt to decrease the shortage.

Refresher nurses are educated and licensed and can help decrease the shortage, but they have not been collectively solicited to help in this current shortage. They also bring added value to nursing today with their previous nursing experience, rejuvenated compassion, and life experience. During her interview one nurse shared that she now had time to care, whereas before in nursing practice, she was too busy.

Through face-to-face interviews in March 2010, 17 inactive registered nurses related what they experienced in returning to nursing practice. Their responses were grouped into seven categories. The true meaning of what it is to experience returning to practice was shared by these nurses, not just the barriers and successes that they encountered.

Reasons for Returning to Practice

Due to the many factors such as time, family, and finances affecting a nurse's life, strong incentives are necessary during this shortage to encourage a nurse to return to practice (Hammer, 2005). Lewin's (1939) force field theory is consistent with this notion, since one set of forces has to outweigh the other for change to occur. My study revealed that the main factors that affected a nurse's decision to return in this shortage were self-fulfillment and financial reasons.

As in previous studies (for example, Asseslin et al., 2006), returning to nursing practice for financial reasons is supported by the responses of 7 of the 17 nurses (41%) that were interviewed. However, I found that the number one reason to return to nursing

practice was for *self-fulfillment*. This was minimally addressed by Barriball et al. (2007) and Hammer and Craig (2008), who also found financial reasons to be one of the most motivating factors that influences the return of inactive nurses. In my study, for 10 of 17 nurses (59%), their need for self-fulfillment was the most cited factor that motivated their desire to return to practice. Comments from these nurses varied from, "I need intellectual stimulation again," to, "Previously in nursing I felt validated in my nursing practice; I need that again," indicating that returning instilled a better understanding of the value placed by nurses on being professional nurses. This study revealed nurses do not perceive nursing as just a job: It leads to a fulfilled life. This conclusion is supported by my experience with nurses in previous refresher courses.

Additionally, nurses who have felt a special calling to the profession often want to return after family responsibilities have taken a back seat in their lives (Hammer & Craig, 2008; Hawley & Foley, 2004; Huggins, 2005). These nurses might have left active nursing as they began building a family and now return looking for the profession that provided them with a sense of belonging. The fulfillment and sense of belonging might be labeled "esteem" according to Maslow's Hierarchy of Needs (Huitt, 2007). This current study found that when nurses return to practice, they reengage themselves into nursing, contribute to their knowledge and skills, and feel accepted and valued again as "professional nurses." Alden and Carrozza's (1997) study showed nurses had an increased self-worth after completing a refresher course.

Barriers to Returning to Practice

The second main contribution from this study was identifying various barriers to returning to practice that were shared by these nurses. These barriers were grouped into several categories. The first identified barriers reported as occurring *before* taking a refresher course, barriers that were identified as inhibiting factors to returning to practice. These nurses shared a lack of confidence and self-doubt in themselves and their ability to return to active nursing. Inactive nurses' lack of confidence and less-than-adequate nursing skills were addressed as reasons nurses fear returning to nursing practice in studies by Langan et al. (2007) and Hammer (2005).

Another group of barriers these nurses faced was categorized as *barriers of a refresher course*. This category is comprised of five barriers that nurses had to overcome *before* a refresher course was taken and *during* participation in the refresher course. The barriers these nurses discovered after making the decision to return to practice included locating a refresher course, cost of the refresher course, time obstacles of the refresher course, barriers of clinical practicum, and family obligation. Motivated to return and with a goal in mind, each nurse must discover what the requirements are to return to practice. The current nursing literature does not identify any mechanism for a nurse to follow to return to practice. When previous nursing shortages occurred, refresher courses were offered as options to update nursing skills and knowledge.

Each State Board of Nursing has a process in place for nurses to return to practice (Table B1, Appendix B). However, these nurses found that access to this information was not clear or efficient. Many of the nurses complained that this process was very time

consuming, deterring their drive to succeed. In addition, although the Internet can be

searched for courses, many are online, and access to the location and details of the

courses was a difficulty stated repeatedly by nurses considering a return to the profession,

thus creating a second barrier to their already weakened confidence in returning to

practice.

Once the barrier of locating a refresher course was overcome, the barrier of

paying for it was a major concern. The literature shows the cost of refresher courses

ranges from $600 to $2599 (Consolidated Learning Systems, 2008; Northern Virginia

Community College, "Tuition and Fees," n.d.). A difficult decision was made by several

nurses in my study to spend a large sum of money and not even know if they could get a

job in return. Two nurses in this study shared that they cashed in stocks and bonds to pay

for their courses, in hopes of getting what they considered a good return on their

investment. Considering that they did not have jobs to begin with, this was a financial

strain they chose to incur. Several nurses in this study referred to the cost of this

refresher course as "the best money I have ever spent." This suggests that nurses are

willing to make great sacrifices to return to practice. Minimal references in the literature

address cost issues of a refresher course. Reported in the literature were startup costs of

beginning a refresher course, and comparison of refresher course cost versus hospital

costs for orientation of experienced nurses (Burns et al., 2006; Gottlieb, 2002).

It is difficult to determine the monetary value of a refresher course since there is

no standardization of refresher course requirements; they vary in length and cost. Each

state has its own requirements for inactive nurses. Requirements could range from

requiring a nurse to pay only $75 and complete 20 hours of continuing education to become active again, to requiring her to take an approved refresher course with specific curriculum, didactic, and clinical hours at considerable expense and investment of time (Mississippi Board of Nursing, n.d.; Table B1, Appendix B). These nurses have to invest a great amount effort in the process of returning to practice. As a society, we all benefit from the returning nurses' perseverance and experience, yet are deterring inactive nurses from returning by not providing consistent information that helps them to return. Because there are inconsistencies nationwide, standardization of requirements and curriculum would ensure that all nurses receive the current state of the science in nursing education and practical application of their skills sets. Mentoring the returning nurse in a clinical setting would produce a better product. Durand and Randhawa (2002) reported that British employers valued returning nurses over new graduates, inferring that the new nurses were less than adequately prepared. In this current study 6 out of 17 nurses (35%) were master's-prepared nurses.

Financial concerns were another major barrier. Research suggests that scholarships should include nurses who are enrolled in refresher courses. Most of the funding from the Nurse Reinvestment Act supports educating new graduates and new nurse educators (American Associations of Colleges of Nursing, 2002). This current study shows that updating nurses through coursework and practice produces a superior product, in a shorter period of time, since they are already educated as registered nurses, licensed, experienced, and invested in returning to practice. Additionally, more nurses can be put into the workforce in a short period of time since refresher courses run from 6

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weeks to 3 months, with independent studies allowing each nurse up to 1 year to complete. It takes 4 years to educate a *new* professional nurse at a cost of approximately $100,992 (George Mason University, "Undergraduate Tuition," 2011). Clearly, it is economically advantageous to bring nurses back for a fraction of the cost it takes to educate new nurses, thus lessening the nursing shortage.

Three other barriers were identified within participating in the refresher course: *time obstacles of the refresher course*, *barriers of clinical practicum*, and *family obligation*. Hawley and Foley (2005) reported time and family obligations had to be overcome when taking a refresher course. The investment of enormous amounts of time required to read and absorb the material was cited as a barrier by all 17 nurses (100%). Although many shared this concern, all stated that they completed the readings—but, voicing how overwhelming it was to accomplish, they feared that they had not been able to retain what they had read. By contrast, many were surprised how much they remembered from their original nursing education and experience and how interesting it was to read the new details of research and evidence of each body system. Several reported their textbooks as being their "bibles" for the first year of their returned practice.

Technology was the final barrier reported in various research studies as a part of the changing practice environment (Barriball et al., 2007; Goodin, 2003; Hammer, 2005). In this current study, technology had many meanings. Within the barriers of clinical practicum, the subtheme *advances in the use of technology in providing nursing care* was a prevalent barrier. Historically, medication administration is a basic core skill of nursing practice and therefore not new to these nurses. However, since there has been integration

of advanced technological processes such as increased use of computers, organization-specific patient identifiers, bar coding systems, and computerized medication dispensing systems, these nurses felt inadequate to complete a job they previously had mastered. They were only able to overcome parts of these barriers within the limitations of being "student nurses" in their practicum. Furthermore, healthcare facilities did not allow them to completely employ the technological processes most currently used in each facility. This was somewhat humbling, since they are knowledgeable nurses who needed to learn these new processes.

An additional technological barrier was the *computerized documentation system*. As one inactive nurse said, "Just give me a piece of paper and I can document my nursing care in 10 minutes." The advanced technology of computerized charting was frustrating and required training, passwords, and supervised charting. It was time consuming and unfamiliar to these nurses, again adding to their frustrations and lack of self-esteem. In 2006, Burns et al. began to address this problem by creating a refresher course promoted as state-of-the-art by integrating Internet use and high fidelity simulation. The majority of the nurses in my study, upon completion of the refresher course, overcame the barrier of computerized documentation. In fact, they explained that because of their newfound confidence, they recognized that patients are still sick, nursing care is the same; just the process and new technologies have changed.

Not only did this study discover barriers to returning to practice, it discovered rewards as well. Nursing literature supports the idea that those who return to practice receive *rewards from completing a refresher course*, as evidenced in Hammer's

dissertation (2005). All 17 nurses (100%) in this study praised, in one form or another, the refresher course. Many nurses described the emotional benefits they gained from completing the refresher course. Others described the significance of support from their classmates that resulted in unexpected camaraderie. Unsolicited, these nurses explained their successes with taking a refresher course.

Rewards From Completing the Refresher Course

To that end, their responses were grouped in a category *rewards from completing a refresher course*. It would be easy to assume that the main reward was that these nurses benefitted from new employment after completing the course. However, many nurses explained that after they completed their refresher course, they gained a love for nursing again. Indeed, they gained self-esteem from being competent to practice nursing again. In this study the nurses exclaimed that the camaraderie they formed in their refresher courses was what got them through, bonded them, and helped them to persevere in the course and afterwards in their jobs. They related that the importance of the newly found friendships they made and how much support and mentoring by the instructors and each other was paramount to their success. Mentoring has been discussed in nursing literature, occasionally referred to as *camaraderie* in reference to refresher nurses (Barriball et al., 2007; Hawley & Foley, 2004; Hammer, 2005).

Roadblocks to Employment

Furthermore, it is important to recognize that once these inactive nurses overcame many personal barriers to return to a service-oriented profession, further barriers to their success occurred after completing the refresher course. In fact, just when they are

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prepared to enter the workforce, they ran into roadblocks to employment. This barrier

consisted of several subthemes: *online job applications*, *rejection*, and *job requirements*

of shiftwork.

In a time when the media continues to proclaim that there is a United States

nursing shortage, all 17 of these returning nurses (100%) assumed that getting a job

would not be difficult and that employers would welcome them back. These nurses

reported the difficulties of using *online application systems* and how unfriendly and

impersonal those tools appeared. With the increase in technology for employment

applications, it might be a reason why more nurses do not return if they are initially

rejected by a *computer* when applying to a service-oriented profession. Many of the

nurses shared that they used to be able to talk with a person at the beginning of the

application process, but that these days after the application was sent, many times there

was no further communication from the healthcare environment. This deterred them

from continuing the process.

In this study, nurses stated this lack of feedback was another form of rejection—

and they had not even returned to nursing practice yet. In a time when the country

continues to need nurses, this is may not be the best business practice. The impersonal

process is discouraging to many returning nurses who are more familiar with an

appointment with a nurse recruiter. Several nurses could not even get through the

process of completing the application because they had graduated from a hospital school

of nursing. Some nurses ran into barriers due to not being able to list their nursing

education since the application only had only boxes to check for associate's, bachelor's,

and master's degrees. Without a degree in nursing (such as a nurse with a 3-year diploma), a few could not continue the application process. This was one more barrier to add to the list the nurses encountered, providing them with yet another form of rejection in their journey to return to practice.

Further rejection was experienced by 3 nurses (18%) in their clinical practicum, and at job interviews for the remainder of the group (14 nurses, 82%). Many applied to hospitals, yet only 2 of the 17 (12%) found jobs in the hospital setting (one on the acute care units, and one in a clinic). One nurse (6%) has not yet found employment that meets the needs of her family. The majority, 14 nurses (82%), found jobs in the community setting. The perception of the public and of most nurses is that nurses returning to practice return to the hospitals. The disappointment is that although many of these nurses believed they would return to a hospital, they discovered that they were not welcomed.

Job requirements of shiftwork were a pervasive factor discovered when nurses applied to work in acute care settings. Hospitals for the most part offered 12-hour shifts, and night and day rotations. All 17 nurses (100%) voiced that they had done their time or paid their dues again with these shifts and hours and previous on-call shifts, which is supported in the literature (Barriball et al., 2007). These nurses expressed resentment in being asked to take undesirable shifts, start at new graduate pay, and be required to take new graduate internships—making them feel no credit had been given for their many years of previous experience, service, and education. Many nurses voiced feelings of humiliation that they were not being given a choice, but were just informed they would be treated like new graduates. Here is another point of rejection and disrespect. As one

nurse stated, "I believe the public has more respect for nurses than we as the nursing profession do for ourselves." This might be a major reason why nurses do not always return to nursing practice. This type of mistreatment is considered horizontal violence, which describes distasteful behavior by nurses such as criticism, sabotage, and undermining sometimes portrayed toward colleagues. Asselin et al. (2006) also discussed the report of horizontal violence and related how it hindered the nurses in her study when returning to practice.

Rewards of Returning to Practice

The wonderful things reported by these nurses are that they found rewards of returning to practice in addition to getting a job. *Personal satisfaction* and *job satisfaction* were the rewards they most talked about. These nurses described the depth of personal satisfaction as feeling fulfilled and valued as a person; and in their jobs shared how important it was to be teaching and educating their patients, and having the time to do it now versus when they practiced last. Many felt strongly that they were making a contribution again.

Summary

In summary, the number one reason inactive nurses in this study returned to practice was not for financial necessity but for self-fulfillment. After each nurse had made a mental commitment to return to practice, she was hindered by barriers in her search of what to return to. Inhibiting factors such as a lack of confidence and self-doubt begin to discourage them on their journey. Undefeated, they continued on to discover what they needed to do next. Since there was no clear pathway to return to practice,

many nurses turned to the Internet to search for answers, solicit state boards, and search for refresher courses. Here they begin to be delayed again with unexpected barriers to taking a refresher course including distance, cost, financial sacrifice, and time away from family.

Discovering that they were not alone in their plight, these nurses were rewarded in their course of study by the camaraderie that was formed in their refresher courses. Each nurse shared that they regained their self-confidence from taking the refresher course. Empowered to succeed, these nurses began the chore of seeking employment—only to discover there were more barriers to impede their success. They framed the problems under the theme of roadblocks to employment.

Using online technology to complete job applications and send them out to be reviewed with little human contact or response caused fear and rejection. These nurses also explained that recruiters and other employed nurses discouraged them by repeatedly asking "Why would you come back to nursing?" and some were even told to "Stay away from nursing." Sixteen out of 17 nurses (94%) in this study were not discouraged by this horizontal violence and continued undeterred in their search for a practice site. They looked for employment in an institution were they could return to practice and gain personal satisfaction by providing compassionate nursing care and education to those in need. Only one nurse (6%) said she did not regain employment due to the family-unfriendly hours of the healthcare system.

Implications for Education

One strength of this study was the implications for education that were revealed. First, educators of fundamental nursing education need to instruct their nursing graduates on how to return to practice if they take a leave of absence. This must be accomplished before they leave nursing school so that they know what path to take when they choose to return from an absence. This could be accomplished by having them seek the counsel from their state board of nursing for the mechanism to return.

Second, there should be national standards by which all refresher courses are developed, thereby increasing the integrity of the course and ensuring the best course availability for everyone. The National Council of State Boards of Nursing could be asked to assist in this area. Institutions that teach the refresher courses need to advertise publically, with the state board of nursing and with the healthcare settings that hire nurses, about their courses, their availability, and curriculum content. This publicity will enhance awareness and availability of the course. The course reading should be offered to the students taking a refresher course several weeks before the first class day to decrease the stress and barriers of the overwhelming time it takes to read and absorb the vast amount of material covered in the condensed refresher course. This was a common complaint of inactive nurses in this study and a barrier revealed in the interviews.

Third, there need to be more classroom-based refresher courses introducing advanced technologies with an accompanying clinical practicum. Partnerships with healthcare agencies could enhance these courses and meet the needs of the inactive nurses returning to practice. This study shows that many inactive registered nurses want

to be able to have face-to-face contact with the instructor and their peers to further help them succeed in returning to practice.

Lastly, refresher course designers need to include some of the newer technological processes, not once but over a period of time in a simulated practicum/lab so the refresher nurse can digest and improve her or his skills without the intimidation and slowness factors. Nurses innately want to be prepared to provide great nursing care; they do not want to feel inadequate. This technological preparation could increase the trust factor of patients, a key component of nursing practice today.

Implications for Practice

Healthcare agencies that hire registered nurses need to be aware of all the refresher courses. They also need to be knowledgeable of the components of the refresher courses in order to better encourage, not discourage, nurses who are returning. Most of the inactive nurses in this study reported that if they had been told when they were leaving nursing that if they worked as little as one weekend a month, that would have helped them remain current enough in nursing practice. These nurses suggested a possible solution to one of the barriers of not knowing what one needed to do to return to practice: They suggested that at a nurse's exit interview from practice, they be informed of the options for working in nursing and/or be directed as to who they need to contact to discover what it is they need to do to return to practice. Practice settings should offer guidance as nurses leave practice regarding what the criteria is to return. These nurses have discovered that having the education and maintaining one's license is *not enough to get a job*.

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Implications for Policy

Recruiting inactive nurses can help lessen the current nursing shortage if steps are taken to ease their access to return. Each state board of nursing should have a clearly identified page/link to the requirements each nurse needs to complete to return to practice. As with the NCLEX exam which measures minimum safe knowledge to practice, an additional set of standards for refresher course development should be created to ensure standardization and outcomes for enrollees. With uniform expectations from refresher course participants, healthcare agencies could expect to hire an educated and well-rounded nursing force. Currently there are no national standards for refresher course development. Standardized refresher courses should be listed on these links. It would be helpful if nurses were reminded at their license renewal time where to find available guidance if they choose to become inactive and later choose to return. There should also be an information page at the National Council of State Boards of Nursing (NCSBN) website that unites all links to each state board of nursing, so the inactive nurse can locate state-specific requirements. NCSBN should create standardized requirements for refresher programs.

Implications for Further Research

This study provides support for recruiting inactive nurses, support for organized refresher courses, identifies the barriers of returning to practice, and details how important it is to persevere through the barriers and succeed. Additional research is needed to identify additional barriers and suggest ways to eliminate identified barriers that nurses encounter when they choose to return to practice.

Additional research is needed to support the return of inactive nurses by comparing the cost of educating and training new graduate nurses versus inactive nurses over the course of the first year of healthcare employment. Research comparing those hired at the same time (new graduates of nursing and returning nurses) in regard to recorded practice errors, specifically medication errors, could add value to returning nurses. Additional research should include a comparison of retention rates of recently hired inactive nurses and new graduates. Healthcare agencies should be involved in the refresher course curriculum, in order to provide content items that would make the refresher nurse a viable candidate for employment. A much-needed study is to request that healthcare agencies hiring returning nurses after refresher courses identify what is needed to better influence refresher course programs.

Finally, a replication of this study in regard to the inactive nurses and the barriers and successes they experience in returning to practice—especially in the current environment of economic downturn—might yield similar or additional barriers and successes which could further explain and perhaps provide additional solutions to the current nursing shortage.

This study contributes to the body of literature of inactive nurses in this current shortage. In a time of need for registered nurses, it is important to remember that these inactive registered nurses can make a practical contribution to the nursing shortage. They are underused and not invited as a whole to return to nursing practice. Yet they are licensed, knowledgeable, and experienced in providing great nursing care. Refresher course nurses practice professional nursing care with compassion in a variety of settings.

Refresher programs provide caring, engaging, nonthreatening environments that promote opportunities for lifelong learning and service that considers the needs of the community of interest.

After deciding to return, these nurses are dedicated to updating their knowledge base and nursing skills and are now known to persevere through many barriers and gain many successes that benefit patients through a variety of healthcare settings. These nurses can be reeducated at a lower cost than that for training a new nurse. Finally, this study adds to the body of knowledge of nursing in education, practice, and policy with respect to providing a voice for the experiences of inactive registered nurses and revealing minimally cited barriers and successes to returning to practice.

APPENDIX A. TABLE OF INACTIVE NURSES' REASONS TO LEAVE AND RETURN

Table A1

Inactive Nurse Reasons to Leave and Reasons to Return: Chronology From the Literature

Author	Study	Date	Reasons to Leave	Reasons to Return
Frye	A study of the effectiveness of RN refresher courses in Washington State	1986 Quantitative Dissertation	Marry and raise children (69%), burnout/ disillusionment with profession (11%) (p. 74)	Update knowledge and skills (34%), regain employment (30%), return to acute care nursing (22%), regain confidence (12%) (p. 78)
Shore	Identification of factors which would attract inactive registered nurse back in to the hospital setting	1990 Quantitative Dissertation	Family responsibilities, child/ elder care, inadequate finances, stressful work environment, inflexible schedule	If returning to hospital work, adequate salary, flexible scheduling, 20 hours or less work per week (p. 132)
Porta and Pearson	"Refresher Courses for the 21st Century"	1997 Survey		Update skills and knowledge, increased financial need, self-fulfillment/self-esteem
Hawley and Foley	"Being Refreshed: Evaluation of a Nurse Refresher Course"	2004 Survey		Return to nursing practice, children are older, change in marital status affecting income
Huggins	Article " Registered Nurse Refresher Course as an Adjunct in Nurse Recruitment"	2005		Single parent needs income, change in marital status, increased financial need due to failing economy
Jones	"Factors Contributing to Voluntary Inactive Licensure status in New Mexico Nurses and the Potential for Change: Implications for Nursing Practice"	2005 Quantitative Dissertation	Workplace-related factors are a greater reason to leave than personal satisfaction factors	Change in workplace-related factors were need to return

Table A1 (continued)

Author	Study	Date	Reasons to Leave	Reasons to Return
Roberts, Brannan, and White	"Outcomes-Based Research: Evaluating the Effectiveness of an Online Nurse Refresher Course"	2005 Quantitative	Literature review says family commitments	Need for extra income
Hammer	"The Experiences of Inactive Nurses Returned to Nursing After Completing a Refresher Course"	2005 Qualitative Dissertation		Financial benefits, something to do after children grew older, a purpose in life (p. 73)
Williams et al.	"Inactive Nurses: A Source for Alleviating the Nursing Shortage?"	2006 Quantitative	A conflict between parenting duties and scheduling requirements at work	If given the opportunity to work part-time, at flexible and shorter shifts
McIntosh, Palumbo, and Rambur	"Does a Shadow Workforce of Inactive Nurses Exist?"	2006 Quantitative	Primary reasons were retirement and family responsibilities	Influences to return were accessibility of re-entry program, flexible work schedule, free/affordable reentry program; 81% would work 30 hours or less a week
Langan, Tadych, and Kao	"Exploring Incentives for RNs to Return to Practice: A Partial Solution to the Nursing Shortage"	2007 Quantitative/ Qualitative	Lack of recognition of one's work, working conditions (12-hour shifts)	Money, improved working conditions, refresher courses, and health insurance, flexible/part-time work

APPENDIX B. TABLE OF REQUIREMENTS OF THE 50 STATES' AND WASHINGTON, DC'S BOARDS OF NURSING

Table B1

Requirements of the 50 States' and Washington, DC's Boards of Nursing for Inactive Registered Nurses, 2011

State	Board Name and Contact Information	Requirements	Refresher Course Offered in State
Alabama	Alabama Board of Nursing P.O. Box 303900 Montgomery, AL. 36130-3900 Ph.334-242-4060 http://www.abn.alabama.gov	• 24 contact hours from approved providers listed on ABN website, within 24 months of application date (15 contact hours = 1 academic semester credit hour) • Completed application • $225 reinstatement fee http://www.abn.state.al.us/Content.aspx?id=264 (11 Feb. 2011)	N/A
Alaska	Alaska Board of Nursing Robert B. Atwood Building 550 W. 7th Avenue, Suite 1500 Anchorage, AK 99501-3567 Ph. 907-269-8161 http://www.dced.state.ak.us/occ/ pnur.htm	• If license has lapsed more than 1 year, must have a background check by submitting a finger print card • Total fees of $284 (license, penalty, and fingerprint fees) • Completed application • If applicant has not worked in 5 years prior, applicant must complete a refresher course http://www.dced.state.ak.us/occ/pnur2.htm (11 Feb. 2011)	Refresher course must be approved by the board and completed within 2 years of application, list of approved courses on ABN website. http://www.dced.state.ak.us/occ/pub/ RefresherCourseInformation.pdf (11 Feb. 2011)
Arizona	Arizona State Board of Nursing 4747 North 7th Street, Suite 200 Phoenix, AZ 85014-3655 Ph. 602-771-7800 http://www.azbn.gov	• Applicants in inactive/retired status can renew licenses online with a fee of $2.00. • Must complete an AZB approved refresher course or have obtained an advanced nursing degree in the past 5 years http://www.azbn.gov/documents/applications/ App%20Packet%20Downloads/RN_LPN%20Renewal %20 Pkt%202011.pdf (11 Feb. 2011)	Applicants must complete an AZB approved refresher course before application deadline, list on AZBN website. http://www.azbn.gov/Documents/ education/Refresher%20Programs/ Refresher%20Course%20List%20 Descriptions.02.04.11.pdf (11 Feb. 2011)

(continued)

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Table B1 (continued)

State	Board Name and Contact Information	Requirements	Refresher Course Offered in State
Arkansas	Arkansas State Board of Nursing University Tower Bldg. 1123 South University, Suite 800 Little Rock, AR 72204-1619 Ph. 501-686-2700 http://www.arsbn.org	• If inactive for more than 5 years, must complete 20 practice hours within past 2 years • Complete ARSBN approved refresher course or competency orientation program https://www.ark.org/support/index.php?projectid=41&#faqid454 (11 Feb. 2011)	Must complete a refresher course from this approved list. http://www.arsbn.arkansas.gov/education/Documents/refresher_course_list.pdf (11 Feb. 2011)
California	California Board of Registered Nursing 1625 North Market Boulevard Suite N217 Sacramento, CA 95834-1924 Ph. 916-322-3350 http://www.rn.ca.gov/	• Completed application • Completed fingerprints • $122 fee • Completed 30 hours of BRN approved continuing education within last 2 years http://www.rn.ca.gov/pdfs/licensees/8yr-app.pdf (11 Feb. 2011); http://www.rn.ca.gov/licensees/ce-renewal.shtml#acceptable (11 Feb. 2011)	N/A
Colorado	Colorado Board of Nursing 1560 Broadway, Suite 1350 Denver, CO 80202 Ph. 303-894-2430 http://www.dora.state.co.us/nursing/	• Completed Reactivation Application • $103 reactivation fee (subject to change every July 1) • If inactive for 2 or more years, must demonstrate competency (refresher courses) http://www.dora.state.co.us/nursing/policies/10-03.pdf (12 Feb. 2011)	Must complete refresher courses (amount depending on how long license has been inactive) from the list in Nursing Board Policy 10-03. http://www.dora.state.co.us/nursing/policies/10-03.pdf (12 Feb. 2011)
Connecticut	Connecticut Board of Examiners for Nursing 410 Capitol Avenue, MS #13PHO P. O. Box 340308 Hartford, CT 06134-0308 Ph. 860-509-7603 http://www.ct.gov/dph/cwp/view.asp?a=3143&q=388910	• Completed application • $180 fee • If out of practice for 3 to 5 years, must complete an approved refresher course • If out of practice for more than 5 years, must complete a refresher course and take NCLEX-RN exam http://www.ct.gov/dph/cwp/view.asp?a=3121&q=389436&dphNav_GID=1821 (12 Feb. 2011)	Completed approved nurse refresher course from approved list. http://www.ct.gov/dph/cwp/view.asp?a=3121&q=389434&dphNav_GID=1821 (12 Feb. 2011)

Table B1 (continued)

State	Board Name and Contact Information	Requirements	Refresher Course Offered in State
Delaware	Delaware Board of Nursing Cannon Building, Suite 203 861 Silver Lake Blvd. Dover, DE 19904 Ph. 302-744-4500 http://dpr.delaware.gov/boards/nursing/	• Completed Application for Reinstatement • $165 fee • Completed board approved refresher program http://dpr.delaware.gov/boards/nursing/reinstatement.shtml (12 Feb. 2011)	Board approved refresher program from the following list. http://dpr.delaware.gov/boards/nursing/documents/SchoolList_0709.pdf (12 Feb. 2011)
Florida	Florida Board of Nursing 4042 Bald Cypress Way Tallahassee, FL 32399 -3250 Ph. 850-245-4125 http://www.doh.state.fl.us/mqa	• Activation fee $145 if license is renewed biannually • Contact the Board for inactive to active licensing requirements http://www.doh.state.fl.us/mqa/Renewal/nurrenewals/renewal-rn3.html • If license remains inactive for more than 4 years you must appear before the board for examination	
Georgia	Georgia Board of Nursing 237 Coliseum Drive Macon, GA 31217-3858 Ph. 478-207-2440 http://www.sos.ga.gov/plb/rn/	• Completed reinstatement application • $90 fee • Criminal background check • Georgia board approved reentry program http://sos.georgia.gov/plb/faqs/38%20faqs.htm (12 Feb. 2011)	Georgia board will individually approve reentry programs. There is a list of approved nursing schools. http://sos.georgia.gov/plb/rn/RN_School%20Directory.pdf (12 Feb. 2011)
Hawaii	Hawaii Board of Nursing King Kalakaua Building 335 Merchant Street, Rm. 301 Honolulu, Hawaii 96813 Ph. 805-586-3000 http://www.hawaii.gov/dcca/areas/pvl/boards/nursing	• If inactive for 5 years, retake NCLEX or complete continuing education individually approved by Hawaii BON http://hawaii.gov/dcca/pvl/boards/nursing (12 Feb. 2011)	N/A

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(continued)

Table B1 (continued)

State	Board Name and Contact Information	Requirements	Refresher Course Offered in State
Idaho	Idaho Board of Nursing 280 North 8th Street, Suite 210 Boise, Idaho 83720-0061 Ph. 208-334-3110 http://ibn.idaho.gov/	• Completed reinstatement application form • $125 fee • Census questionnaire • Background check • Obtain temporary license ($25) to update nursing knowledge which will be specified when license is issued http://ibn.idaho.gov/UPDATED%20FORMS%202009/APPN_Initial_Licensure_-_Lapsed_Idaho_RN.pdf (12 Feb. 2011)	N/A
Illinois	Illinois Board of Nursing 320 West Washington St Springfield, IL 62786 Ph. 312-814-2715 http://www.idfpr.com/dpr/WHO/nurs.asp	• Completed application • $25 restoration fee • Proof of completion of division-approved RN licensure examination • Can receive a temporary license to be able to work until licensing is achieved http://www.ilga.gov/commission/jcar/admincode/068/06801300sections.html (12 Feb. 2011)	N/A
Indiana	Indiana State Board of Nursing Professional Licensing Agency 402 W. Washington Street Room W072 Indianapolis, IN 46204 Ph. 317-234-2043 http://www.in.gov/pla/	• No inactive status. (repealed 1996) **If expired 3 to 10 years;** • Reactivation application • $50 renewal fee + $50 late fee • Continuing education requirement: 24 contact hours of continuing education, 6 hours in each of four areas: Assessment, Documentation, Pharmacology, Legal/Ethics **If expired more than 10 years:** Application through the Board of Nursing is necessary on a case-by-case basis.	N/A

Table B1 (continued)

State	Board Name and Contact Information	Requirements	Refresher Course Offered in State
Iowa	Iowa Board of Nursing RiverPoint Business Park 400 S.W. 8th Street, Suite B Des Moines, IA 50309-4685 Ph. 515-281-3255 http://www.iowa.gov/nursing	- Reactivation application - Fingerprint cards - Signed waiver $225 total fee - Continuing education certificates for 1.2 continuing education units or 12 contact hours earned in past 12 months http://nursing.iowa.gov/licensure/reactivation.html (12 Feb. 2011)	N/A
Kansas	Kansas State Board of Nursing 900 SW Jackson Street Suite 1051 Topeka, Kansas 66612-123 Ph.785-296-4926 http://www.ksbn.org	- Reinstatement application $70 fee - Evidence of a refresher course http://www.ksbn.org/forms/reinstatement.pdf (12 Feb. 2011)	Refresher course approved by KSBN (application needs to be sent before clinical portion) from this list. http://www.ksbn.org/cne/ RefresherCourseProv.pdf (12 Feb. 2011)
Kentucky	Kentucky Board of Nursing 312 Whittington Pky Suite 300 Louisville, KY 40222 Ph. 502-429-3300 http://www.kbn.ky.gov/	- Completed application $120 fee 120 continuing education units or KBN-approved refresher course http://kbn.ky.gov/license/reinstate/ (12 Feb. 2011)	KBN-approved refresher course from the following list. http://test.kbn.ky.gov/kbn/downloads/ ce_rc.pdf (12 Feb. 2011)
Louisiana	Louisiana State Board of Nursing 17373 Perkins Road Baton Rouge, LA 70810 Ph. 255-755-7500 http://www.lsbn.state.la.us/	- Completed application for reinstatement $100 fee - Letter explaining lapse and date of last employment - Criminal background check 15 contact hours per year license was inactive completed within last 4 years http://www.lsbn.state.la.us/documents/Forms/ ReinstatementPacket.pdf (12 Feb. 2011)	N/A

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(continued)

Table B1 (continued)

State	Board Name and Contact Information	Requirements	Refresher Course Offered in State
Maine	Maine State Board of Nursing 161 Capitol St. 158 State House Station Augusta, ME , 04333-0158 Ph. 207-287-1133 http://www.maine.gov/ boardofnursing/	• Contact linda.f.elliot@maine.gov or call (207)287-9946 http://www.maine.gov/boardofnursing/licensing/index.html#reactivate)	N/A
Maryland	Maryland Board of Nursing 4140 Patterson Avenue Baltimore, Maryland, 21215-2254 410-585-1900 Ph. 410-585-1900 http://www.mbon.org	• If practicing less than 1000 hours in the last 5 years or not worked at all requires you to take a refresher course • Copy of course certificate • Completed form • $48 fee http://www.mbon.org/main.php?v=norm&p=0&c=licensure/inactive.html (13 Feb. 2011)	BON instructions in detail of how to reactivate on website and list of approved refresher programs. http://www.mbon.org/licensure/refresh_course.pdf (13 Feb. 2011)
Massachusetts	Massachusetts Board of Registration in Nursing 239 Causeway Street, Suite 200 Boston, MA 02114 Ph. 617-973-0900 http://www.mass.gov/dph/boards/rn/	• No inactive status (current or expired) • Renewal fee $120 + $57 late fee if after renewal period or expired • Required continuing education of 15 contact hours every 2 years or one college credit approved by the Board http://www.mass.gov/?pageID=eohhs2terminal&L=6&L0=Home&L1=Provider&L2=Certification,+Licensure,+and+Registration&L3=Occupational+and+Professional&L4=Nursing&L5=Licensing&sid=Eeohhs2&b=terminalcontent&f=dph_quality_boards_nursing_p_licensure_faq&csid=Eeohhs2)	N/A
Michigan	Michigan/DCH/Bureau of Health Professions PO Box 30670 Lansing MI 48909 Ph. 517-335-0918 http://www.michigan.gov/healthlicense	• Relicensure application • Retake the NCLEX • $74 fee http://www.michigan.gov/documents/cis_fhs_bhser_nurserelicpkt_74412_7.pdf (13 Feb. 2011)	N/A

(continued)

Table B1 (continued)

State	Board Name and Contact Information	Requirements	Refresher Course Offered in State
Minnesota	Minnesota Board of Nursing 2829 University Ave SE, Suite 200 Minneapolis, MN 55414 Ph. 612-617-2270 http://www.nursingboard.state.mn.us	• Reregistration application • $93.50 fee • If not practiced in more than 10 years, must complete a refresher course or equivalent • May need to complete continuing education (amount of hours depending on how long license has lapsed) http://www.state.mn.us/mn/externalDocs/Nursing/ Reregistration_application_packet_041603123455_ Reregistration%20packet%2071610.pdf (13 Feb. 2011)	Board will contact applicant regarding how many contact hours are needed or whether or not to take a refresher course. There is a list of continuing education and refresher programs on the website. http://www.state.mn.us/portal/mn/jsp/ content.do?rc_layout=bottom&subchannel =-536893594&programid=536913940& sc3=null&sc2=null&id=-536893080 &agency=NursingBoard (13 Feb. 2011)
Mississippi	Mississippi Board of Nursing 1080 River Oaks Drive, Suite A100 Flowood, MS 39232 Ph. 601-664-9303 http://www.msbn.state.ms.us/	• Reinstatement application • $75 fee • Board-approved Reorientation/Refresher Program or 20 hours of continuing education http://www.msbn.state.ms.us/pdf/RNLate10.pdf (13 Feb. 2011)	If not practiced in 5 or more years, requires a board-approved Reorientation/Refresher Program within last 5 years (may apply for a temporary license while enrolled) or 20 hours of continuing education from the list on the website.
Missouri	Missouri State Board of Nursing 3605 Missouri Boulevard P.O. Box 656 Jefferson City, MO 65102-0656 Ph. 573-751-0681 http://pr.mo.gov/nursing.asp	• Completed petition for license renewal (board will review for licensure decision) • $50 fee http://pr.mo.gov/boards/nursing/RNPetition.pdf (13 Feb. 2011)	N/A
Montana	Montana State Board of Nursing 301 South Park, 4th Floor P.O. Box 200513 Helena, MT 59620-0513 Ph. 406-841-2345 http://www.nurse.mt.gov	• Application • $100 fee • No continuing education required • No experience required http://bsd.dli.mt.gov/license/bsd_boards/nur_board/ board_page.asp (13 Feb. 2011)	N/A
Nebraska	Nebraska Board of Nursing P.O. Box 95026 Lincoln, NE 68509-5026 Ph. 402-471-4376 http:www.hhs.state.ne.us/crl/ nursing/nursingindex.htm	• Reinstatement application • $158 fee • Refresher course http://www.hhs.state.ne.us/crl/nursing/rn-lpn/ reinstatement.htm (13 Feb. 2011)	Complete board-approved refresher course from this list within the last 5 years. http://www.hhs.state.ne.us/crl/nursing/ rn-lpn/refresher.htm (13 Feb. 2011)

Table B1 (continued)

State	Board Name and Contact Information	Requirements	Refresher Course Offered in State
Nevada	Nevada State Board of Nursing 2500 W. Sahara Ave., Suite 207 Las Vegas, NV 89102-4392 Ph. 775-687-7700 http://www.nursingboard.state.nv.us/	• Renewal application • $100 fee • Refresher course http://www.nursingboard.state.nv.us/ frequentlyaskedquestions.htm (13 Feb. 2011)	If applicant has not practiced nursing in the last 5 years, must complete a refresher course from this approved list. http://www.nursingboard.state.nv.us/edu/ refresher%20courses.htm (13 Feb. 2011)
New Hampshire	New Hampshire Board of Nursing 21 South Fruit Street, Suite 16 Concord NH 03301-2431 Ph. 603-271-2323 http://www.nh.gov/nursing/	• Option 1: Refresher course • Option 2: Retake NCLEX • Option 3: Completion of 4 Excelsior College examinations that (Essentials of Nursing Care: Chronicity and Reproductive Health, Health Differences Across the Life Span 1 and 2)	Refresher course must be 120 hours (40 theory/classroom hours and 80 clinical hours) and from this approved list. A temporary license must be obtained before beginning course. http://www.nh.gov/nursing/licensure/ documents/reentrynursing.doc (13 Feb. 2011)
New Jersey	New Jersey Board of Nursing PO Box 45010 Newark, NJ 07101 Ph. 973-504-6430 http://www.njconsumeraffairs.gov/ nursing/	• Reactivation application • $125 fee • Refresher course http://www.njconsumeraffairs.gov/nursing/ ReactApp.pdf (13 Feb. 2011)	Refresher course required if have not practiced in previous 5 years. Course must be 30 hours of didactic and clinical education. There is no list of approved courses.
New Mexico	New Mexico Board of Nursing 6301 Indian School Road NE Suite 710 Albuquerque, NM 87110 Ph. 505-841-8340 http://www.bon.state.nm.us/	• Application • $110 reactivation fee • 30 hours of continuing education http://ww.bon.state.nm.us/pdf/ApprovedNursing ProgramsNov10.pdf (13 Feb. 2011) http://ww.bon.state.nm.us/forms/AP_Renewal_ Dec10.pdf (13 Feb. 2011)	N/A
New York	New York State Board of Nursing Office of the Professions State Education Building - 2nd Floor Albany, NY 12234 Ph. 518-474-3817 ext. 280 http://www.op.nysed.gov/prof/nurse/	• Contact OP Registration Unit at OPREGFEE@mail.nysed.gov or at 518-874-3817 ext410 http://www.op.nysed.gov/renewalinfo.htm http://www.op.nysed.gov/prof/nurse/nurse-guide-april09.pdf	N/A

(continued)

Table B1 (continued)

State	Board Name and Contact Information	Requirements	Refresher Course Offered in State
North Carolina	North Carolina Board of Nursing 4516 Lake Boone Trail Raleigh, NC 27607 Ph. 919-782-3211 http://www.ncbon.com/	• Complete online renewal application • Required refresher course • $180 reinstatement fee http://ncbon.com/content.aspx?id=374 (13 Feb. 2011)	If lapsed, retired, inactive for more than years, must complete a board-approved refresher course from this list. http://ncbon.com/content.aspx?id=410 (13 Feb. 2011)
North Dakota	North Dakota Board of Nursing 919 South 7th Street, Suite 504 Bismarck, ND 58504 Ph.701- 328-9777 http://www.ndbon.org	• 100 hours of theory • No clinical practicum required. Must pass a final exam with 75%.	Self Paced Refresher course offered by ND Nurses Association. http://sites.google.com/site/ndnaprairierosepetal/refresher-courses-lpn-iv-course (18 Feb. 2011)
Ohio	Ohio Board of Nursing 17 South High Street, Suite 400 Columbus, Ohio 43215 Ph.614-466-3947 http://www.nursing.ohio.gov	• Fill out questionnaire requesting an application for reinstatement • 24 contact hours on the following topics from this list http://www.nursing.ohio.gov/PDFS/Forms/web%20 react_reinstate.pdf (18 Feb. 2011)	N/A
Oklahoma	Oklahoma Board of Nursing 2915 N Classen, Suite 524 Oklahoma City, OK 73106 Ph. 405-962-1800 http://www.ok.gov/nursing/	• Application • $115 fee • Certificate of completion from a refresher course http://www.ok.gov/nursing/reinstateappl07.pdf (18 Feb. 2011)	Refresher course required that fits the standard of the following policy or board-approved list. http://www.ok.gov/nursing/refresher.pdf (18 Feb. 2011) http://www.ok.gov/nursing/nrefresher.pdf (18 Feb. 2011)
Oregon	Oregon State Board of Nursing 17938 SW Upper Boones Ferry Rd. Portland, OR 97224-7012 Ph. 971-673-0685 http://www.osbn.state.or.us/	• Re-Entry into Nursing Program Contact: OSBN Education Consultant 971-673-0685 or visit this page for information http://www.oregon.gov/OSBN/pdfs/reentry_info.pdf (19 Feb. 2011)	Program must include 120 hours of instruction in current nursing practice including pharmacology. 160 hours of supervised clinical practicum (in a student role) http://www.oregon.gov/OSBN/pdfs/reentry_info.pdf (19 Feb. 2011)

(continued)

Table B1 (continued)

State	Board Name and Contact Information	Requirements	Refresher Course Offered in State
Pennsylvania	Pennsylvania State Board of Nursing PO Box 2649 Harrisburg, PA 17105-2649 Ph.717-783-7142 http://www.portal.state.pa.us/portal/ server.pt/community/state_board_of _nursing/12515	• To reactivate an expired or inactive license call 717-783-7142 http://www.portal.state.pa.us/portal/server.pt/ community/state_board_of_nursing/12515/licensure_ information/572048 (19 Feb. 2011)	N/A
Rhode Island	Rhode Island Board of Nurse Registration and Nursing Education Department of Health Three Capitol Hill Providence, RI 02908 Ph.401-222-5700 http://www.health.ri.gov/	• $130 renewal fee • 5 hours continuing education for every year license was inactive or re-entry program approved by the board prior to taking http://www2.sec.ri.gov/dar/regdocs/released/pdf/DOH/ 5128.pdf (19 Feb. 2011)	N/A
South Carolina	South Carolina State Board of Nursing Ph. 803-896-4550 http://www.llr.state.sc.us/pol/nursing	• Application • $94 fee • Successful completion of a board-approved refresher course or the NCLEX http://www.llr.state.sc.us/POL/Nursing/forms/ ReactivationApp.pdf (19 Feb. 2011)	South Carolina Board-approved refresher course from this approved list. http://www.llr.state.sc.us/POL/Nursing/ forms/RefresherCourses.pdf (19 Feb. 2011)
South Dakota	South Dakota Board of Nursing 4305 South Louise Ave., Suite 201 Sioux Falls, SD 57106-3115 Ph.605-362-2760 http://nursing.sd.gov/	• Application • $90 fee • Refresher course if have not worked in the last 6 years http://doh.sd.gov/boards/nursing/PDF/ ReactivateInstructionsAppRNLPN072009.pdf (19 Feb. 2011)	Links from BON website to South Dakota State's refresher course. http://doh.sd.gov/boards/nursing/ refreshers.aspx (19 Feb. 2011)

Table B1 (continued)

State	Board Name and Contact Information	Requirements	Refresher Course Offered in State
Tennessee	Tennessee State Board of Nursing 227 French Landing, Suite 300 Nashville, TN 37243 Ph. 615-532-5166 http://health.state.tn.us/Boards/ Nursing/index.htm	• Application • One of the following: 5 contact hours for each year inactive, proof of having an article published during the years of inactivity, successful completion of a 2-week refresher course, successful completion of a 2-week orientation program by a prospective employer, proof of enrollment in an accredited nursing program, proof of certification in a nursing specialty area, or proof of retaking and passing the exam http://tennessee.gov/sos/rules/1000/1000-01.pdf (19 Feb. 2011)	Tennessee State University Course CE 9402 Refresher course http://www.tnstate.edu/interior.asp?mid= 2058&ptid=1 (19 Feb. 2011)
Texas	Texas Board of Nursing 333 Guadalupe #3-460 Austin, TX 78701 Ph. 512-305-7400 http://www.bon.state.tx.us	• Inactive status Renewal Form • $85 fee • Six-month temporary permit if not practiced in the last 4 years • 20 contact hours of continuing education within the last 2 years http://www.bon.state.tx.us/olv/pdfs/ RN-react.pdf (19 Feb. 2011)	N/A
Utah	Utah State Board of Nursing 160 East 300 South Salt Lake City, UT 84111 Ph. 801-530-6628 http://www.dopl.utah.gov/licensing/ nursing.html	• $50 activation fee • Retake and pass the required examination if have not practiced in more than 5 years and have not had a license in another state http://www.dopl.utah.gov/licensing/forms/applications/ 099_nurse_inactive.pdf (19 Feb. 2011)	N/A
Vermont	Vermont State Board of Nursing National Life Bldg, North FL2, Montpelier, VT 05620-3402 Ph. 802-828-2396 http://vtprofessionals.org/opr1/ nurses/	• Re-entry application • $25 fee • Re-entry program http://vtprofessionals.org/opr1/nurses/rn_forms/ NU_RN_Re_Entry_Application.pdf (19 Feb. 2011)	Must complete required re-entry program by the Vermont BON. http://vtprofessionals.org/opr1/nurses/ education/NU_Re_Entry_Programs.pdf (19 Feb. 2011)

(continued)

Table B1 (continued)

State	Board Name and Contact Information	Requirements	Refresher Course Offered in State
Virginia	Virginia Board of Nursing 9960 Mayland Drive, Suite 300 Henrico, VA 23233-1463 Ph. 804-367-4515 http://www.dhp.virginia.gov/nursing	• Reinstatement application • $145 fee • Continuing Education Requirements: 15 CEUs • No refresher course required http://www.dhp.virginia.gov/Forms/nursing/RN/ RNReinstate_APP_instructions1010.doc (19 Feb. 2011)	List of 3 in the state. George Mason University: 40 hours of theory and skills, 60 hours of supervised clinical
Washington	Washington State Nursing Care Quality Assurance Commission PO Box 47864 Olympia, WA 98504-785 Ph. 360-236-4700 http://www.doh.wa.gov/	• Application • $65 fee • If your license has lapsed 3 years or more and you do not have a current license in another state, you must complete a refresher course. http://www.doh.wa.gov/hsqa/Professions/Nursing/documents/RN_LPNReactApp.pdf (19 Feb. 2011)	In refresher course, RNs must complete 80 hours of theory content and 160 hours of clinical practice in the specialty area. BON gives a list of available courses. http://www.doh.wa.gov/hsqa/Professions/Nursing/documents/refresher.pdf (19 Feb. 2011)
Washington, DC	District of Columbia Board of Nursing 717 14th Street, NW Suite 600 Washington, DC 20005 Ph. 877-672-2174 http://hpla.doh.dc.gov/hpla/cwp/view,A,1195,Q,488526,hplaNav,(30661).asp	• Renewal application • $34 fee • 24 contact hours of continuing education http://hpla.doh.dc.gov/hpla/lib/hpla/nursing/10_rn_renewal_application.pdf (19 Feb. 2011)	N/A
West Virginia	West Virginia Board of Nursing Examiners for Registered Professional Nurses 101 Dee Drive, Suite 102 Charleston, WV 25311-162 Ph. 304-558-3596 http://www.wvrnboard.com	• Continuing Education Requirements only on BON website	Per Director of Education/Practice: From home page click on "Law/Scope "located on the left in blue. Then click on "Code of Legislative Rules." This takes you to the WV Sec. of State website and Title 19 series 1-12. Click on 19-11. Print. In Word, requirements are 19-03 for licensure.

Table B1 (continued)

State	Board Name and Contact Information	Requirements	Refresher Course Offered in State
Wisconsin	Wisconsin Department of Regulation and Licensing 1400 East Washington Ave., Rm. 112 Madison, WI 53703 Ph. 608-266-2112 http://drl.wi.gov/	• Application • $82 fee • BON has link to RN re-registration application packet: "if not practicing for 5 years or more." Refresher course required list of available http://drl.wi.gov/docview.asp?docid=293&locid=0 (19 Feb. 2011)	Refresher course with theory review, a skills lab refresher, and directly supervised or precepted clinical of 100 hours or more from the following list. http://165.189.60.145/docview.asp?docid=735&locid=0 (19 Feb. 2011)
Wyoming	Wyoming State Board of Nursing Ph. 307-777-7601 http://nursing.state.wy.us	• Application • $135 fee • Complete refresher course if not worked in last 5 years (https://nursing-online.state.wy.us/Resources/CurrentCHAPTER2.pdf (19 Feb. 2011))	Website lists approved refresher courses. https://nursing-online.state.wy.us/Default.aspx?page=15 (19 Feb. 2011)

APPENDIX C. INVITATION LETTER TO ALL STUDENTS

Deborah Hobbs, RN
George Mason University, School of Nursing
4400 University Drive 3C4
Fairfax, Virginia 22030

February 16, 2010

Dear Nurse,

I'm contacting you because I am conducting a research study with nurses who were inactive for 5 or more years, maintained their license, and completed a refresher course at GMU, GW or AACC. My study will focus on the experiences of inactive registered nurses who are returning to practice. This research will help to remove barriers for returning RNs, contribute to the design of recruitment strategies for inactive nurses, improve communication and polices, and provide better on the job transitions experiences.

I am a registered nurse who has taught many refresher courses and knows second hand what returning nurses have had to deal with in order to return to nursing practice. Your direct input in this research will help me articulate what it is that return to practice nurses need in returning to the workforce. This research will fulfill the dissertation requirements for a Doctorate of Nursing degree with a focus in Nursing Education at George Mason University. My dissertation proposal has been approved by my doctoral committee and George Mason's Institutional Review Board.

If you choose to participate, I will interview you in person in the next few months. I will travel to your locale and the interview will take place at a private location that we mutually agree on. In the interview, I will ask you questions related to your experiences in returning to active practice, before, during and after the refresher course. Because the interview involves open-ended questions that explore your experiences and opinions, rather than fixed-response, survey-type questions, it will last about 60 minutes and will be audio recorded. Participation is voluntary and you may withdraw at any time.

I will transcribe the interview and return a summary to you to verify for accuracy. In the dissertation, you will be given a pseudonym. I will analyze the transcriptions for themes. The study findings will be written in a narrative form and the participants will not be identified. The audio recordings will be kept for 3 years after the completion of the study by the researcher in a locked cabinet and then destroyed. I will send you a copy of the research findings if you request this. .

If you would be willing to be a participant in this study, please contact me by phone at 703-▮▮▮ or email ▮▮▮@gmu.edu so that I may send you an informed consent form and set up a time for the interview. Please call me if you have any questions. I encourage you to participate and let your voice be heard.

Sincerely,

Deborah Hobbs, RN

Deborah Hobbs RN
Doctoral Candidate
George Mason University
School of Nursing

APPENDIX D. LETTER FROM THE COMMUNITY COLLEGE

Date

Dear Student:

_____ Community College _____ has been asked to participate in a doctoral dissertation study entitled *Inactive Registered Nurses: The Barriers and Success to Returning to Practice*. The study is being conducted by Deborah Hobbs, RN, doctoral candidate, at George Mason University.

Although some time has passed since you have completed the Nurse Refresher course at _____, your opinions and experiences in returning to practice are very valuable. We have been asked to offer you the opportunity to participate in this study. Please note, _____ Community College **has not** shared any of your personal information with Ms. Hobbs.

If you would like to participate in this research study, please contact Ms. Hobbs directly as per her invitational outline which is enclosed.

Thank you,

_____

Director, Continuing & Professional Education

Approval for the use
of this document
EXPIRES

FEB 2 8 2011

APPENDIX E. DEMOGRAPHICS TABLE

Table E1

Demographics Table

Name	Gender	Birth Year	Ethnicity	When Attended Nursing School	NSY Graduation Date	How Long in Nursing Before Went Inactive	How Long Inactive	Highest Degree	Where Last Practiced Nursing	Specialty Area
Erin*	F	1961	White (Non-Hispanic)	1979 - 1983	1983	17 years	8 years	MN	Hospital	Critical Care
Katie	F	1952	White (Non-Hispanic)	1970 - 1973 (RN) 1975 - 1977 (BSN)	1973 (RN) 1977 (BSN)	5 - 6 years	28 years	Bachelor's of Science in Nursing	Hospital	Critical Care
Yolanda	F	1963	White (Non-Hispanic)	1981	1984	19 years	7 years	Associate's Degree	Hospital	Surgical
Lea	F	1963	White (Non-Hispanic)	1988 - 1992	1992	5 years	10 years	Master's in Education	Hospital	Neuroscience
Trixie	F	1960	White (Non-Hispanic)	1983 - 1985	1985	5 years	17 years	Bachelor's of science in Zoology	Community	Maternal Child Care
Susie	F	1955	White (Non-Hispanic)	1973 - 1976	1976 (Dip) 1980 (BSN)	27 years	4 - 5 years	Master's of Arts in Management	School	Pediatrics

(continued)

Table E1 (continued)

Name	Gender	Birth Year	Ethnicity	When Attended Nursing School	NSY Graduation Date	How Long in Nursing Before Went Inactive	How Long Inactive	Highest Degree	Where Last Practiced Nursing	Specialty Area
Priscilla	F	1958	White (Non-Hispanic)	1980 (BSN) 1985 (MSN)	1980 (BSN) 1985(MSN)	10 years	15 years	Master's of Science in Nursing	Community	Medical
Jesabelle	F	1953	White (Non-Hispanic)	1971 - 1974	1974	3 years	32 years	Associate's Degree	Hospital	Emergency Room
Nancy	F	1958	White (Non-Hispanic)	1979	1981	11 years	14 years	Diploma	Hospital	Critical Care
Maryann	F	1955	White (Non-Hispanic)	1973 - 1977	1977	8 years	23 years	Master's of Science in Nursing	University	Critical Care
Victoria	F	1953	White (Non-Hispanic)	1972 - 1975	1975	20 years	5 years	Bachelor's of Science in Nursing	Community	Community Health
Christine	F	1954	White (Non-Hispanic)	1979 - 1981	1981	9 years	2 2/3 years 11 years 1991 - 2002	Master's of Science in Nursing	Hospice	Hospice
Rain	F	1973	White (Non-Hispanic)	1991 - 1995	1995	7 years	5 years	Bachelor's of Science in Nursing	Community	Pediatrics
Jeanne	F	1956	White (Non-Hispanic)	1979 (AD) 1983 (BS)	1979 (AD) 1983 (BS)	21 years	7 years	Bachelor's of Science in Nursing	School Nurse	Medical Surgical
Thelma Lou	F	1957	White (Non-Hispanic)	1975 - 1978	1978	14 years	15 years	Bachelor's of Science in Electrical Engineering	Outpatient Clinic Dialysis Unit	Dialysis

(continued)

Table E1 (continued)

Name	Gender	Birth Year	Ethnicity	When Attended Nursing School	NSY Graduation Date	How Long in Nursing Before Went Inactive	How Long Inactive	Highest Degree	Where Last Practiced Nursing	Specialty Area
Maria	F	1954	White (Non-Hispanic)	1972 - 1976	1976	6 years	25 years	Master's of Arts in Anthropology	Hospital	Critical Care
Denise	F	1964	White (Non-Hispanic)	1988 - 1990	1990	6 years	12 years	Associate's Degree	Hospital	Post-Operative Cardiac Care/Emergency Department

Note. * Names are participant-selected pseudonyms.

APPENDIX F. HUMAN SUBJECTS REVIEW BOARD APPROVAL

GEORGE MASON UNIVERSITY

Office of Research Subject Protections

Research 1 Building
4400 University Drive, MS 4C6, Fairfax, Virginia 22030
Phone: 703-993-4121; Fax: 703-993-9590

TO: Renee Milligan, College of Health and Human Services

FROM: Sandra M. Sanford, RN, MSN, CIP
          Director, Office of Research Subject Protections

PROTOCOL NO.: 6815   Research Category: Doctoral Dissertation

PROPOSAL NO.: N/A

TITLE: Inactive Registered Nurses: The Barriers and Successes to Practice

DATE: March 2, 2010

Cc: Deborah Hobbs

On 3/1/2010, the George Mason University Human Subjects Review Board (GMU HSRB)
reviewed and approved the above-cited protocol following expedited review procedures.

Please note the following:

1. A copy of the final approved consent document is attached. You must use this copy with
    the HSRB stamp of approval for your research. Please keep copies of the signed consent
    forms used for this research for three years after the completion of the research.
2. **Any modification to your research (including the protocol, consent, advertisements,
    instruments, funding, etc.) must be submitted to the Office of Research Subject
    Protections for review and approval prior to implementation.**
3. Any adverse events or unanticipated problems involving risks to subjects including
    problems involving confidentiality of the data identifying the participants must be
    reported to Office of Research Subject Protections and reviewed by the HSRB.

The anniversary date of this study is 2/28/2011. **You may not collect data beyond that date
without GMU HSRB approval.** A continuing review form must be completed and submitted to
the Office of Research Subject Protections 30 days prior to the anniversary date or upon
completion of the project. A copy of the continuing review form is attached. In addition, prior
to that date, the Office of Research Subject Protections will send you a reminder regarding
continuing review procedures.

If you have any questions, please do not hesitate to contact me at 703-993-4015.

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APPENDIX G. INFORMED CONSENT FORM

INACTIVE REGISTERED NURSES: THE BARRIERS AND SUCCESS TO RETURNING TO PRACTICE

INFORMED CONSENT FORM

RESEARCH PROCEDURES
This qualitative research study is being conducted to explore the perceived barriers and successes experienced by inactive registered nurses in their journey back to nursing practice. If you agree to participate, you will be asked to complete a demographics form, and agree to a tape- recorded interview lasting approximately 1 hour. After the analysis of the interview, you will be offered the option to review the summary of the transcription and make any suggestions for accuracy.

RISKS
There are no foreseeable risks for participating in this research.

BENEFITS
There are no benefits to you as a participant.

Approval for the use
of this document
EXPIRES

FEB 2 8 2011

Protocol # 6815
George Mason Universi

CONFIDENTIALITY
The data in this study will be kept confidential. You will be asked to complete a demographics form prior to your interview and all measures to maintain your confidentiality will be applied. Only the researcher will view this demographics form and will keep it in a locked cabinet. The researcher will ask the participant to sign a consent form to agree to participate in the study and to have the interview audio-taped. Once the interview is completed, the researcher will transcribe the recording and apply a pseudonym instead of your name to the transcript for identification purposes. To ensure confidentiality is maintained only the researcher will have the identification code. The study findings will be written in a narrative form and the participants will not be identified. .The transcriptions and audio tapes will remain with researcher in a locked cabinet for three years after the study is completed and then they will be destroyed. No one other than the researcher will have access to the demographics forms, audio-tapes, transcripts or the identification code.

PARTICIPATION
Your participation is voluntary, and you may withdraw from the study at any time and for any reason. If you decide not to participate or if you withdraw from the study, there is no penalty or loss of benefits to which you are otherwise entitled. There are no costs to you or any other party

CONTACT
This research is being conducted   Deborah Hobbs, PhD(c) RN , School of Nursing(doctoral dissertation) at George Mason University. She may be reached at 703-   for questions or to report a research-related problem. You may also contact, Renee Milligan, PhD RN, faculty advisor at 703-   . You may contact the George Mason University Office of Research Subject Protections at 703-993-4121 if you have questions or comments regarding your rights as a participant in the research.

This research has been reviewed according to George Mason University procedures governing your participation in this research.

CONSENT
I have read this form and agree to participate in this study.

_____ Name   _____ Date of Signature

Research involving audio-taping must include:

_____ I agree to audio taping.   _____ I do not agree to audio taping.

APPENDIX H. INACTIVE REGISTERED NURSE DEMOGRAPHIC INFORMATION QUESTIONNAIRE

Inactive Registered Nurse Demographic Information

Please provide the following information by either checking (√) or filling in the necessary information. Thank you for participating in this part of my research.

Name

_____

Address_____

Phone (cell or home) _____

Email for returning transcripts _____

Gender   Male_____ Female_____ Birth Year_____

Ethnicity Black(Non Hispanic)_____ White(Non Hispanic)_____ Asian/ Pacific Islander_____
Hispanic/Latino/Chicano/Spanish Surname_____ Native American_____ Other_____

When did you attend nursing school? _____

What year did you graduate from nursing school? _____

How long did you practice nursing before you went inactive? _____

How long have you been inactive from nursing practice? _____

What is your highest degree/Educational Background? Please select from the following:
   a. Diploma
   b. Associate Degree
   c. BSN
   d. MSN
   e. PhD
   f. other _____

Where was your last nursing practice? Please select from the following::
   a. doctors office
   b. community
   c. hospital
   d. other _____

What was your last specialty area? Please select from the following:
   a. Medical
   b. Surgical

c. Pediatrics
d. OB
e. Critical Care
f. Other_____

APPENDIX I. GUIDED INTERVIEW QUESTIONS WITH PROMPTS

1. Tell me about how you came to the decision to return to nursing practice?
   Finances?
   Desire to work?
   Empty nesting?
   Divorce?

2. How easy was the process of discovering what you needed to do to return to practice?
   Finding out what you needed to do?
   Requirements?
   Locating a refresher course?

3. Tell me about your journey to returning to practice.
   When did it begin?
   How long did it take?

4. What were the barriers you encountered in returning to practice?
   Before the refresher course
   During the course – reading, children, other jobs while taking the course?
   Attending clinical?

5. Tell about your experiences in seeking employment after completing the course?
   Resume?
   Job application ?
   Areas of employment sought?

6. How would you describe your success in returning to practice?

7. Is there anything else you experienced you would like to share?

APPENDIX J. AUDIT TRAIL

January 11, 2010 Proposal Defense accepted by Dr. Milligan, Chair; Dr. Moss; Dr. Maxwell; and Dr. Vail.

January 13, 2010 Revisions made to proposal as suggested and sent to committee. Demographics sheet revised after peer and previous refresher reviewed.

January 14, 2010 Completed draft of HSRB form, contacted faculty from Site B (Hospital) source for participation, updated her on status of research and requested an approval letter for study from her research approval site.

January 15, 2010 Completed draft informed consent and had it reviewed by committee, contacted HSRB for guidance on what letters they need to be attached with informed consent for participants from 3 sites.

January 20, 2010 Scheduled an appointment to meet with HSRB representative on Friday at 1000. Spoke with potential participation site for Group C, faculty very interested, will check with her director, and locate her research person. Spoke with HSRB who says we need a letter from IRB from site B regarding participation.

January 22, 2010 Met with Sandy at HSRB, had preliminary review of my draft application and draft informed consent. Corrections made and more information required.

January 25, 2010 Spoke with IRB at hospital-based program, who explains that the hospital is a separate entity and that they do not have an IRB. They often choose to use the IRB from the affiliated university but they may use others. So, for this process, I must get approval from the senior nursing faculty to participate in this research process. I must get a letter of permission addressed to me (Alicia Bier, Risk Manager at GWH 202-994-1000) and then I may submit it to HSRB at GMU. Once the HSRB approves the study, I may contact the Education Research Coordinator at the affiliated university at Office of Human Research and they will allow the hospital to be added as a site for research.

January 26, 2010 Emailed draft of invitational letter of participants to Dr. Maxwell and nurse content expert for review. Contacted the Research area in community college that includes human subjects and located the dean in charge of research, left message.

January 27, 2010 Spoke with the dean for Human Subjects Research department at the community college regarding this study and invited the participants from this college to participate. The dean requested the invitational letter, my doctoral transcript, and the research advisor from GMU in order to review and process my request for approval of the research at the community college. Once she approved the study, she agreed to electronically send the IRB consent from the community college to me and GMU's HSRB. Written and verbal permission given from the Director of Professional Development at the hospital-based program that they could participate in the study and requested a template of what was needed. I met with

Dr. Maxwell, revised invitational letter, and reviewed informed consent and HSRB application. Revised the dissertation proposal page 8.

January 29, 2010 A letter of written approval received from the hospital-based program.

January 30, 2010 HSRB form, informed consent form and invitational letter reviewed by Chair and member checked by previous refresher students.

January 31, 2010 Began working on table of a list of all of the individual state's boards of nursing and the requirements for inactive nurses to return to active practice.

February 5, 2010 Spoke with the dean from the community college who agreed to participate in study. They also informed me that they would to send a letter out and enclose my invitational letter. I then sent the Director the requested information, a copy of the Invitational letter, HSRB forms and informed consent.

February 14, 2010 Began working on table of current studies on why nurses leave nursing and why they may return. Rough draft of interview guide with prompts made.

February 16, 2010 Phone call received from dean at community college informing me that their IRB approved my research and that the IRB approval would be sent to GMU's HSRB. I called Dr. Milligan and Dr. Maxwell and informed them of this news.

February 17, 2010 Emails sent to Dr. Milligan and Dr. Maxwell of the HSRB paperwork sent and received. HSRB application in total taken to GMU HSRB and application stamped for review.

February 22, 2010 I received email from HSRB explaining the research would be expedited and HSRB approval was being sent out in hard copy form.

February 23, 2010 Unknown to me, the invitational advertisement letter from the community college was sent out, and I received my first phone call from a participant asking if she could participate in my study. We communicated through email to set up the interview for March 9, 2010. Ten other nurses contacted me by phone and email an asked to participate in the study.

February 28, 2010 I sent the interview guide with prompts out to Dr. Maxwell and content experts for review. I bought two audio recorders and practiced asking questions and taping the interview with my peer and daughter.

March 2, 2010 I received the hard copy of the HSRB approval for my study. I emailed 10 nurses back who had contacted me wanting to participate in the interview and then began scheduling the interview times in March at their convenience.

March 3, 2010 My first interview was completed today. I reviewed both tape recordings, and discovered the digital recorder worked best and the audio was louder. The response of the answers was too simple and direct. However, I discovered in her nervousness, once the tape recorder was shut off, she started talking more freely. So I will leave the tape recorder on and running even after the interview questions are complete, to capture anything else that the participants remember or want to share.

March 2 through March 29, 2010 Seventeen interviews were conducted, 11 from GMU and 5 from the community college. An email also arrived from the hospital-based program explaining no participants responded wanting to participate.

March 2, 2010 My first transcription was completed today. From here on out, after each interview, the audio recording was uploaded to my computer and listened to by me, allowing me to make additional notes to my field notes of what the take away points were from the interview. I felt it was important to make sure I documented the areas highlighted as significant by my participants as I transcribed each interview. Each interview was then transcribed in its entirety first, and then sentences were highlighted in the transcription according to what potential category they might fit into.

March 3 through March 17, 2010 Eleven interviews were completed from GMU participants and 5 from the community college. I contacted the instructor from the hospital-based program but no students volunteered. As soon as I finished transcribing one interview, I completed a one-page summary to send out as a member check.

May 15, 2010 Met with Dr. Maxwell in regard to how to best complete the analysis once the transcriptions were completed. Spoke with Dr. Milligan to several times by phone, keeping her updated on transcriptions' process and sent her several one-page summaries to view.

June 12, 2010 The last transcription was completed. Several transcriptions were reviewed for summarization by content experts for appropriate summary points prior to being sent out to members.

June 13, 2010 One-page summaries of 16/17 transcriptions were emailed out to each member for a member check. One summary was held due to the impending death of a participant's spouse and the sensitive nature of the interview. Nine responses from participants were emailed today with no corrections.

June 14, 2010 Transcripts reviewed for overarching threads, 10 discovered within the concepts of barriers and successes. Threads placed on my office wall to be filled in with quotes from the interviews to see if appropriate themes appear.

June 15 and 16, 2010 Six more responses from participants regarding the one-page summaries were emailed to me with no corrections, but gave support for me in this dissertation.

July and August, 2010 Multiple days spent reviewing transcripts and listening to interviews and making notes of the concepts discovered and those themes that seemed to appear most often.

August 19, 2010 Computer died, fortunately while on vacation. All of my dissertation was saved on two thumb drives, locked away, and the computer hard drive was still intact.

September 1, 2010 With a new computer, I began writing each theme in the first two questions on poster paper and all barriers on separate poster paper identifying each comment with the interview number and paragraph comment came from.

September 17, 2010 Completed first layer of themes and concepts; totaled 13; were placed on poster board from 17 interviews.

September 20 through October 30, 2010 I entered themes into a matrix with large quotes trying to separate Barriers and Successes. With each set of subtopics in the matrix, I sent it out to content experts for review. They agreed that I had one strong theme, two potential, and several that needed further work.

November 2010 I met with my committee members individually and had them review some transcripts and my matrix to see if they agreed with the categories I had. I also had three content experts perform blind reviews of four random transcripts and write the themes they got in the margins of the documents. All three of them got the same categories I got, with one suggesting that several other concepts could be collapsed within one of the broad concepts. I also had two member checks regarding my proposed themes who both agreed I was on the right track..

Last week of November through December 1, 2010 I continued to reread the transcripts to understand what the participants were saying. I also began rewriting chapter 3 per Dr. Maxwell's suggestions of adding detail of my methods.

December 9, 2010 Met with Dr. Milligan by phone, updating her on the current progress.

December 10, 2010 Completed Chapter 3 section "data collection" for review by content expert with suggestion made for modification.

December 28, 2010 Corrections to Chapter 3 "data analysis" sent for peer review.

January 12, 2011 Met with Dr. Maxwell and discussed how to write Chapter 4 and continue adding detail and modifications to Chapter 3.

January 13, 2011 Met with Dr. Milligan, reviewed progress of writing and analysis thus far and we set the tentative defense date as March 25, 2011, 10 a.m. to 12:30 p.m.

January, 13 through 30, 2011 I wrote parts of Chapter 3, sent it out for peer review, made corrections, then sent to Dr. Maxwell for review, made corrections and began the cycle again. Chapter 3 was finished January 30.

February 1 through 25, 2011 Chapter 4 was written following a prosed matrix of categories and subthemes, but was modified into collapsed categories and themes after each section was written. Each category was written with large quotes, sent for peer review and content expert review and then returned to me for modification. Once completed, the chapter as a whole was reviewed by several content experts and peers for its overall meaning. Member checks were completed for Chapter 4 and supported the categories and themes.

February 25 through March 5, 2011 Chapter 5 was written, sent out for review, modified, and sent out for review again to my committee, and peer reviewed. After several revisions, the dissertation in its entity was sent for editing.

March 3, 2011 My chair informed me that a copy of my dissertation was to be distributed to each committee member and placed in the library March 11, 2011.

March 19, 2010 Reread through the entire dissertation and began creating PowerPoint presentation and prepared for defense. Final participant member check received.

March 25, 2011 Dissertation defense at 10:00 a.m. Dean's Conference Room, George Mason University.

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CURRICULUM VITAE

Deborah L. Hobbs was born in Milford, Delaware. She started out as a volunteer in Peninsula General Medical Center, and proceeded on to achieve her LPN license 5 years later in 1980. Followed by a few years of experience, she obtained her Associate's Degree in Nursing in from Central Carolina Technical Community College in 1986. Her Bachelor's of Science in Nursing from George Mason University was completed in 2000, followed by her Master's of Science in Nursing with focus in Advanced Clinical Track in 2001. Hobbs has held a variety of hospital-based cardiac care and surgical nursing clinical positions in Maryland, North Carolina, and Virginia (1986 through present). She currently works prn on the surgical/orthopedic unit at Inova Fair Oaks Hospital where she began working in 1990. In 2001 Hobbs began a career in academia at the School of Nursing at George Mason University. Hobbs has taught for the George Mason University School of Nursing as adjunct faculty since 2001, initially with undergraduate nursing students. In 2003 she began teaching the clinical practicum for the Nurse Refresher Course and then teaching the didactic portion in 2005; she currently teaches and coordinates the Refresher Nurse Course. Additionally, in 2010 she began working as the Nursing Practice and Education Specialist for the American Psychiatric Nurses Association. She is a member of Sigma Theta Tau and the American Association of Critical Care Nurses (AACN).