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Health and social care professionals return to practice: A systematic review

Executive Summary

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EXECUTIVE SUMMARY

BACKGROUND

This literature review was jointly funded and commissioned by the Chief Nursing Office in Scotland and the Health and Care Professions Council. It was carried out by researchers from the Nursing, Midwifery and Allied Health Professions Research Unit, in collaboration with the funding bodies.

The goal was to bring together evidence relating to the return to clinical or frontline practice of health and social care professionals following an extended period of absence (of longer than 3 months) not resulting from disciplinary or fitness to practise issues. In particular, evidence was sought about:
(1) the risks associated with return to practice; and
(2) approaches which could support return to safe and effective practice.

METHODS

A systematic literature review was carried out using established methods, following a pre-determined protocol. Comprehensive electronic searches, informed by initial searches of grey literature, were carried out. Rigorous processes were used to identify studies which met defined eligibility criteria. Included studies were full-text peer reviewed publications, including those with quantitative, qualitative and mixed methods, which were focussed on return to practice of a health and social care professionals. This included the 16 professions currently regulated by HCPC plus other relevant professional groups (e.g. doctors, nurses, midwives, pharmacists, dentists), after a period of absence (> 3 months). The transparency, or potential for reproducibility, of publications was appraised, and data extracted and synthesised from studies judged to have sufficient description of the method of compiling evidence to enable reproduction. Extracted data was coded to identify risks/harms associated with return to practice, and factors which positively or negatively contributed to

risks or safe return to practice. Data were tabulated and brought together within narrative syntheses which addressed pre-defined research questions.

FINDINGS

Evidence relating to return to practice

While 226 relevant full-text publications were identified, only 28 of these were judged to have sufficient description of the method and report data relevant to the research questions. These were a diverse group of heterogeneous studies, with a variety of qualitative/quantitative and primary/secondary study designs, with the majority conducted in the US and UK. The length of time that professionals were out of practice varied from 3 months to more than 20 years.

The most common reported reason for return to practice was caring responsibilities, although a number of other reasons were identified. More than half of the studies (15/28) focussed on return to practice of doctors, while the remainder focussed on other nursing, pharmacy and allied health professions.

In general, studies reported largely qualitative results, often in a narrative format, and the majority of evidence extracted related to factors which were implicitly – rather than explicitly - linked to successful return to practice.

Time away from clinical practice

There is widespread consensus that the longer a professional is out of practice the greater the potential risk is to the public, however the actual risks to service user safety are not described in the literature. Time away from clinical practice was associated with “skills fade”, or attrition of clinical knowledge and practice skills; and emotional factors, such as self-esteem and confidence.

Factors impacting on return to practice

Lack of skills, training schemes, placements, supervision, peer and employer support, funding for training, and lack of guidance, and variations in processes and poor administrative practice were all negatively associated with return to practice.

Individual, or personal, factors such as continued breast feeding, or personal feelings could also negatively impact on return to practice. Barriers relating to knowledge, performance and aspects of personal life could also impact on return to work. Age, gender, personal health and marital status were all related to return to practice.

Approaches to support return to practice

Organisational processes, such as well-organised and resourced return to work programmes, training and mentoring schemes, and clear policies and planning, could positively support return to work. National strategies, financial incentives, and improved work conditions/environment could all positively impact on return to practice.

Evidence relating to regulation

There is little research-based evidence available relating to the management of risk at a regulatory level in relation to return to practice, but guidance and recommendations, developed principally through expert opinion and primarily focussed on doctors, demonstrates consistency. To ensure a comprehensive, transparent and feasible regulatory process to support return to practice, recommendations include; the involvement of all relevant stakeholders, clear policy guidelines and mechanisms for clinical supervision, processes for certificating competency, adoption of flexible models, and the formation of a national return to practice database.

Regulators frequently prescribe a minimum number of hours of practice (often arbitrarily) for professionals wishing to return to practice. While there was broad consensus that that the

return to practice policies should be triggered following an absence of between 2 and 3 years, there was variation in this, and the evidence for this is unclear. There is no evidence that completing the required number of hours ensures competence.

IMPLICATIONS

Implications to support return to work

Health and social care practitioners wishing to return to practice would benefit from appropriate planning and preparation for their break and subsequent return; increased awareness of the potential impact of emotional, behavioural and social factors which may impact on return to practice; and early consideration of childcare arrangements (where relevant). Maintenance of social and professional networks during a career break can support subsequent return to work.

To support return to work, employers and organisations should provide well-organised, resourced, flexible return to work programmes, supported by clear policies and guidance. Employers should maintain clear communication with staff, including during the period of absence, and should consider the workload and environment of people returning to work. Provision of adequate breastfeeding facilities and policies can be important.

All relevant stakeholders should be involved in the process of developing guidance and policies relating to return to practice. New policy guidelines must clarify issues relating to time away from practice and what constitutes active practice. Policies should establish and clarify mechanisms for clinical supervision and certification of competency and should incorporate flexibility to accommodate the individual needs of staff and organisations.

A national return to practice database could be beneficial, documenting information such as the number of professionals returning to practice, their professional group, length and reason of absence, and the number of hours of training, supervision or mentoring.

Implications for future research

There are important gaps in the current evidence base. In particular, there is lack of evidence relating to the risks to, or perspectives of, service users. Identification of reliable, validated tools to assess aspects of return to work, including the impact on outcomes such as safety of service users and health and social care professionals, is essential. Further systematic review of evidence focussed on competence to practice, and the association with return to work, which has not been incorporated into this review, is advised.

CONCLUSIONS

A comprehensive review of evidence relating to return to practice of health and social care practitioners has been conducted. While the quality and comprehensiveness of current evidence is limited, a number of key factors which impact on return to practice have been identified. Implications for both health and social care staff wishing to return to practice and their employers and organisations have been highlighted. There is a need for clear guidance, policies and mechanisms in order to enhance the process of return to practice. This should be supported by carefully planned research to establish a high-quality evidence-base in this field.