The use of the exit interview to reduce turnover amongst health care professionals (Protocol)

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The use of the exit interview to reduce turnover amongst health care professionals

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Abstract

This is the protocol for a review and there is no abstract. The objectives are as follows:

To determine the effectiveness of various exit interview strategies in decreasing turnover rates amongst health care professionals working in healthcare organisations.

To address these objectives the following comparisons are planned:

1) Exit interviews compared to no exit interview.

2) We will also explore the effects of the following characteristics of the intervention on the magnitude of the effect across studies: method of delivery (face to face, telephone, self-complied, electronic or postal).

3) Depending on the number and quality of studies found we will also explore the effects of the following characteristics of the intervention on the magnitude of the effect across studies:

- The timing of the interview in relation to the health care professional’s resignation.
- The person who carries out the interview in relation to the employee’s immediate work environment.
- The location of the interview in relation to the employee’s work environment.
BACKGROUND

Description of condition

Turnover is defined as “the process whereby staff resign from the organization or transfer within the hospital environment” (Bland Jones 1990). It is a problem that affects all organizations and has become a focus of healthcare institutions because of expenses related to time and money. Wise defines this phenomenon as an erosion of human resources within an organization resulting in an increase in the cost of doing business (Wise 1993). Unfortunately, when health care is involved the end result of turnover can impact on patient care and clinical outcomes. Turnover has been a focus of interest for organizations since the early 1900’s (Cotton 1986). It can be viewed as beneficial to an organization to a certain degree, stopping it from becoming stagnant and non productive (Weisman 1981). Tai et al suggests in any organisation, trying to retain staff and keep turnover rates at an acceptable level is beneficial. In healthcare facilities turnover rates range between 10.1% to 50% (Tai 1998), however, rates between 15% to 20% annually are considered acceptable to prevent an organisation becoming stagnant (Capko 2001).

Description of intervention

Exit interviews are conducted in many organisations to elicit reasons for employee turnover (Leahey 1991). The practice dates back over half a century (Melcher 1955; Moran 1956) and takes the form of either a formal or informal verbal interchange, conducted at a point between the time of resignation and the employees’ last working day; a written questionnaire, completed either before or after leaving the organisation; or a combination of both approaches. The exit interview can be defined as “a widely used tool for gathering information from separating employees” (Giacalone 2003, p.398). An excellent summation of the process is “that the scope of inquiry is not simply why employees quit their jobs, but the impact of the total work environment on those who chose to stay” (Drost 1987, p.104). Although there is argument for and against the exit interview, it remains a recommended component of the exiting process. Well accepted reasons for conducting such interviews include: attempting to change the person’s mind about leaving; using the interview as part of an ‘image management’ exercise (Lefkowitz 1969), documenting specific reasons for the resignation so that managers can use the information to improve the service (Erickson 1996; Leahey 1991; Neidermeyer 1987); and, more recently to ‘trend’ reasons for turnover (Erickson 1996).

An exit interview also provides organisational feedback about unethical or bad behavior and information about current practices, working conditions, management and training programs (Drost 1987; Giacalone 2003; Jackson 2002; Jurkiewicz 2001). In ideal circumstances the employee is interviewed by someone other than the line manager, information is then gathered and analysed and fed back to managers and executives in a timely manner. Although the exit interview is widely used, validity of the approach has been questioned (Jurkiewicz 2001; Lefkowitz 1969). There are often inconsistencies in the way the interview is managed, and it may be conducted by people who are unskilled in interview techniques. The exercise is costly, and information may not be analysed and fed back in a timely manner, or may be disregarded completely. More importantly, the information elicited may not be accurate. For example, departing employees may wish to leave a good impression to improve chances of a positive future reference or re-employment (Hinrichs 1971; Yourman 1965) they may feel intimidated about discussing the true reason for leaving, especially if conflict is involved and the interview is conducted well before the person’s departure date; or they may feel that disclosing their real reason is a waste of time, based on previous experience with the service (Yourman 1965).

How the intervention might work

The intervention under consideration in this review is the exit interview and the primary outcome is staff turnover. In theory, the exit interview reduces turnover by alerting management about organisational deficits or problems that may be amenable to quality improvement activities. Responding to concerns raised during the exit interview, provides the organisation with a reputation of caring, which may, in turn, contribute to staff retention.

Why it is important to do this review?

There is a world-wide shortage of health care professionals (WHO 2006), so many strategies have been utilised in an attempt to reduce this phenomena, the exit interview being just one of them. This review is timely and important because retaining health care professionals has become a priority for most countries around the world. To understand the organisational environment, the manager must be aware of the tools available to assist them in trying to reduce turnover and retain staff. The exit interview is one such tool, but whether it is effective in reducing turnover or the number of health care professionals who leave the profession is still disputed.

OBJECTIVES

To determine the effectiveness of various exit interview strategies in decreasing turnover rates amongst health care professionals working in healthcare organisations.

To address these objectives the following comparisons are planned:

1) Exit interviews compared to no exit interview.
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- The location of the interview in relation to the employees work environment.

METHODS

Criteria for considering studies for this review

Types of studies
Randomised controlled trials (RCT’s) or well designed quasi-experimental studies (QES). Studies published in all languages will be included.

Types of participants
Health care professionals (includes medical, nursing, allied health) who have undergone any type of exit interview from a healthcare organisation.

Types of interventions
Any form of exit interview undertaken at the voluntary cessation of employment or at a prescribed time following departure from the organisation. These can be defined as a face to face exit interview, a telephone exit interview, a self-completed exit interview survey, electronic exit interview survey and mailed exit interview survey.

Types of outcome measures

Primary outcome
- Turnover rate (defined as the proportion of the population that leaves the organisation in any given year or over the period of the study).

Secondary outcomes
- Organisational change as a result of the exit interview process (for example evidence of policy change).
- Cost incurred as a result of voluntary cessation of an employee (for example productivity losses incurred when the new employee is training and orientating, or any other costs reported by the author).
- Absenteeism (days of sickness absence during the study period. Sickness absence may be extracted from the employee attendance records, or may be self-reported).
- Burn out measured by any validated burnout instrument.
- Job satisfaction measured by any validated job satisfaction instrument.
- Stress measured by any validated job satisfaction instrument.
- Patient outcomes as defined by the study author.

Search methods for identification of studies
See: Effective Practice and Organisation of Care Group methods used in reviews.
The Database of Abstracts of Reviews of Effectiveness (DARE) will be searched for related reviews.
The following electronic databases will be searched for primary studies:
(a) The EPOC Specialised Register (and the database of studies awaiting assessment) will be reviewed (see SPECIALISED REGISTER under GROUP DETAILS)
(b) The Cochrane Central Register of Controlled Trials (CENTRAL)
(c) Bibliographic databases, including MEDLINE and CINAHL, PsycInfo and ERIC
Electronic databases will be searched using a strategy developed incorporating the methodological component of the EPOC search strategy combined with selected MeSH terms and free text terms relating to exit interviews, this search strategy will be translated into the other databases using the appropriate controlled vocabulary as applicable.
We will search MEDLINE from 1950 using the following search strategy, which will be modified as appropriate for CINAHL and other databases:
1.exp Health personnel/
2.exp Health occupations/
3.exp Health manpower/
4.exp Health personnel/
5.exp Allied Health Occupations/
6.exp Allied Health Personnel/
7.exp Allied Health Personnel/
8.or/1-7
9.Job Satisfaction/
10."Attitude of Health Personnel"/
Other sources
(d) Handsearching of those high-yield journals and conference proceedings which have not already been handsearched on behalf of the Cochrane Collaboration.
(e) Reference lists of all papers and relevant reviews identified.
(f) Authors of relevant papers will be contacted regarding any further published or unpublished work.
(g) Authors of other reviews in the field of effective professional practice will be contacted regarding relevant studies that they may be aware of.
(h) We will search ISI Web of Science for papers which site studies included in this review.
(i) We will search the internet for non-peer reviewed reports (e.g. professional organisations and governmental agencies).

Data collection and analysis

Screening
All titles and abstracts identified through the search strategies will be screened independently by both review authors to assess which studies meet the inclusion criteria. Full text copies of all papers that are potentially relevant will be retrieved and assessed for inclusion and methodological quality. Any disagreement will be resolved by discussion between the review authors.

Data abstraction
Two review authors will undertake data abstraction independently using a modified version of the EPOC data collection checklist. Any disagreement will be resolved by discussion between the coders. If data is missing we will attempt to contact the authors of the studies to obtain missing information. The study will only be excluded if data relating to the primary outcome is not available.

Quality
The quality of all eligible studies will be assessed by two independent review authors using criteria described in the EPOC module (see ADDITIONAL INFORMATION, ASSESSMENT OF METHODOLOGICAL QUALITY under GROUP DETAILS).

Any discrepancies in quality rating will be resolved by discussion between coders.

Reporting
Outcomes will be reported in natural units. Where baseline results are available from RCT and QES designs, pre-interventions and post-intervention means or proportions will be reported for both study and control groups and the unadjusted and adjusted change from baseline will be calculated with 95% confidence limits. Dichotomous outcome measures will be presented as both risk differences and relative risk reductions.

Analytical approach
Primary analyses
We will base primary analyses on consideration of dichotomous outcome measures (for example the proportion of health care professionals leaving). When studies report more than one measure for each end point, we will extract the primary measure (as defined by the authors of the study) or the median measure identified. We will present the results for all comparisons using a standard method of presentation where possible. For comparisons of RCT and QES designs we will report (separately for each design):

- Median effect across included study.
- Inter-quartile ranges of effect size across included studies.
- Range effect sizes across included studies.

We will report individual tables comparing effect sizes of interventions grouped according to EPOC taxonomy (structural, professional and organisational) (EPOC 2002).

Where appropriate, we will use the standard statistical methods of the Cochrane Collaboration for pooling of data from randomised and quasi-randomised control trials. For categorical and continuous data, we will calculate the risk ratios (RR) and weighted mean difference (WMD) respectively with 95% confidence intervals. We will use a random-effects model to take into account the heterogeneity of the various studies.

Secondary analyses
Secondary analyses will explore consistency of primary analyses with other types of end points. We will calculate standardised effect sizes for continuous measures by dividing the difference in mean scores between the intervention and comparison group in each study by an estimate of the (pooled) standard deviation.

Methods of re-analysis
We will re-analyse RCT and QES designs with potential unit of analysis errors where possible by recalculating results using the appropriate unit of analysis; otherwise we will contact the authors of each study for clarification.

Summary of findings tables
We will use summary of findings tables for main comparisons in the review to interpret the results and draw conclusions about the
effects (benefits, potential harm and costs) of different interventions including the size of effects and quality of the evidence for outcomes for which there is evidence.

Exploring heterogeneity
We will prepare tables and bubble plots comparing effect sizes of studies grouped according to potential effect modifiers (timing of the interview, person carrying out the interview and location of the interview). A bubble plot graphically presents the relationship between the outcome of each study and a given effect modifier with the use of regression lines. Each study is represented by a bubble; the size of the bubble represents a study characteristic, often the size and quality of the study.

Ongoing studies
Ongoing studies identified will be described where available, detailing the primary author, research question(s), methods and outcome measures together with an estimate of the reporting date.

REFERENCES
Additional references

Bland Jones 1990

Capko 2001
Capko J. Identifying the causes of staff turnover. Family Practice Management 2001;April:29–33.

Cotton 1986

Drost 1987

EPOC 2002

Erickson 1996

Giacalone 2003

Higgins 2002

Hinrichs 1971

Jackson 2002

Jurkiewicz 2001

Leahy 1991

Lefkowitz 1969

Melcher 1955

Moran 1956

Neidermeyer 1987

Tai 1998

Weisman 1981

WHO 2006

Wise 1993
Yourman 1965
  Yourman J. An alternative to the exit interview. Personnel 1965; July/August: 51–5.

Zarandona 1985
  * Indicates the major publication for the study

WHAT'S NEW

| 6 August 2008 | Amended | Converted to new review format. |

HISTORY


CONTRIBUTIONS OF AUTHORS

All review authors have contributed to the production of the protocol. ALF lead the writing of the protocol, all other review authors provided comment and feedback. For the full review: ALF and JW will develop and run the search strategy, ALF and JW will screen records for eligibility.

DECLARATIONS OF INTEREST

None known.