

# Stressors Experienced By Emergency Department Registered Nurses At The Bedside: A Phenomenological Study

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STRESSORS EXPERIENCED BY EMERGENCY DEPARTMENT REGISTERED  
NURSES AT THE BEDSIDE: A PHENOMENOLOGICAL STUDY

by

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## ABSTRACT

The Emergency Department (ED) as a workplace for the Registered Nurse (RN) is a stressful environment. Reasons are thought to include interactions with other members of the interdisciplinary team as well as the situations associated with the environment of the ED such as trauma, death, sadness, joy and the general unpredictability of each moment. Studies have documented general health care workplace stress and its influence on staff, but a very limited number of studies have concentrated on the ED. No widely published studies have identified stressors from the perspective of the ED RN.

This dissertation is an interpretive phenomenological study that seeks to understand the experience of being an ED RN through the exploration of the perceptions of stress as lived by individuals who practice their art and science in this unique setting. Materials for evaluation and thematic identification were obtained through personal interviews of practicing nurses. The stories told by the participants communicated what each individual found to be negatively stressful as well as what each found to be positively stressful.

Conclusions based on the findings of this work suggest a need for the ED RN to be able to depend on the presence of several factors in order to be able to function with as little distress as possible. The optimal ED environment for the RN is posited to be supportive of the individual goals of the RN, provide adequate resources and foster a communicative interdisciplinary environment. Recommendations are made to improve resource management and interdisciplinary relations.

Keywords: distress, ED, emergency department, eustress, nurse, RN, stress, stressor

To my patient wife, Darlene—  
Thank you for supporting my dream: even when I did not realize that it was.  
Thank you for being my watchful gardener.

To all those who have been convinced that they are nothing—  
Overcome.

To the Long Slow Distance run—  
You are the best thought centering activity in existence.

## ACKNOWLEDGMENTS

My most sincere gratitude is offered to all those who were instrumental in the completion of this work. I have a true appreciation for Nick's choice.

Noen ganger er den peneste blomstene vokse fra de største haug med illeluktende avføring.

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## CHAPTER 1: INTRODUCTION

Several sources cite the Emergency Department (ED) as a fast-paced, high acuity care practice environment (Cox, 2004; Dwyer, 1996; Gillespie & Melby, 2003; Jonsson & Halabi, 2006; Laposa, Alden, & Fullerton, 2003; Ross-Adjie, Leslie, & Gillman, 2007). Studies have documented factors associated with nursing Burnout (Gillespie & Melby, 2003), the incidence of post-traumatic stress disorder among ED workers (Ross-Adjie, et al., 2007) and social factors that may contribute to these phenomena such as a lack of collegiality among co-workers contributing to isolation in the workplace (Jonsson & Halabi, 2006).

With rare exception, studies of ED nursing and the stressors associated with the work environment have approached the investigations from a quantitative standpoint. Researchers have approached the subjects with preconceived concepts of stressors about which subjects were then surveyed. Studies have used a variety of measurement tools with various levels of established reliability that attempt to measure stressors commonly associated with the nursing profession at large in the unique setting of the ED. A description of the experience of what it is like to provide care to ED patients as a Registered Nurse (RN) from the perspective of those who have lived the experience is lacking. The purpose of this study is to qualitatively explore the perceptions of stress as experienced by ED RNs at the bedside.

As an ED RN for more than 10 years who currently practices in the ED environment as an Advanced Registered Nurse Practitioner, this author has some insight into the experience. However, this insight is limited to personal career

experience and is mostly anecdotal. At best, this background may allow for more open conversations with informants, while at worst it is recognized as having the potential to introduce bias into this study. Even though this may be a limitation, the insight of personal experience may outweigh the disadvantage that researchers from outside the ED workplace suffer. These researchers do not have the ED experience which may be needed to draw out the stories of the informants in order to fully discover what perceptions of stress are experienced by the RN. While previous researchers have conducted studies that included workers from the ED setting (Cox, 2004; Gillespie & Melby, 2003; Scullion, 1994), few have inquired in an open ended fashion as to what RNs perceive to be stressors while caring for patients in the ED. Qualitative inquiry into this area exists only in a few open-ended questions within a few quantitative works that seek general input from the study subjects (Gillespie & Melby, Scullion). No truly qualitative work has been discovered, with the exception of Cox's dissertation, that sought the input of ED nurses to determine the stressors of working in the ED.

### Background of the Phenomenon of Interest

A large body of literature addresses the negative effects of stress on individuals in many workplace settings. A smaller body of work is specific to the ED. A subset of that body of work is concerned with the RN. However, these works investigate the negative effects of stress rather than considering the sources of general workplace stressors in the ED for nurses.

For example, there are many studies that investigate the phenomenon of nursing Burnout in general. Potter (2006) performed a review of the literature that dealt

specifically with ED physicians and nurses. Of the 11 studies that met the criteria for review, only one used a qualitative approach. All other works included in the review used a previously created, broad based quantitative survey tool. The term “Burn-Out” is attributed to Herbert J. Freudenberger (Canter & Freudenberger, 2001) as he pondered about, and published his thoughts on the concept in the mid 1970s (Freudenberger, 1974, 1975, 1977a, 1977b). The most frequent tool used to measure the characteristics of Burnout was the Maslach Burnout Inventory (MBI) (Maslach, Jackson, Leiter & Schaufeli, 1996) which was cited in eight of the 11 articles reviewed (Potter). The MBI measures 22 items that are categorized into three subscales: depersonalization, personal accomplishment and emotional exhaustion. It does not measure the antecedents to these items, nor is it environment specific. The MBI is a widely used measurement tool with consistently high reliability ratings and well-established validity for measuring the characteristics of the phenomenon of Burnout (Gillespie & Melby, 2003).

While the phenomenon of Burnout is generally accepted, it is not a recognized medical diagnosis. However, conditions such as Acute Distress Disorder (ASD) and Post-Traumatic Stress Disorder (PTSD) are both recognized in the fourth revision of the *Diagnostic and Statistical Manual of Mental Disorders* and are expected to remain in the fifth revision as noted on the web site of the American Psychiatric Association DSM-5 Development group (2010). The descriptions of contributing factors (witnessing death, near death, serious injury and sexual violation or threats thereof) to the conditions are similar to what nurses working in the ED experience on a regular basis. In the

descriptions of the manifestations of these disorders, persons are expected to exhibit avoidance behaviors, irritability, aggression and poor concentration. All of these characteristics are detrimental to the practice of emergency nursing and could be contributing factors to errors of commission or omission. There are no studies that have asked the average ED nurse what phenomena he or she experiences at the point of care that contribute to or distract from providing quality patient care.

### Purpose of the Study

The purpose of this study is to explore the perceptions of stress as experienced by ED nurses at the bedside. Specifically, the orienting question is, "What experiences do you appraise to be stressful working in an ED setting?" In depth conversation with participants about the experience of being an ED RN is hoped to yield stories of their experiences. These stories are expected to include examples of both positive and negative experiences. Subsequent examination of the gathered material is hoped to yield themes that not only identify stressful situations experienced by ED RNs, but differentiate those stressful situations as positive (eustress) or negative (distress).

### Importance of the Study and Knowledge to be Gained

Foundational information is needed because there is no sound evidence that true knowledge of what nurses find to be stressful in the ED has been documented. Previous scientists have applied findings from other disciplines to nursing and a few have even supposed that the stimuli from other workplaces fit the life of the ED RN. However, this approach does not hold true in light of the extensive research and theorization

published by Lazarus and Folkman (1984, 1987). Their transactional model about stress and coping clearly illustrates that the phenomenon of stress, and how people adjust to it, is a unique and individual experience based on the triad of person, environment and stimulus.

The discoveries from this study may provide insight into what ED nurses in general find to be stressful. This insight may, or may not, be the basis for future studies associated with several areas of interest including, but not limited to, the reduction of nursing Burnout, improved retention of experienced ED nurses, the reduction of costs and the delivery of quality nursing care in the ED. However, the correlation of stress and these possible outcomes are not the focus of this study, but could follow based on the findings from this work.

#### Outline of the Remainder of the Dissertation

Chapter 2 provides an analysis of the current literature that supports the investigation and clearly documents the lack of information directly obtained from the community of ED RNs.

Chapter 3 provides an outline of the methods used to gather and analyze the data from participants. Information is sufficiently detailed to allow for replication of the project.

Chapter 4 documents the findings of the study. It contains the qualitative themes that were interpreted from interviews with study participants and presents a rich description of the essence of the experience of stress for ED nurses.

Chapter 5 provides a discussion of the study findings; implications for nursing education, practice and policy; study limitations and recommendations for further efforts to contribute to nursing knowledge.

## CHAPTER 2: REVIEW OF THE LITERATURE

This chapter reviews the research literature on workplace stress experienced by ED RNs. The focus of the study is about ED RNs practicing at hospitals along the central east coast of Florida in the United States. Due to the predominance of studies from other countries, literature from outside the United States is considered as it provides relevant information to the practice of nursing in the ED setting in general.

### Literature Search

A search for a clear definition of stress was conducted in various sources including standard and medical dictionaries, government publications and peer-reviewed publications. Additionally, a search for, and review of, published research on stress as experienced by ED personnel was performed using the following guidelines.

### *Inclusion Criteria*

Peer-reviewed articles published by scholarly journals, doctoral dissertations and governmental agency publications were eligible for evaluation. Studies performed using a qualitative, quantitative or mixed methods approach were eligible for inclusion. Quasi-scholarly works such as dictionaries, published editorials, critiques of previous works, rebuttals of commentary and anecdotal instances were eligible for inclusion so long as they appeared in either peer-reviewed scholarly publications or governmental agency publications.

The primary focus of all works reviewed encompassed not only ED nursing, but nursing in many other settings. Even though this investigation is specifically oriented to the experience of RNs in the ED, a review of literature regarding the wider experience of nurses in general was considered to provide background information because of the paucity of literature specific to the ED setting.

#### *Exclusion Criteria*

Reports based on incidents such as multiple-passenger vehicle crashes (planes, trains and buses), bombings, floods, tornadoes and hurricanes and other such major events were excluded due to the unique nature and rarity of such events. Literature that was not peer-reviewed, not available in full-text or not available in English was excluded.

#### *Databases Explored*

The primary means of collection of literature for review was electronic searches performed via the University of Central Florida Library electronic subscriptions, physical literature holdings and interlibrary loan access. Databases accessed included Academic Search Premier, Alternate Health Watch, Business Source Premier, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Cochrane Review, Health Source: Nursing/Academic Edition, Human Resources Abstracts, MEDLINE, Philosopher's Index, Primary Search, PsycARTICLES, PsycBOOKS and PsycINFO.

Primary search terms included Emergency, Emergency Room, ER, Emergency Department, ED, Job Strain, Malpractice, Nurs\*, Performance, RN, Registered Nurse,

Situation\* and Stress\*. Terms were searched in varied combinations. Terms listed with an asterisk represent terms truncated to improve search results. Additionally, search headings in several databases were followed to improve results from the primary search terms.

### Evaluation of the Literature

No works were discovered that sought to identify specific stress inducing stimuli for RNs in the ED environment in the United States. Searches yielded literature that primarily addressed topics such as Stress, Workplace Safety, Critical Incident Stress (CIS), Acute Stress Disorder (ASD), Secondary Trauma, Post-Traumatic Stress Disorder (PTSD) and Burnout in the ED setting. The overall amount of literature dealing with the stresses of emergency nursing was minimal. Of the 16 works reviewed, five studied nurses working in an emergency setting either exclusively or as a comparison group. Two of these studies were performed in the United States and the remaining works studied nurses in the United Kingdom. The remaining 11 works studied physicians, health care service workers, and nurses from various practice specialties other than emergency services. Countries in which these studies took place included the United States (3), the United Kingdom (2), Australia and the South Pacific nations (1), Iran (1), Jordan (1), Switzerland (1) and Taiwan (2). In total, five studies originated from the United States and the remaining studies originated in other countries. Considering the significant differences in how health care services are delivered in different areas of the world such as universal coverage of care expenses for the patient, the findings and conclusions of research from other countries may or may not be

applicable to the ED setting in the United States. The literature also spans the extensive time period of 1983 to 2004. Given the changes in how health care is delivered today as opposed to 10 to 20 years ago, the conclusions of many sources may no longer be valid. Themes identified within the literature are hereafter clustered according to the effects of stress on the ED RN and the delivery of health care.

### *Stress Definitions*

According to the *New Oxford American Dictionary* (2010), the word “stress” is based on the Latin “strictus” meaning, “drawn tight.” From this root, the modern term originated from the combination of the Old French “estresse” meaning “oppression” and the Middle English term “distress” which denotes the “hardship or force exerted on a person for the purpose of compulsion.” Currently, the word may be used as either a noun or a verb. When used as a noun, it denotes “a state of mental or emotional strain or tension resulting from adverse or very demanding circumstances”. When used as a verb, it is a reference to the “cause of mental or emotional strain or tension.”

Additionally, the terms coined by Selye (1975) “distress” and “eustress” have since become part of the common lexicon and are currently defined in the *New Oxford American Dictionary* (2010). “Distress” is defined as extreme difficulty, anxiety, pain or sorrow. This is the negative connotation of stress as noted by its root in the Latin “distringere” meaning to “stretch apart”. The positive manifestation of stress is referred to as “eustress” and is defined as “moderate or normal psychological stress interpreted as being beneficial for the experiencer.” An individual balance between the positive and

negative was proposed by Selye to promote optimal functioning both physically and emotionally.

The concepts of distress and eustress have evolved over time as is illustrated in the comparison of two editions of Taber's Cyclopedic Medical Dictionary. The 16<sup>th</sup> Edition (Thomas, 1989) defines stress from both a physical and a psychological basis. In the physical, stress is a force that is exerted on a particular material entity. Psychological stress is similar, but instead brings about disequilibrium in an emotional rather than physical sense such as fear, anxiety, and joy. The term "joy" in this discussion does not seem to match, but it is illustrative of a Distress-Eustress continuum, which may include the concept of "challenge." The positive reference to stress has been removed from the 21<sup>st</sup> Edition of Taber's Cyclopedic Medical Dictionary (Venes, 2009). Despite its deletion, the Distress-Eustress spectrum remains important to appreciate the necessity of balanced stimulation or stress to maintain both physical and psychological well-being (Selye, 1975). The shift from a balanced definition to one of negativity is illustrative of how the term has become more synonymous with the harmful effects of stress.

Lazarus and Folkman (1987) describe stress more specifically as a self-repeating cycle of stimulus, appraisal and response with an intricate interplay between the individual, their environment and how the individual holistically interprets the situation. The process is very complex in that elements can take on multiple roles within the process and any given stimulus may or may not elicit a response, which is dependent upon the appraisal of the stimulus by the individual and in consideration of the

environment. In other words, what is negatively stressful to one person in a given environment and experiencing the same stimulus may be either positively stressful or completely ignored by another person experiencing the same combination of factors (Gruen, Folkman & Lazarus, 1988). Additionally, conditions that come about as a result of a stimulus may, in turn, become stressors in future situations (Lazarus & Folkman).

For example, fear of being attacked could be the result of suffering an assault. That fear, if it persists, could subsequently become a stressor to which the individual may respond by taking action. Taken positively, an individual might take self-defense classes in order to gain the skill to fend off an attacker. Taken negatively, that same individual might choose to not venture out into the world thus preventing a second incident altogether.

### *Workplace Stress*

As a means to support the need for the study of stressors to the ED RN, works having to do with the correlation of stress and job performance were reviewed. The National Institute of Occupational Safety and Health workplace stress information pamphlet posits that a connection exists between stress and error, but does not provide empirical evidence for the claim (Sauter, et al., 1999). The publication also puts forth the workplace-based definition of stress as “harmful physical and emotional responses that occur when the requirements of the job do not match the capabilities, resources, or needs of the worker” (p.6). This definition of workplace stress is echoed by Welker-Hood (2006) in a published commentary, but she does not provide any original research to establish her thought as anything more than conjecture. A third work makes the

assertion that there is a correlation between job stress, stress related illnesses and the quality of patient care but fails to support this statement with either secondary references or original evidence (Visser, Smets, Oort, & deHaes, 2003). Even though these resources are editorial in nature, they do provide material that provides valuable insight into workplace stress in general.

For example, Macdonald, Karasek, Punnett and Scharf (2001) studied the relationship between physical and psychosocial stressors and musculoskeletal disorders in both blue-collar and white-collar workers. Their work supports the notion that although a difference in the stimulus is clear, the negative results of exposure to different stressors may produce similar results. Similarly, Gruen, et al. (1988) state what one individual may find negatively stressful, another may find to be positive. The individual interpretation of what is and what is not stressful is in agreement with the works by Lazarus and Folkman with reference to the effect of appraisal of stimuli on stress and coping (Lazarus & Folkman, 1984, Folkman & Lazarus, 1988).

The Demand/Control model posited by Karasek (1979) states that the workplace environment in which an individual is situated produces more deleterious outcomes when that individual perceives that they possess minimal control over that environment. This model framed a study among 228 subjects from 30 states (Browning, Ryan, Thomas, Greenberg & Rolnak, 2007). ED nurses who practiced in three different roles were surveyed about their perception of control in the workplace and their level of Burnout. The roles included nurse managers, nurse practitioners and staff nurses. An inverse relationship was found to exist between perceived control in the work

environment and Burnout. Staff nurses reported the lowest perception of control and also reported the highest instance of Burnout. However, the study failed to identify any specific stressors other than the perceived lack of control in the workplace. While the cited works other than this single study have not been conducted in a nursing setting, the issue of control over one's situation is certainly something of interest to the practicing ED RN. This is especially interesting considering the unpredictable nature of the ED environment. None of these works attempt to identify specific stressors that are universally applicable to the ED, nor do they mention the experience of the ED RN beyond the issue of control in the workplace.

A comprehensive review of literature on the subject of job stress, as manifested in the community and health services sector, was completed by Dollard, LaMontagne, Caulfield, Blewett, and Shaw (2007). The review primarily focused on literature that originated in Australia, but included studies performed in other South Pacific countries. The choice to expand the study beyond Australia was due to the limited number of studies published on the topic, which provides more strength to the argument that qualitative data is needed in this area. All research reviewed for their study was quantitative in nature and all studies used the *General Health Questionnaire* (GHQ), an established and reliable instrument, to assess the participant-reported levels and effects of stress on various professionals. Participants in the 35 studies reviewed ranged from nursing assistants and paramedics to health service workers, nurses, physicians and clergymen. No study included in the review singled out ED RNs as a population of interest. No conclusions were drawn to associate stress level to levels of error.

However, the review did reveal that health service workers reported a higher level of distress than the general population.

To summarize, the literature regarding workplace stress posits that no matter what the setting (nursing or non-nursing) negative stress has a deleterious effect on the worker and the quality of job performance. Each individual worker's perception of the environment and the associated stimuli determines whether or not the stress is considered negative or positive. Likewise, the level of control in the workplace as perceived by the worker influences the appraisal of stress in the workplace.

### *Stress as Negative and Positive*

#### *Negative*

Gillespie and Melby (2003) investigated the effect of workplace stress on the phenomenon of Burnout among nurses in the United Kingdom, comparing rates of Burnout among Medical versus Accident and Emergency (AE) nursing staff. (The term "Accident and Emergency" as used in the United Kingdom is synonymous with the term "Emergency Department" in the United States.) The primary focus of the study was the effect of workplace stress on nurses (i.e., Burnout) and the MBI was used as an investigative tool for the study.

Consistent with other works included in this review, minimal input as to what AE RNs experienced as stressors was sought. However, Gillespie and Melby (2003) did solicit subjects to volunteer their perceptions of things they found to be stressful by asking them to provide, at the close of the written survey tool, three things they found to

be stressful in their practice. After analysis was complete, the themes of staffing, patient issues, administrative issues, medical staff and work pressures were listed. The authors offered no explanation, definitions or process protocol information about what these terms represented or how these themes were extracted from the raw data.

### *Positive*

A study conducted in a single AE unit in the United Kingdom to investigate what nurses expressed as stressful and how they felt it affected them was completed using a mixed methods approach (Helps, 1997). Study subjects completed four different quantitative surveys and participated in a semi-structured interview. Helps assessed not only what they found to be positively and negatively stressful, but how those stressors affected them personally and professionally by incorporating the *Hassles Questionnaire*, a *General Health Questionnaire (GHQ-28)*, the *Responses to Stress Questionnaire* and the *Maslach Burnout Inventory (MBI)* in conjunction with the semi-structured interview which was designed specifically for the study. Each of these tools was used to assess the stresses participants were experiencing and the effects of exposure to those stresses. The *Hassles Questionnaire* was created specifically for the study and was a collection of previously reported minor stressors that the participants were asked to rate on a Likert Scale. No psychometric evaluation of the reliability or validity of the tool was documented. The authors reported several items that the participants found to be sources of stress in their daily functioning as an ED RN. Likewise, the *Responses to Stress Questionnaire* was created by the author for the study and collected the frequency of which participants reported experiencing symptoms of PTSD. Again, no

psychometric evaluation of the reliability or validity of the tool was documented. The results from this tool were reported as showing that one third of the participants showed some signs of PTSD. The remaining data collection tools are well-established survey tools with statistically established reliability. Results from the MBI showed moderate levels of Burnout amongst participants and the GHQ-28 showed one quarter of the respondents indicating psychological disturbance. Each tool was reported separately and the possible associations and correlations were not commented upon.

Similar to previously mentioned studies, sources of stress were identified as having to do with staffing levels, interactions with medical and administrative staff, abuse (not specified against whom), patients' families and pediatric death. Unlike other studies reviewed, the stress of environmental factors (ambient lighting and temperature control) and dealing with faulty equipment was documented in the study (Helps, 1997). (Note: the physical facility in which the study took place was undergoing a major renovation at the time. Lighting and temperature control was often erratic, most likely contributing to it being rated as the highest source of stress in the study findings (Helps).

With the exception of the Helps' (1997) study and Cox's (2004) work, no other studies in this review attempted to identify positive stressors. Helps reported that saving lives and improving the conditions of patients were sources of satisfaction. Similarly, a job well done and having gratitude expressed for that work were identified as positive stressors. Interestingly, the unpredictable nature of working as an AE nurse was not only listed as a positive stressor, but the erratic workload was listed as a hassle as well.

The difference between the terms unpredictable and erratic is not documented in the study.

### *Stress and the Emergency Services Setting Nurse*

A literature review completed by McVicar (2003) compiled the findings of research between 1985 and 2003 on the subject of stress in the nursing profession. As is the situation with the majority of the research uncovered, McVicar's (2003) work concentrates on the practice of nursing within the United Kingdom. The review was broad based and spanned many clinical areas and included the AE setting. Many of the same sources of workplace stress emerged and were categorized as workplace issues, violent behavior, interpersonal conflict, dealing with the families of patients, dealing with death and workload. Unique issues identified in the review were discrimination (unspecified) and uncertainty of treatment for patients.

A study based in the United Kingdom using a correlational survey design investigated the existence of an association between stress and being an AE nurse (Scullion, 1994). A total of 44 nurses were surveyed using a mixed methods design that used a tool the author specifically created for the study. Subjects were asked to rate different potential stressors on a five point Likert scale. Scullion also sought input from the subjects by adding a single, open-ended item that asked for descriptions of what it felt like to be an AE nurse. No other information was provided as to the development of the tool or consideration for this portion of the study.

The survey portion of the study asked subjects to rank-order ten items that the author had personally identified as negative stressors. Items included pediatric death

and pain, unstable patients, contact with the families of patients, violent complaints, overcrowding and having families witness staff being idle. The qualitative portion of the study identified four themes. They were enjoyment and stressfulness as well as both positive and negative feelings about being a staff member of an AE unit (Scullion, 1994).

No indications of reliability or validity were provided. The survey tool used was designed specifically for the project and underwent no significant preliminary review or statistical testing. The qualitative data analysis was significantly lacking in trustworthiness. The data collection tool allowed only a limited amount of writing space on the survey for subjects to respond to a single question about the lived experience of being an emergency nurse. No indication of how the themes were identified was included in the report (Scullion, 1994).

Adeb-Saeedi (2002) completed a similar study to that of Scullion (1994) by measuring the stresses of ED nurses in two Tehran, Iran hospitals by using a pre-determined list of stressors that Adeb-Saeedi hypothesized might be stressors for nurses in the ED setting. Validity of the items is addressed in the work, but there is no explanation of how the items were initially selected for inclusion in the survey. No open responses from study subjects were solicited.

Survey items included stressors similar to those rank ordered by Scullion (1994) and later supported by Cox (2004) such as issues of pain, suffering of patients, workload excesses, the presence of family and their reactions to the care provided to the patient and several other unique items. Some of the unique stress items posited

included vague terms such as “decision making” and “unpleasant tasks”, but Adeb-Saeedi (2002) offers no conceptual definitions, clarification or explanation of these terms or what they represent.

Cox (2004) supports themes previously discussed by Karasek (1979), Scullion (1994), and Adeb-Saeedi (2002) in his commercially unpublished descriptive phenomenological dissertation that sought to identify the stress experience of ED RNs with the goal of using the findings to improve that experience and thereby improve retention of staff. To complete the dissertation, Cox interviewed ED RNs using a phenomenological approach to identify themes about why nurses chose to work in the ED setting and what they found to be stressful.

Cox (2004) identifies many stressors in his work such as: being witness to significant trauma to persons of all ages, sleep deprivation as experienced by night shift workers, a lack of control, poor communications with administration and professional impressions. Cox identifies the positive stressor of the excitement experience that may be a significant factor in what draws nurses to the ED and keeps them coming back, despite the negative stressors identified, including the risk of harm to self. Participants in Cox’s study used terms such as rush, adrenalin rush and adrenalin junkie to describe the excitement experience associated with working in the ED. Themes identified by Scullion (1994), used by Adeb-Saeedi (2002), and serendipitously supported (neither Scullion or Adeb-Saeedi are referenced) by Cox were the theme of violence experienced by ED RNs and the theme of experiencing the death of a child. Beyond these two themes, the works of the different authors diverge.

### *Stress and Error*

As previously noted, the National Institute of Occupational Safety and Health considers stress to be a factor associated with the commission of errors in the workplace (Sauter, et al., 1999, Visser, et al., 2003). However, neither of these publications offers evidence to support this association. The following provides evaluations of literature that attempt to support this supposition.

The concept of emotional instability is posited to be a contributing factor to reduced patient safety (Teng, Chang, & Hsu, 2009). To investigate this assertion, a mail survey of Taiwanese nurses, without regard to the clinical area of practice, was conducted to investigate the correlation between the emotional stability of nurses and error rates while providing nursing care. The authors reported a 92.6% response rate to a survey tool that was delivered and returned by mail. This is a notably high response rate for a mailed survey. In the survey, Teng, et al. ask about the emotional stability of the respondent, staffing levels of their workplace and their perception of the level of patient safety. All survey items requested the respondent's self-report and no correlative information is provided in the report to support the responses of the survey participants. Their conclusions are reported to support the hypothesis that the less emotionally stable a nurse is, the more likely that nurse is to commit an error in care. No measures of emotional stability or patient safety other than the self report of survey respondents was used in the study to support this correlation. If one posits that the chronic stress under which nurses function can lead to emotional instability, it becomes apparent that this possibility strikes as being worthy of more scholarly investigations.

Elfering, Semmer, and Grebner (2006) directly observed 23 nurses in their individual practice environments in 19 hospitals in the German-speaking portion of Switzerland during the first 18 months of their nursing careers to document what they observed as stressful events for the subjects. Subjects in the study were selected based on their experience level and not on their area of clinical practice. As a result, the subjects' were grouped by facility and not by practice area. Subjects also used personal journals to record what they themselves interpreted to be stressful events. Items recorded included time pressure, concentration demands and job control. The subjects also documented what they considered to be errors that threatened patient safety. This included errors in documentation, medication administration mistakes and delays in patient care. All of these items were considered to be stressors of the workplace and the combination of external stressors and the stress of committing an error is consistent with Lazarus and Folkman (1987).

Elfering, et al. (2006) found that the level of control over the work environment (especially time constraints) contributed significantly to the commission of errors in patient care. Another interesting finding discussed was the more frequently errors were repeated in the patient care area, the less likely they were to be recognized as errors which was hypothesized by Elfering, et al. to increase the rate of later occurrences of the same error. However, no reliability statistics or processes to assure validity of these conclusions were documented in the study.

While not specifically focused on ED nursing, Firth-Cozens and Greenhalgh (1997) qualitatively evaluated the views and experiences of physicians in regard to

medical errors and stress as demonstrated by tiredness and lack of sleep. Over 300 physicians in the United Kingdom participated in the longitudinal study that spanned ten years. This particular report addressed performance of medical duties while experiencing stress and provides evidence of a link between stress levels and safe delivery of health care.

Several themes identified by Firth-Cozens and Greenhalgh (1997) related to factors contributing to medical errors. Themes included lack of sleep, overwork, depression, alcohol consumption by the physician and boredom. While the themes having to do with sleep and excess job responsibilities make cognitive sense, the themes of the effects of alcohol consumption and boredom are disturbing when coupled with the occurrence of errors in medical care; especially when they accounted for slightly more than six percent of the reported incidents. Even though this study did not include nurses and was not specific to ED physicians, the themes of stress and error correlation provide useful foundational information that may prove to assist in identifying themes that are unique to the ED RN experience.

A study designed to test the relationship between self-identified nurse stress and quality of care in a facility as reflected in malpractice claims resulted in report that encompassed four distinct studies and included more than 60 hospitals and 12,000 participants (Jones, et al. 1988). These studies evaluated the reports of stress levels among the staff members of these facilities and their malpractice rates. Retrospective reviews of malpractice claim filings were compared with the results of the *Human Factors Inventory* tool that had been completed by physicians and nurses on care units

within the participating facilities. Unfortunately, the research protocol did not control for the order in which stress levels rose or fell and when errors occurred while caring for patients on these units. Therefore, no determination could be made that would suggest a causal relationship since the measured variables were chronologically independent.

The report refers to two of the four combined studies (identified as three and four) in which some participating hospitals introduced stress reduction programs and others did not (Jones, et al. 1988). Hospitals that implemented stress reduction programs simultaneously experienced significant reductions in malpractice claim filings. Matched hospitals that did not implement stress reduction programs did not experience a reduction of malpractice claim filings. Therefore, the possibility exists that there is a positive correlation between stress experienced by staff members and the rate of malpractice lawsuit filings (Jones, et al. 1988).

Rutledge, et al. (2009) addressed this very possibility and studied the relationship of work stress, sleep and patterns of activity of working physicians and nurses in a real-time clinical environment, although not in the ED setting. By using modified personal digital assistants with specialized survey software, participants documented points of stress, workload and patient load. Compared with the results of memory performance assessments of the participants, Rutledge, et al. were able to identify patterns that illustrated the relationship between stress, memory performance and participants' sleep quality in order to make recommendations for error reduction in the clinical workplace.

Essentially, error rates rose when workers were experiencing greater levels of stress as a result of poor sleep, increased emotional stress or stressful tasks of care.

While Rutledge, et al. (2009) included nurses in their investigation; they cite no background studies pertaining to the ED nursing workplace or ED nursing performance. Rather, they cite only studies that examined performance of nurses and physicians in other specialties. They also cite the findings from three nursing focused studies that address only the prevalence of Burnout and do not investigate the correlation of stress and error (Hillhouse, 1997; Imai, Nakao, Tsuchiya, Kuroda, & Katoh, 2004; Lee, 2002). Rutledge, et al. did observe, and appropriately document, that the performance of medical duties differed significantly from the performance of nursing duties. The two groups (nurses and physicians) were compared and contrasted in the study as a result of this observation. The main difference between the two groups was noted to be the amount of time spent in contact with patients and the greater interpersonal demands this places on the nurse as opposed to the physician despite the reported level emotional demands of patient care being quite similar in both groups. This is an important consideration for the ED due to the interdisciplinary nature of the staff and the constant presence of both nurses and physicians in the ED setting.

The attempts of the reviewed studies to connect stress levels with job performance provide some insight into the importance of recognizing the need to reduce negative stress levels in various health care settings as well as among various health care workers. Each supports the hypothesis that a correlation does exist between distress and error commission and degradation of job performance in general. These studies provide rationale for further research that is specifically aimed at gaining an understanding of the sources of stress. Gaining such insight will provide a foundation

upon which interventions may be designed and implemented to improve the work environment of the ED RN.

### Synthesis of the Literature

A review of the available literature pertaining to the stresses of being an ED RN revealed several themes. To categorize them into general topics, they include workplace issues, patient issues, personal issues and safety. Stressors related to the workplace include issues such as poor interdisciplinary communications, respect, shift work, pay, too many patients to care for, unreliable equipment and uncertainty of care. Stressors related to the interaction with patients included dealing with their pain and suffering, dealing with death, delivering bad news to patients and their loved ones, experiencing the death of a child, interacting with patient families and making care decisions. Stressors of a personal nature included shift work and pay in addition to scheduling and co-worker relations. The sole theme related to safety was the stressor of the constant threat of violence perpetrated by those for whom the nurse is caring.

Research related to the experience of being an ED RN has been previously based on the investigation of themes identified in advance of contact with study subjects by the principle investigator. The exceptions to this statement are the sporadic examples of the researcher providing the study subject with the opportunity to respond to an open-ended question to offer a glimpse into what it is like to be an Emergency Nurse. While a number of works were reviewed that dealt with the ED setting, all works reviewed approached the subject solely from a workplace point of view. While Cox (2004) comes the closest to the phenomenon of interest for this work, no other research

was discovered that specifically investigated the experience of being an RN at the bedside of a patient in the ED.

### Summary of Knowledge

Based on the literature reviewed, it can be posited that the practice of nursing in general is stressful and that being exposed to stressors carries with it negative consequences. Less supported in the literature is the thought that some stresses (types, amounts, intensity) are considered positive. Exactly what is considered to be stressful to the ED RN is not known. It is not known if there is a collection of stimuli that could be identified by the ED RN group as universally stressful in either a positive or negative manner.

## CHAPTER 3: METHODOLOGY

*“Discovery consists of seeing what everybody has seen  
and thinking what nobody has thought.”*

~Albert Szent-Györgi (Good, 1963, p.15).

As presented in the preceding chapters of this work, nursing has been shown to be a stressful occupation. Being a nurse practicing in the ED may carry stressors that are unique to that environment as well as stressors that are shared with other areas of practice. However, there have been no widely published works heretofore discovered that have sought to investigate, and thereby begin to understand, the experience of being a practicing nurse in the ED; with the notable exception of the dissertation by Cox (2004). The primary focus of this work is the Lifeworld of the ED RN with the purpose of exploring the perceptions of stress as experienced by ED nurses at the bedside. The term, Lifeworld, is a descriptive term used in phenomenology to refer to the perspective from which individuals who participate in a study will relate their experience of the phenomenon of interest (van Manen, 1990). To put it plainly, their Lifeworld is where they come from.

By gaining insight from practicing nurses into the experience of being an ED RN, improvements in the work environment or support for that experience might be suggested. It will serve as the basis for other research on the practice of nursing in the ED. This research used a hermeneutical phenomenological approach to gain this insight.

## Design

An interpretive phenomenological approach as developed by van Manen (1990) was used to conduct this study. Interpretive phenomenology was chosen because it is best suited to gain an understanding of the phenomenon of interest by enlisting the input of individuals who have the lived experience. Rather than simply providing a description of the stories provided by participants, it requires the researcher to search for the deeper meaning of those stories. According to van Manen, “the methodology of phenomenology is more a carefully cultivated thoughtfulness than a technique” (p.131). Therefore, while a concrete stepwise methodology is incongruous with qualitative research in general, the following activities served to guide the process of this study.

## *Sample*

Since this study sought to understand the experience of what it is to be an ED RN, study participants were RNs who were currently practicing in an ED. Specifically, the selection criteria included licensure as a Professional Registered Nurse in the State of Florida, a minimum of one year of full time employment in an ED and current employment in an ED setting. Demographics regarding years of experience, areas of practice, educational preparation and nursing certifications were collected, but were not considered as inclusion or exclusion criteria. Demographics are reported in the participant profiles in Chapter 4.

A purposive snowball sampling approach was used to gain participants. Snowball sampling uses the personal and professional network of contacts of the individuals who

possess the characteristics being sought after for inclusion in a study. When an individual meeting inclusion criteria for a study agrees to participate, they are asked to refer similar individuals from their network of associates thus connecting potential participants with the researcher. For this study, participants were recruited from the researcher's network of professional acquaintances of working RNs from various hospitals within the central and central east coast areas of Florida. Methods to gain participants included word of mouth, printed flyer distribution (Appendix A), and a social media network. Nurses with whom the researcher had a working relationship were asked to refer appropriate potential participants to the researcher and provide the researcher with possibly interested individuals. Initial contact with potential participants was made by phone or email, depending on the preference of the potential participant as relayed by the referring contact. Upon completion of each interview, the participant was asked to refer other potential participants.

Fifteen initial participants were recruited. Data saturation began to appear during the fourth interview and continued through the sixth where no additional significant information was forthcoming. The volunteers who were not interviewed were thanked by the researcher for their willingness to participate.

### *Informed Consent*

Upon initially contacting prospective participants, the researcher provided the prospective participant with a written statement outlining the study in general (Appendix B). The University of Central Florida Institutional Review Board approved this statement. The statement includes the purpose of the study, the interview process, time

commitments expected of the participant, measures taken by the researcher to assure the participants' confidentiality, the rights of the participants (including the right to withdraw from the study at any time), the risks involved in participating in the study and contact information for the researcher, the researcher's supervising faculty and the University of Central Florida Institutional Review Board. Each participant was screened for eligibility and indicated their consent to participate by making an appointment to be interviewed and completing that interview with the researcher.

### *Confidentiality*

In order to enhance confidentiality, participants were not required to sign a consent form. Upon completion of the audio-recorded interview, each participant was assigned a pseudonym by which they are referred to in all subsequent documentation related to the study. Contact information for each participant has been securely and separately stored from the corresponding list of pseudonyms.

All audio recordings were transcribed without including information by which the participant might be identified such as the names of hospitals, co-workers and participants. The researcher used *HyperTRANSCRIBE™* software to complete this process. Audio recordings were transferred to password protected digital files as part of the transcription process and stored on an encrypted and password-protected external hard disc apart from the aforementioned confidential study materials. While participant profiles and quotes are used as part of data reporting, the individual characteristics of each individual have been sufficiently limited to inhibit readers from identifying the study participants.

### *Materials Collection*

After obtaining informed consent, each participant was interviewed. In keeping with the attributes of van Manen's (1990) approach to phenomenological investigation, repeated interviews with one or more of the participants was a distinct possibility in order to properly dwell within the material provided by the participants. However, sufficient interpretation was possible from a single interview with each participant. The researcher conducted and transcribed each interview personally. The location of each interview was of the participant's choosing and was conducive to private, uninterrupted conversation. Locations included private homes of participants, offices of participants and the office of the researcher.

Each interview was audio recorded using three different devices; a digital voice recording device, a password protected iPad and a password protected iPhone 4 both using *AudioMemos*<sup>™</sup> software to record the interactions with the devices. Audio recording quality was exemplary which contributed to the completeness of the interview transcripts and the elimination of the need to repeat any interview for audio clarity or statement clarification.

The choice of using the alternate devices was made not only to pre-empt device failure, but to attempt to reduce the anxiety of being recorded through the use of a more familiar device that is not typically associated with recording. This measure proved to be useful during two of the interviews. During one interview, the digital recording device failed during the interview. The failure was not discovered until after the interview was completed. During a different interview, upon seeing the researcher turn off the digital

recorder, the participant explosively expressed relief and then continued to provide data despite having been advised at the onset of the interview that the iPad and iPhone 4 were also being used to record the interaction. However, no materials obtained after this point were included in the study for reasons of ethics and the insignificance of the conversation after the recorder was switched off.

Minimal journal notes were written during each interview in order to allow the researcher to be fully engaged with and actively listening to the participant. Instead, verbal cues were infused by the researcher as part of the natural flow of conversation to record significant visual cues that would have otherwise been lost. Personal impressions of the researcher at such moments were noted during the initial interview recording reviews as well as during subsequent reviews of the audio recordings and readings of the transcribed interactions. Multiple reviews of the recordings proved to be the most valuable method of holistic evaluation and initial theme identification. Transcription by the researcher allowed for greater insight into the meanings found in the interviews.

Due to the novice level of expertise of the researcher, the transcribed interviews were reviewed by and discussed with the researcher's qualitative research methodologist, Dr. Susan Chase. Additional notations were made during each of these sessions.

### *The Interview*

It is at this point where van Manen (1990) identifies the beginnings of the collection of data in the phenomenological approach. The "triad" of conversation (p. 98)

between the researcher, the participant and the phenomenon of interest marks the point at which the experiences of the ED nurses began to be discovered. By remaining oriented on the experience of stress of being a nurse in the ED, rich stories that were later dwelt upon and reflectively evaluated were gathered. A semi-structured interview format guided the initial conversation (Appendix C). However, the researcher did allow the participant a significant amount of freedom when engaging in the dialog. The purpose of the semi-structured interview was only to assist in maintaining orientation to the phenomenon of interest.

### *Analysis of the Data*

Following the tenets of van Manen (1990), the primary researcher conducted multiple reviews of the recorded interviews as well as multiple readings of the interview transcriptions in order to sufficiently dwell in the material provided by the participants. First was a replaying and noting of the researcher's impressions from the conversation. Next, personally transcribing the audio-recorded interview conversations deepened the researcher's familiarity with the material. Reflection upon the interaction between the researcher and the participant continued throughout the process. The computer software program, *HyperRESEARCH™*, was then used to code, organize and document the researcher's thoughts regarding the materials thus identifying the pertinent data from which to interpret meaning.

While reviewing, transcribing, replaying, re-reading and reflecting upon the materials, themes were identified and codified. Notations of these topics were made first by the researcher and separately by the research methodologist during her independent

review of the transcribed interviews. Comparisons of these observations were made during multiple discussions of interview transcripts and the researcher categorized and defined each topic. In accordance with the tenets of van Manen (1990), if it had been identified that there were areas in need of further exploration, a second interview with the participant would have been sought in order for as much of the participant's story as possible to be expressed and evaluated. The initial interviews yielded significant insight into the Lifeworld of the ED RN and as such, no such secondary interviews were required.

To assist in the interpretation of themes expressed by the participants, materials were reviewed while the researcher maintained the mindset that experiences have qualities from four existentials (van Manen, 1990). These existentials are the lived body (corporeality), lived time (temporality), lived space (spatiality) and lived human relation (relationality or communality). Each of these existentials assisted in the exploration of the materials in a deeper fashion than what was presented at face value and codified. The mindset that each story should be appreciated from each of these four vantage points assured that the materials yielded descriptions of the Lifeworld of the ED RN. The researcher then used the knowledge offered in each interview to strengthen the conversational triad with subsequent participants until no new materials presented. It was at this juncture of the investigation that the skill of interpreting the data in an unbiased fashion from within the study was paramount. It was also at this point where a concerted effort was made by the researcher to refrain from interjecting his own thoughts into the conversation and adding only items brought out by previous

participants. Data saturation became apparent when themes from latter interviews fit the interpretations of materials offered by previously interviewed participants.

It is important to note that the thematic identification process does not lend itself to a true step-by-step approach. While the steps of topic of interest selection, participant recruitment, methods of experience transfer (writing, drawing, speaking, interviewing, etc.) and distillation of themes may appear to be linear, it is in the interpretation of the materials for meaning that this linearity dissolves.

This dissolution is as a result of the different life experiences of all persons involved. What words and experiences hold a meaning for the one relating the experience may not hold the same meaning for the recipient of that story. It is for this reason that secondary interviews might have been required, a second reader of the interviews was used and the primary researcher, while being a practicing ED Nurse Practitioner, was acutely aware that the perspective of the storyteller is superior to his own when interpreting the materials. Identified themes are documented with exemplars to support the researcher's interpretations in the latter chapters of this dissertation.

## CHAPTER 4: FINDINGS

*“You must learn... to see what you are looking at.”*

~Glaedr in *Inheritance* (Paolini, 2011, p.96)

As Glaedr said to his young apprentice, Eragon, one must be able to develop the skill to truly see what one is looking at in order to become fully aware of reality (Paolini, 2011). Interpretive phenomenology requires such skill and uses hermeneutic techniques to truly see. Listening to the stories of experienced ED nurses and then interpreting what they were expressing has resulted in the findings of this work. As such, the first finding of this research *is* understanding what the ED RN was truly expressing when asked to describe the experience of stress. On the surface, each nurse who was interviewed expressed a need to share. Whether for, as expressed by Hazel and Janet, the personal “therapy” of being able to voice their individual concerns and frustrations they experienced as an ED RN or as a cry for support, they were eager to share their stories. Connie expressed her willingness and excitement to support the effort to identify the value of the ED RN through the printed word of her stories. She was motivated by the thought that her experiences as an ED RN would be documented and available for anyone to read and, thereby, gain a greater understanding of the Lifeworld of the ED RN. No matter what the individual motivation, all were willing to share from their Lifeworld in order to bring forth an understanding of what an ED RN finds to be positively and negatively stressful.

The overarching theme of this work culminates in the idea that each ED RN

addresses their work in the ED with personal goals as to how they want to practice nursing. Stress, both positive and negative, is dependent upon how the ED RN appraises how the themes of Environment, Accomplishment and Interpersonal Relations interact with the goal of practicing as a professional ED RN. Eustressful conditions are those that are assessed by the ED RN as goal facilitating. In opposition, conditions that impede or prevent nurses from meeting their goals are assessed as being distressful. Introductions to the participants and vignettes from the interviews supporting the findings are expounded upon in this chapter.

### Goals and the Participants

Every participant framed the experience of success and frustration in the ED in association with practice habits and characteristics. The habits and characteristics were interpreted as the means by which each ED RN attempted to meet the goal of practicing as a professional. While the idea of having goals was not directly stated by any participant, it was interpreted by the researcher from participant responses to be a driving force of practice and the determinant of how stressful a given situation might be experienced. As such, having the goal of practice is the major theme from which all other themes are derived. To bring the reader into the Lifeworld of the ED RN, the following participant introductions illustrate the practice focus and goals of each participant as an individual. From the holistic standpoint of interpretive phenomenology, each participant portrays the main theme of having a practice goal by serving as an example of the phenomenon. Just as each participant is an individual, each participant presented a unique practice goal by which they assessed different stimuli in the ED to

be stressful. The following profiles provide the reader with insight to the major impressions they provided the researcher during the interview.

### *Carol*

Carol followed her mother into the field of nursing. Her initial education was at the bachelor's degree level and she went directly into bedside care on a medical surgical unit of a hospital where she stayed for 14 years. During that time, she went from bedside care to unit management and worked varied shifts. She developed a keen sense of self as a nurse and began to become dissatisfied with the work. She expressed this dissatisfaction by stating, "...every time I walked into the hospital I just had that sinking gut feeling, like, I didn't want to be there. Like, you know, it just sucked the life out of me."

To offset this dissatisfaction, Carol sought the newness of the ED despite having never dreamed of working in that department. The mystique of not knowing what was going to come in the door at any given moment coupled with the significant difference of the department were the lures for her to seek the practice of ED nursing. She has since discovered a new vigor to her career and has enjoyed the past three years in her new surroundings. She described finding a totally new identity as an ED RN. She stated,

It just wasn't fun anymore. I found no reward into it anymore. It was just like, "OK. Enough's enough." I needed to do something different... A new place. New identity, you know, where I could really hone in. Almost like back to basics.

Along with her newfound identity, she discovered a teamwork aspect to ED nursing that was lacking in her previous setting. This teamwork has motivated her to

support others and expect support from other members of the interdisciplinary team of the ED. When these expectations are or are not met, she experiences stress that can be of a positive or negative nature. Carol's goal of professional practice was interpreted to be team centered. She expressed her stories from the reference point of both being a contributing member of the interdisciplinary team and as expecting other persons in the ED to act in a similar manner by being persons with whom she could collaborate and upon whom she could depend as stated here.

You know because you've got your patients. You know, you chart on your patients, you give whatever is scheduled on the MARS [Medication Administration Record Sheet] You know, when you're in an emergent situation you're relying on everybody around you to pitch in and help out. It can't just be a one-man show down there. So it was, you know... (sigh)... its a...its good to have that camaraderie, you know, teamwork that you don't really get with the floor.

#### *Hazel*

Like Carol, Hazel's mother was a nurse. But Hazel's mother was an ED nurse. Hazel began her lived experience of being an ED RN at a very young age. She stated, My mom was a nurse. I spent my life in the ER. She took me on shifts with her when I was little. She was an ER nurse and I would sleep on the couch... That's how I grew up.

Hazel has been an ED nurse for 14 years. Her only breaks from the ED have been at the extreme ends of her career. Right after she completed her Associate of Science degree, her first position was on a medical unit that cared exclusively for

persons with Acquired Immune Deficiency Syndrome. She remained in this role for only four months and jumped at the chance to duplicate her mother's role as an ED RN when it presented. More recently, she left the ED for a short time to explore a career in medical research. However, her love of the role of ED RN motivated her to return after only a few months. She has worked in a few ED facilities, the most notable being in a New York City ED on September 11, 2001. She completed a Bachelor of Science Degree in Nursing 13 years after becoming a licensed nurse and holds several specialty certifications such as Certified Emergency Nurse (CEN) and completed the Trauma Nurse Core Curriculum (TNCC) training as well.

Hazel thrives on pleasing those around her. She looks to meet the demands of the law, the facility, the team and the patient but sometimes struggles with the prioritization of the demands from each. She knows what each source of demand needs and strives to respond to these, sometimes to the point of self-sacrifice. Hazel explained,

One wrong mistake...you know...your doctor is not always around...you've got to be quick on your feet. If you make one wrong mistake, one wrong decision it can impact a lot of things. A lot of...you've got to know your COBRA [Consolidated Omnibus Budget Reconciliation Act], you've got to know your EMTALA [Emergency Medical Treatment and Active Labor Act]...you know...what to get for that you've got to know protocols. It's a lot. It's a lot of stress. And then if you make the wrong decision you hear it in the morning! Boy! You hear it! (giggles)

She expects that desire to meet the needs of others to be common amongst all members of the ED and hospital teams. She expressed distress when other team members did not share this goal. Stresses arise when her goal of meeting the needs of others is met or not met. She continued,

Because you don't have resources at night. You have Nursing Supervisors that have no ER background. And...you know...at times it's just me. Sometimes the doctors don't even...don't really know some of the EMTALA [Emergency Medical Treatment and Active Labor Act] protocols and what you are supposed to do when transferring; uh...minors in the ER...things like that. So, if you make the wrong decision, it could really be...(paused and waited for the interviewer to continue).

### *Connie*

Connie came to nursing later in life after raising children and holding an administrative assistant role in business outside of the health care industry. Between her business and nursing careers, she was a professional paramedic. It was the members of the interdisciplinary team who encouraged her to become an RN in the ED. Her first formal education in nursing was at the bachelor's degree level and, like Hazel, she has completed an array of certifications and continuing education programs. Connie has been a nurse for 31 years and has always practiced in the ED. For the majority of those years, she worked as a traveling nurse and, as a result, she could not recount how many places she had worked.

Connie's goal is to practice nursing as a professional by providing care to patients that is not only safe and effective, but empowers patients to be able to care for themselves. Distress for Connie occurs when those around her do not meet this standard of professional nursing care. She has a keen sense of what fundamental skills are for an ED nurse and practices them rigidly, thus holding herself to the same standard by which she assesses others. This has benefitted more than one patient, but one particular story that she related summed up a few of her major points of distress.

I had a permanent job. I worked there for about three years. And change of shift, which I hate change of shift, because you never know what you are getting, who's been taking care of them, what they've done...and its almost like you have to see them as a new patient. So I get this kid. A little four or five year old that they said,

'He's up for discharge. So that's all you have to do is discharge him.'

Well, I went in there and looked over the assessment and I wasn't real comfortable with the assessment, so I didn't know how I was going to discharge him if I wasn't. So I started to do an assessment on him. And this kid was critically ill! When I undressed him, because he hadn't been undressed, he was all...he was all ecchymotic all through the trunk of his body. He had not been undressed the whole time.

So I went to the doctor and I said, 'I think you need to go see this child again. I've undressed him so you can get a better assessment on him.'

(mimicking doctor) 'Huff, tsk, just discharge him!'

I said, 'Mmmmm, no. I'm not going to do that. You need to go and see him.' I said, 'Listen, I'll bake you some chocolate chip cookies.' (Because he always liked my chocolate chip cookies.) So I said, 'I'll get you a batch of chocolate chip cookies.'

So he went in and here they...he didn't have a head injury, he had fallen from a bunk bed...he had a transverse colon rupture.

This story exemplifies a several things that stress Connie. She is driven by standards learned in her basic nursing education and maintains the goal of delivering safe and effective care. She expects nothing less from the other members of the ED team, including the ED physician. She is stressed by not being recognized for holding herself and others to that standard. Being brushed aside and not taken seriously by other members of the team is a specific example of this stressor for Connie.

### *Ike*

Like Connie, Ike was a professional paramedic. However, Ike was a professional paramedic for 13 years before he became a nurse. He went directly into the ED after gaining his license as an RN less than three years ago and it is the only area of nursing he has practiced. He does not consider himself to be a novice in the field of emergency care and feels that his current RN role is simply an extension of his long history in the Emergency Medical Services (EMS) system. Ike enjoys the fast pace of the ED and the opportunity it offers to perform procedural tasks.

When asked about what a perfect day in the ED would consist of, Ike leaned back, thought and replied that the perfect ED patient would be one that came in with a

cardiac problem that he could stabilize and then follow to the cardiac catheterization lab where he could assist in the resolution of the problem. Ike's practice goal is to always meet the needs of his patients by being able to provide every nursing intervention that a patient may require. When he is required to prioritize between multiple demands of patients and the demands of departmental goals, he experiences stress.

National standard is pushing for 30 minutes to get a patient who's admitted out of the ER to the floor. Period. So that's fine and dandy. In our emergency room, we still call reports to the floors. To every floor, every unit.

Um...so if I just got a chest pain patient, then I have to deal with that chest pain. So, monitor, IVs, blood, any Morphine, Nitro, Aspirin, oxygen, all of that. By the time I get back to my computer, I may have had a bed for a patient that may have come in 10-15-20 minutes ago. So now I have 10 minutes to call report, to call report to the nurse and get the patient upstairs. And if it's a PCU patient or higher, I have to take the patient up. A nurse has to go with them on the monitor.

So if I have 10 minutes, I've got to call report, get a monitor, get 'em on the patient, get 'em upstairs, turn 'em over, come back and get them off the chart [and] off the tracking board. [That] is what they're looking at.

And I have 10 minutes to do that. But, on top of that, I just had a chest pain patient and if I had discharged a patient before and we're busy, they may have cleaned a room and put another chest pain patient in there. So now, what's more important? Getting a patient who's stable, who's admitted, up to the floor or dealing with a chest pain?

Interviewer: Which is more important?

Ike: Me personally?

Interviewer: Uh huh

Ike: Chest pain. Because you are dealing with someone's life. This patient is stable (gestures to one side and the other to indicate two patients) this patient's admitted. This (gestures to first side) patient is going from one unit to another. Care for this (gestures to second side) patient has not decreased.

So, that's the stress I deal with. Patient care, doesn't really affect me that much.

The stress can be either positive or negative. When his goals for patients are consistent with departmental goals, he experiences eustress. When these goals are in conflict and he loses control over his professional practice goal, he experiences distress.

### *Janet*

Janet is a third generation nurse despite having no interest in the profession in her young adult years. It wasn't until she needed a job and obtained one as a secretary in an ED that she considered education beyond her incomplete high school education. She was so enthralled by the ED environment that she was motivated to earn her General Equivalency Diploma with the goal of going further for a chance to work in the field. She did just that 31 years ago when she completed her Associate's Degree in Nursing. Since 1980, she worked in many different facilities in several areas of the United States as both an agency nurse and as a permanent member of an ED staff.

She has been in her current position continuously for three years, but has been intermittently associated with the facility for nearly ten years. Janet considered earning a bachelor's degree in management to enable her to move into nursing administration, but abandoned the scholastic effort when she found a new administrative role she undertook too distasteful and returned to the bedside. She considered a Bachelor of Science Degree in Nursing, but found the academic requirements of her chosen institution to be too demanding and irrelevant to her personal goals. She loves the interpersonal interaction that she found only at the side of someone in need of a nurse.

It is the act of caring for persons and the receiving of their appreciation that motivate Janet. She sees herself as their guardian with the goal of protecting them from harm. She stated, "And to me safety, patient safety, should not be negotiable. It shouldn't be anything we ever compromise ever for any reason." She does not fear losing her license by practicing in an unsafe environment nor does she perceive a threat of violence in the workplace. Her only concern was for her patients and she is distressed by anything that threatens their safety. Conversely, any factor that allowed her to safely care for her patients was eustressful.

### *Audrey*

Like the other participants of the study, Audrey has been an RN for many years. She is a highly educated woman outside the realm of nursing. She holds a bachelor's degree in another field as well as her Associate's Degree in Nursing. She has taken her breaks from the ED on one or two instances to either practice nursing outside of the ED or to ply her craft as a fine artist. But with the exception of these one or two intermittent

years, she has worked in the ED for her entire nursing career. Audrey recognizes that there are many facets to what stress her while practicing her art of nursing.

Of main concern to Audrey is the sense of having the raw materials with which to meet the needs of patients during a day in the ED. This means not only having the proper equipment and number of staff members required, but that both the equipment and the professionals are in good working order. Her experience in facilities from large metropolitan areas to rural settings (what she refers to as her “Mayberry” practice) has given her the sense that nurses and physicians alike have an arch of effective practice habits. One could express it as a career trajectory of effectiveness. Despite their novice status, she values the youth and excitement brought to a team by the newly graduated professional. She values the high skill level and depth of knowledge offered by the seasoned professional. But when that “season” has turned to winter, and the individual is either professionally or physically frozen, she deems them to be a stress to her professional practice. She believes a good mix of skills, agility and experience is one that spans the practice continuum so that the shortcomings of one team member are offset by the strengths of another. Similar to what was expressed by Carol, Audrey also strives to meet the goal of professional practice by being a contributing member of the interdisciplinary team and expects the same level of contribution from all other team members. She carefully spoke about team members, who cannot contribute as much as is required by saying,

People on the end of their life shift. One nurse I work with only has two years until retirement but she is mentally and physically retired already...

She is incompetent given how she has to practice now. He is physically incompetent at this point. She cannot do for patients at this point.

### Summary of Goals and the Participants

The preceding profiles provide insight to the major interpretations of the researcher. Each ED RN comes to the ED with the goal of practicing nursing as a professional. This concept is integral to understanding the stressors experienced by the ED RN. It connects 1) the ED RN's appraisal of their surroundings, 2) the persons with whom they will work in the ED and 3) the expectations and reviews of what they can and have achieved. These three considerations are later introduced fully as the themes of Environment, Interpersonal Relations and Accomplishment.

### Being the Emergency Nurse

The interpretation of the stories relayed by the participants resulted in an image of what it is to *be* an ED RN. *Being* an ED RN is to be a professional as a result of one's education in addition to being socialized into the profession. Traits exemplified by the professional include being an advocate of the helpless, being an intelligent technician who possesses both the ability to critically think as well as the physical abilities to perform the role of the ED RN. Being a professional ED RN is to be a seeker of fulfillment of self through accomplishment. As a professional, the ED RN is also the fulfiller of the goals of others. The ED RN is creative, innovative and ambitious. The ED RN is sometimes fearless in the face of utter helplessness. The ED RN is an actress, as Carol stated, with the ability to personify the goals that are needed for the moment she

is needed at the bedside of the patient, despite her personal opinions and desires. As a professional, the ED RN can provide a patient with a good death or assist in the effort to restore optimal health, all the while caring for the family of the patient and in some cases being a surrogate family for the patient. The ED RN desires and is moved only to execute his or her professional duties in the provision of care to persons in need.

The researcher found the imagery of the memorial to the women who served in the Vietnam War, who were mostly nurses, representative of the theme *being* the ED RN. This image may provide the reader with a mental representation of the persona of an ED RN. The bronze Vietnam War Memorial sculpture contains four figures. One is a patient and three are women in different postures that could be representative of the ED RN. One female figure depicts the delivery of care as she is seated with a soldier draped across her lap with one of her hands on the soldier's chest while she is supporting his head with the other hand. The remaining two figures are posed in attitudes of seeking external resources. One is looking to the sky in search of a helicopter and the other is kneeling in a position of prayer. The former figure represents the theme of needing adequate material resources while the latter portrays exactly what Janet expressed when she spoke of thanking her God after completing each shift. This imagery could be symbolic of the ED RN illustrating direct caregiving, mutual support of other team members and the hope of accomplishing the identified care delivery goals.

The participants interviewed for this study expressed a love of the work they perform and keep coming back until they are no longer fulfilled. As Janet stated, "I need that feedback." They return until they cannot meet the goals they set, consciously or

unconsciously, for themselves. The stressors that either block or facilitate meeting their goals are unique to the individual, but are thematic to the specialty.

Audrey stated that working in the ED as a nurse both “addicts” and “taints”. In support, Hazel, Ike and Janet all referred to themselves as “adrenaline junkies.” Hazel described it best by saying,

I don't know...the crazier it gets, the better it is! I mean ER nurses don't, and generally I don't either, I don't like sitting around waiting for a patient or waiting for a patient to arrive. It makes us go crazy. We just don't know what to do with ourselves. And there are some nurses that are OK with that. (With a lowered voice tone) They're probably not a real ER nurse. (laughs)

The nurse experiences this addiction. The fix for the addiction is obtained in ways which range from the stimuli of meeting a goal to getting accolades, being a witness to healing, learning, and the blossoming of self-reliance. Perhaps the strongest fix is to experience being a benefit to someone else. But when the addiction can no longer be satisfied, the motivation to continue in the role of the ED RN may dissipate as hinted by Janet when she stated that the primary reason for working in the ED was the personal benefit.

Audrey meant that being “tainted” is the perception that others may have about the ED nurse. She said, “It’s like you are the addict who will never recover. That’s how they look at you.” This is interpreted from Hazel’s experiences as she spoke about the interactions she has had with nurses from other departments. When telling her story of attending meetings designed to foster interdepartmental communications, she states, “I

sit in the corner and no one will sit next to me.” She further relays at several points in the interview that the ED is a “separate part” of the hospital and is often left to its own devices to serve the needs of all other departments. All participants voiced the negative stress of battles between the ED and the rest of the hospital. Examples ranged from not being a part of the social milieu in interdepartmental gatherings to being abandoned by nursing supervision and denied the professional cooperation of other departments when transitioning patients to various levels and venues of care. Hazel stated,

Um, a lot of the nursing supervisors have no ER background or don't even support the ER. It's always...if I tell you something about the ER or the floor, you're going to go with the floor. You're going to side with the floor. Bad, good, doesn't matter because you are just prone to that. We are separate entity of the whole hospital. And the ER for a very long time was a separate entity of the hospital.

You know, you are on your own, you do what you have to for yourself or 'We'll just take the patient off your hands, but that patient better be stable!' (Wagging her finger as if being scolded.) 'And everything better be done before they go upstairs!'

We treated the emergency, now we can do whatever we need to do with them. But people don't see it like that, you know?

Overall, the goal of the ED RN is to practice nursing as a professional. To practice nursing as a professional means to not only provide safe and effective care to all patients, but to be an contributing part of the interdisciplinary team and to

autonomously use their knowledge of nursing to its fullest extent. Having the control in the workplace environment to function according to the dictates of what each ED RN envisions is eustressful. Repeatedly experiencing a eustressful working environment fosters satisfaction in the role thus fostering continued practice, acquisition of experience in patient care, professionalism and serves as a deterrent to burnout (MacDonald, et al., 2001).

### Stress and the Goal of the ED RN

When asked about their experience of stress, all participants were able to offer stories of stress as they lived the experience of being an ED RN. It was interpreted from these stories that while each participant was in the act of expressing examples of distress and eustress, they were making a comparison between their vision of how they wanted to practice as an ED RN and how they were actually practicing as an ED RN. If the environment was conducive to meeting their goals, they expressed stories of eustress. Distress was the result of a non-supportive environment. Likewise, the persons with whom they had worked played a significant role in distress and eustress. If the staff made for positive interpersonal relations, the ED RN could expect to accomplish his or her goals. If the staff interacted negatively, the likelihood of accomplishing goals was reduced which, in turn, fostered negative stress. When the experience matched the vision, they told stories of eustress. When the opposite was true and the experience was in contrast to the vision, they told stories of distress.

The circumstances experienced by each of the participants were often similar. But no matter the similarities, the theme of having the support to provide professional

nursing care was interpreted to be the goal, which all the participants worked to achieve. This goal can be objectively conceptualized as being able to provide safe and effective care for patients. Stress was assessed in relation to being able to meet the goal of being able to provide what they defined as safe and effective care. When the ED RN experienced circumstances that affected their ability to meet the goal of professionalism it caused frustration and they experienced distress. When the ED RN experienced circumstances that supported their ability to meet the goal of professionalism, eustress was experienced. The appraisal of stress was identified within the context of three themes: Environment, Accomplishment and Interpersonal Relations.

### Stress Appraisal

The technique of considering the existential concepts of Spatiality, Corporeality, Relationality and Temporality as suggested by van Manen (1990) was used to create the themes of Environment, Accomplishment and Interpersonal Relations. The spatial existential is represented by the theme of Environment and its supporting subthemes. The corporeal existential is represented by the theme of Accomplishment and its supporting subthemes. The theme of Interpersonal Relations and its supporting subthemes represent the relational existential concept and creates a connection between the spatial and the corporeal. As a whole, the themes of Environment, Accomplishment and Interpersonal Relations as experienced by the ED RN make up the temporal existential. Temporality can be used as a gauge of distress and eustress while working a shift in the ED. The proverbial statement, "Time flies when you are having fun," and the antithetical implications of that proverb perfectly illustrate the

interweaving of these concepts as thematically connected. Figure 1 illustrates the Stress Appraisal Triad as it depicts the relationship of the themes of Environment, Accomplishment and Interpersonal Relations.

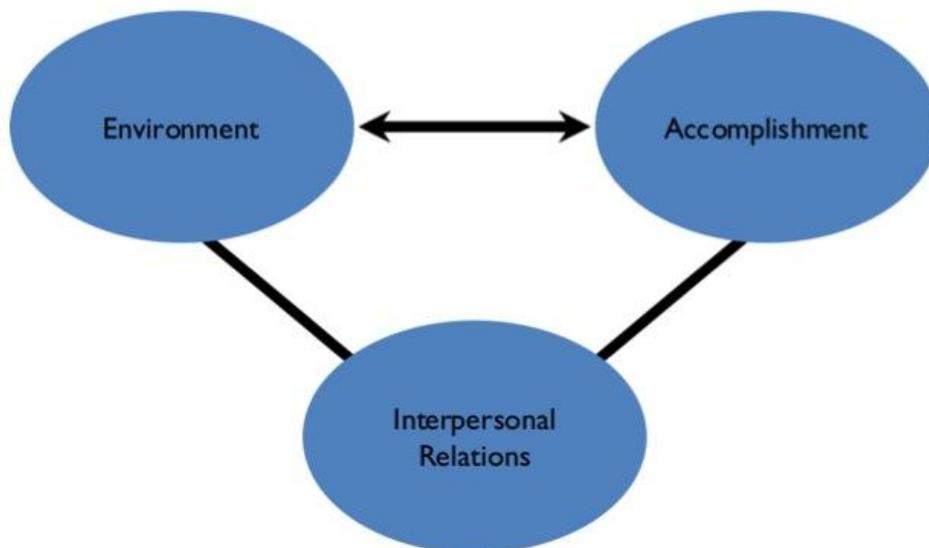


Figure 1: Stress Appraisal Triad

*Environmental*

From the spatial existential perspective (van Manen, 1990), the surroundings of the ED are unique. No other physical area of the acute care facility resembles the ED. The Environment represents the physical space as well as the overall appraisal of the working environment by the ED RN. The make-up of the Environment is twofold. It

includes the members of the interdisciplinary team and the skills and knowledge each brings to the team. It also includes the material resources such as supplies and equipment that are required by, and available to, the ED RN.

Study participants expressed several aspects of the ED environment that contribute to the experience of being an ED RN. The subthemes that were interpreted as contributory to the perception of the Environment include the following: 1) Chaos and Resources, 2) Shift Culture, 3) Knowing the Patient, 4) Excitement, and 5) Practice Efficiency. Each of these subthemes had a positive and negative potential effect when the ED RN considered the stress associated with the Environment. Each of these subthemes is expounded upon in the following sections.

### *Chaos and Resources*

The participants brought out one particularly applicable example. It was that of chaos. Interpretation of the Lifeworld of the ED RN would be incorrect if the intersection of temporality and spatiality were left out. Specifically, the ED represents chaos to some. However, the temporality of chaos is tempered by probably the most common determinant of stress, which is that of the resources of the environment. An abundance of resources resulted in the transformation of a potentially disastrous day into being a day of triumph. A day without the necessary resources was the source and commonality of all things negative from feeling unfulfilled in the role of the nurse to committing errors of care, terminating in feelings of being abandoned by those whose role it is to support the ED staff. Having a busy day was both a great and a terrible thing. It was great in that it could make the day swish by in a flash or terrible in that the clock could seem to drag

on endlessly no matter how busy the department. The temporal difference was directly attributed in the interviews to the level of resources at the command of the ED RN.

The concept of resources took multiple forms. Janet and Audrey strongly voiced distress from the lack of functioning equipment they needed to offer safe and effective care. In response to the question of what negatively stressed her, Audrey stated, "When there is no back up and no functioning equipment around." Refusing to swap equipment with in-patient units when admitting patients and hoarding supplies were ways Audrey spoke of to ensure that the ED was stocked with the necessary tools such as reference materials to provide safe care and thereby prevent negative stress. She said, "I bring my Droid to work so I can look up things because the nurses do not have Internet access." Janet voiced a specific concern when she spoke of dreading being assigned to a specific set of rooms for her shift. She told the story of her battle to obtain suction regulators for four rooms in her department. She related that this battle has raged for the entire three years of her association with her facility. Having been defeated in her quest to work in a well-supplied environment, Janet simply resorts to stealing the equipment from other areas of the facility when she is able to anticipate that her need for a suction regulator is imminent. While they both experienced negative stress due to a lack of basic equipment, they still identified ways to meet the goal of being prepared to provide safe care. Unfortunately, confiscating equipment from one area in the facility to be used in another does not address the root cause of the problem, the overall shortage of basic equipment in the ED.

### *Shift Culture*

The Environment of the ED takes on a different character as it is influenced by the culture of each shift. Hospital departments such as the ER are operational 24 hours per day, 365 days of the year and the nurses function in the department at all times. However, unlike other hospital departments, unlimited numbers of patients of all levels of severity arrive and depart from the ED around the clock. The number of patients coming and going to and from the department tends to ebb and flow in a circadian rhythm to match the activity level of society. As a result, the day shift, typically from 0700 to 1900, is different from the night shift, which spans from 1900 to 0700 the following calendar day. Additional work shifts overlap the traditional day and night shifts match the ebb and flow of patient census. Thus, the subtheme being addressed different shift cultures according to the time of day.

Individual nurses interpret the benefits and drawbacks of each shift or time period according to their own perceptions and preferences. The notion of shift culture can take on a dual meaning; a distressful or eustressful experience as experienced by the individual nurse. For example, Ike sees the final hours of the overlapping shifts and the majority of the night shift as boring because he perceives it to have the potential to not be as busy.

We have 5pm to 3am... and we have a, um, 1pm to 11pm. So the 1 to 11pm is a really cool shift. Five to 3 is OK up until about midnight, 1 o'clock. Then it starts to wind down.

In contrast, Carol sees the night shift as potentially more chaotic due to the limited resources available.

Well, there have been times where we can get 7 and 8 ambulances in a matter of an hour. And when you are on night shift and those resources are a skeleton crew, its very overwhelming. And basically you do whatever you can do to get by and to (pause) not to get by, but to stabilize the patient and move on to the next one. You know, make sure the patient's safe. Make sure the patient's pain free. OK! Next ambulance!

But despite this possible stressor, she prefers the night shift because it fits her familial need to spend more time with her child during normal waking hours of the day. Ike sees the lower number of patients as a barrier to his goal of being able to use his skills, thus he assesses certain shifts accordingly. On the other hand, Carol's goals are balanced by allowing her to meet familial needs by risking experiencing a distressful shift as a result of having department resources overwhelmed. Therefore, the theme of shift culture is not in itself a positive or negative influence on the individual ED RN, but merely a consideration to be made when assessing the contribution to the individual's experience.

### *Knowing the Patient*

The transient nature of patients is part of the ED Environment. Patients arrive and depart in a matter of hours as opposed to a matter of days as in other areas of the hospital. A great attraction for many of this study's participants was the thought of taking care of different people during their time in the ED as opposed to caring for the same

individual shift after shift. Carol introduced the subtheme of knowing the patient when she spoke about both the boredom and the advantage of caring for the same patient for several shifts when she was a nurse on an inpatient Medical/Surgical unit. She expressed that caring for the same patient shift after shift became negatively stressful because of the familiarity gained and subsequent boredom. In contrast, she spoke of the advantage of knowing her patients' histories and their needs intimately in order to facilitate their care. From her experience as an ED RN, she relived this positively when she spoke about being able to more effectively care for a recent ED patient when he returned the day after she had cared for him and his family.

The other day we had this guy that came in and I had just taken care of him a couple days before and I was like, 'You know what? I'll take him.' Because I know his history. I know the family, you know, yes it sucks what's going on for him right now, but it's kind of like refreshing to know that you are taking care of a patient that you know everything about. You already know the history, you know, that whole piece of it is already [there] and you can focus on the interpersonal things with the family and with the patient.

They are like 'Hey [Carol]! How's it going?' (Laughs) And its comforting for them too, that they don't have to sound like a record player repeating themselves over and over again.

But for Carol, the overall advantage of not having the same patients repeatedly was a positive aspect of the ED. For Carol, the dual nature of knowing the patient

required her to assess its stressfulness from the two different surroundings of her Medical/Surgical practice and her practice in the ED.

Knowing the patient from Ike's experience took on a negative connotation when he relayed two stories about patients that were well known to the staff of his ED. His perception of both of these patients further illustrated the dual nature of knowing a patient. While both patients had a condition in need of treatment, Ike relayed that the staff of his facility viewed the patients as using resources that could be better used by others due to the individual self-care choices of the patients.

In his first story, Ike spoke of a patient with chronic pancreatitis. As is not unusual for the condition, the patient routinely sought care in his ED for acute exacerbations of the condition. These exacerbations could be as often as two or three times per week with periods of remission during which the patient did not present to his ED for care. Similarly, a second patient presented to his ED routinely for acute episodes of pain as a result of Sickle Cell Anemia. Both patients required unusually high doses of pain relieving medications and other palliative modalities.

Ike relayed the staff's perception of these two individuals with both compassionate pity and frustration.

Well this particular patient, she may have, um, there's some time frames in three months she's be there 20 times. And in the next three months she's been there twice. And the next three months she's there 60 times. So...and I don't know what her cycle is. She does have medical issues, but once she's discharged or admitted, I don't know what her home, not necessarily her home situation, what

her follow up care is...So she has chronic and continued abdominal pain.

The staff had compassion for the objective maladies that each patient suffered. However, when one of the patients was discovered to have broken into a sharps container in search of narcotics, Ike and the staff began to view that patient with distain because of personal choices that bring into doubt the actual motivation for seeking care.

She has sickle cell anemia. And she has sickle cell crises. But hers is different. We've actually caught her taking the sharps box, wrapping it up in the towel, walking to the bathroom, cracking it open and pulling out syringes. So hers is drug as well as she has a medical issue. She did have a port for some amount of time which helped because you can't get IVs on her either. But her port became infected, so they had to remove that.

Therefore, knowing the patient carries a dual meaning. In situations where the party is known and assessed by the ED RN to have legitimate complaints as seen in many acute or chronically ill persons with objective maladies, the stimulus is deemed to be positive as it facilitates compassionate care. Conversely, when the patient is known and assessed to have maladies of a more subjective or socially unacceptable nature, the interaction can be negatively stressful because that individual can be seen as wasting the time and resources that would otherwise be spent caring for others.

### *Excitement*

Unlike many other areas of a hospital, the ED must accept, evaluate and stabilize every person upon arrival at the department for care, no matter what their complaint, prior to being processed for admission. As a result, the ED RN cannot anticipate what

conditions a patient will have when they arrive at the ED.. Unstable patients cannot be transferred to most inpatient units or to another facility until they are fully evaluated and stabilized. The study participants cited this facet of the ED as one of the reasons they chose to become an ED RN. The excitement of the Environment of the ED was interpreted from the materials provided in all the interviews eustressful experience.

The mystery and surprise of each patient, however, was not the sole reason that the participants considered the ED to be exciting. Contributing to the subtheme of excitement is the related idea of using one's skills to solve patient problems. Figuring out what problems patients were experiencing and taking on the challenge to unravel such mysteries added to the excitement of the ED Environment. The idea of excitement was best captured when Hazel discussed the challenge of deciphering the signs and symptoms of patients. The interpretation came not so much from her words as it did from her facial expression and body language. Even though her words were simple, when describing an incident where a patient had a potentially contagious condition, "I'll investigate you with my full gear on!" her eyes opened wide, her mouth spread into a large and toothy grin, she sat up in her chair and leaned in towards the interviewer with a straight back and shoulders held high when her thoughts changed to this aspect of being an ED RN. Being able to use the skills and intellect that the ED RN possesses to meet the goal of solving the mystery and providing care is an exciting proposition and source of eustress for the ED RN.

### *Practice Efficiency*

Practice efficiency is a subtheme of the Environment that directly affects the stress level of the ED RN. Practice efficiency must be understood to mean the provision of safe and effective care without delay or excessive expenditure of resources. The excitement of taking on whatever comes through the doors of the ED is tempered by how efficient the practice is at any given moment during the time the ED RN is working. Having the time to fully explore and decipher the complaints of every patient not only depends on the number of personnel and resources the ED RN has, but depends on how well the team is functioning. The more efficient the practice of the department, the more motivating the situation is assessed to be and is, therefore, eustressful. Concepts that have been interpreted to influence practice efficiency include interdisciplinary collaboration, interpersonal friction, peer support or friction, interruptions while engaged in critical tasks such as medication preparation or charting, resource shortage or abundance and managerial demands and innovations that are assessed to be counterproductive by the individual RN.

The Environment of the ED is a representation of the Lifeworld of the ED RN. It is the physical space in which the ED RN practices. Even though that physical space cannot be altered, it can be appraised by the individual ED RN to be a distressful or eustressful setting based upon the time of day or night being worked, who the ED RN is caring for, what conditions pathologies the ED RN is dealing with, members of the interdisciplinary team and how all of these considerations fit together to support the goal of being able to practice nursing as a professional.

### *Accomplishment*

Each of the study participants addressed the fact that they had a goal related to what they wished to accomplish while functioning as an ED RN. The idea of asserting a personal goal is by definition, egocentric, therefore, the theme of Accomplishment is created from the corporeal existential (van Manen, 1990). Whether or not each participant met the challenge of achieving his or her goal resulted in a level of satisfaction somewhere on a continuum from Being Satisfied to Being Dissatisfied. These polar end points will be presented as subthemes related to Accomplishment. Being unable to meet goals produced distress in the ED RN and was generally manifested in a feeling of Being Dissatisfied. The subtheme of Being Dissatisfied resulted in the following: 1) Helplessness, 2) Restricted Autonomy and 3) Doing Harm. All of these sequelae of Being Dissatisfied are in opposition to meeting the goal of professional nursing practice. Conversely, being able to meet the goal of professional practice produced eustress and generally manifested as Being Satisfied. When the ED RN was Being Satisfied, they were engaged in: 1) Solving the Mystery, 2) Using Skills, 3) Doing Good and 4) Being Appreciated. To illustrate the importance of Accomplishment to the ED RN, nurses expressed having a love of the nursing role and placing great value on the ethos for caring for the patient. Being able to practice the nursing role as a professional brought great satisfaction. Janet said,

I love nursing. (uses a soft, endearing whisper) I can't imagine. I come home and say to my husband, 'You know, if I couldn't do this, I don't know what I'd do. There's nothing else I could ever do. I love nursing.'

You connect with people so regularly and get the feedback that you helped them and I just (pause) love that. I thrive on that.

### *Being Dissatisfied*

Dissatisfaction as a result of not being able to practice as a professional ED RN occurred after experiencing situations in which the participants felt that they could not act according to the needs and best interests of their patients. Instances relayed by the participants are presented as the supporting subthemes of 1) Helplessness, 2) Restricted Autonomy and 3) Doing Harm. All of these subthemes are in opposition to meeting the goal of professional nursing practice.

### Helplessness

When participants told the stories of their worst days as an ED RN, they reflected upon the feeling of not being able to accomplish what they have identified as needing or wanting to do. Hazel told a tale of having a patient who was in need of a neurosurgeon. She indicated that the neurosurgeon on call that night actively shirked his responsibility to care for the patient and refused to cooperate by not assuming the in-patient care of the patient. Meanwhile, the ED physician remained insistent that the patient be cared for by a neurosurgeon. With the refusal of the neurosurgeon in direct opposition, Hazel was caught in a tug of war that could only be won by breaking the Emergency Medical Treatment and Active Labor Act (EMTALA), a Federal law which regulates the transfer of patients to and from acute care facilities. This breach of statute brought with it a new host of repercussions from not only the federal government but from the facility to which

she transferred the patient as well as the administration of her own hospital. Hazel was caught in a no-win situation and felt completely helpless because no matter what she did, she expected to be blamed for being wrong.

It wasn't even so much that I made the wrong decision. I already knew that I was making the wrong decision, but I couldn't stop it. It was a transfer; that one of our; um; one of our neurosurgeons was on call. This patient was a neurosurgical patient. Doctor was on call. He was in Georgia. Would not come and see the patient. Would not accept the patient. His, the person that was over him, told us to keep calling him, which we did.

He finally called back and the same thing. He wouldn't come and I told the [ED] physician 'You cannot transfer this patient.' and he says,

'Well, I can't get anyone to come in and see them, so I have to.' I said,

'I know, but you have to start calling people. If not, we'll start calling people.'

In the middle of the night, no one responded. So it came down to either you transfer this patient or this patient is going to go down very quickly. We chose to transfer and we got fined.

I know I was doing the wrong thing, but it, its, there was no way to go around it.

Being helpless may include refusal to accept or otherwise prevent an inevitable event. It may include being overwhelmed due to inadequate resources. It may include

being ignorant of what course to take in a situation that demands swift action. Whatever the combination, feeling helpless was a theme of negative stress for the ED RN.

### Restricted Autonomy

Part of being a professional RN is having the knowledge, ability and expectation to function autonomously given the education and role responsibility of the individual. Having one's autonomy restricted was expressed on more than one occasion as a precursor to frustration and distress. Carol, Ike, Janet and Audrey all experienced distress when working with providers who ordered tests and treatments for patients that based upon their professional judgment as an ED RN understood to be unnecessarily investigative. The study participants viewed excessive testing as wasteful and potentially hurtful for patients, especially pediatric patients. Ike expressed this through a story of a child for whom intravenous access could not be gained. The nursing staff had assessed the child as being ill, but not in any distress or extremis. When he approached the physician with an inquiry as to why the child needed intravenous access, the rationale was to simply give fluids. Ike expressed frustration that oral fluids after oral anti-emetics had not been considered. Instead, the child was veni-punctured multiple times without successfully gaining intravenous access and ultimately did well with an oral approach as Ike had advocated.

Being unable to initiate patient assessment and treatment processes independently using established protocols was highly stressful to Janet. She expressed frustration in caring for a female patient of childbearing age when she could not order a urine pregnancy test. Janet expressed her rationale for verifying pregnancy status as

an action that was not only streamlining the ED visit but was safe practice for this specific patient. Her frustration was palpable in the interview when she recounted, “But I also know I'm going to get an ass reaming from him if I do it. So, if he's on duty I can't know who's going to pick up that chart, so I do nothing.” As a result, the patient waits and care is delayed.

### Doing Harm

Just as Hazel was trapped into violating a principle as defined by the Emergency Medical Treatment and Active Labor Act and was helpless to avoid such a commission, she ultimately chose to avoid the option that would have harmed the patient. The concept of being responsible for harming a patient was interpreted to be in conflict with the goal of being a professional ED RN. As an example, a key goal of the experience of the ED RN is to come away from every shift thankful that no one was injured or died as a result of the actions or inactions of the ED RN. Janet shared a habit of actively thanking her God after every shift for caring for the people she had come in contact with during her shift. She shared her experience of inserting a latex catheter into a patient who had a latex allergy. She awoke in the middle of the night after the shift with feelings of dread and guilt upon the realization. She called the department to check on the status of the patient and report the possibility of an adverse reaction. The next day, she reported herself to Risk Management. While she cited the environment of haste and inadequate resources as a barrier to her goal of providing safe care, she accepted the responsibility of committing the error.

After such an incident, Janet voiced that she is always cognizant of safety issues surrounding nursing practice in the ED. Remaining aware of the stresses and distractions that could facilitate an error of commission or omission is a professional practice goal. Janet spoke of a threat to her professional practice and patient safety through education when she said,

I mean, I literally, this was a contributing factor to the last job that I left, literally was leaning against the door to the room to keep the person who wanted to bring the next patient in, to a dirty room, where I'm still standing there giving discharge instructions.

I literally had to lean against the door to keep them from coming in while I was doing discharge instructions with the person.

The threat of not being able to fulfill professional standards of patient education was real to Janet. Having that reality facilitated by another team member was distressful. The interpersonal relationship with such a team member was sufficiently negative to contribute to Janet's leaving the employment of the facility.

### *Summary of Being Dissatisfied*

Helplessness, Restricted Autonomy and Doing Harm are subthemes to Being Dissatisfied. Each provides an example of how the goal of professional practice can be blocked thus creating negative stress for the ED RN. When these situations occur, dissatisfaction with one's accomplishment becomes apparent.

### *Being Satisfied*

The satisfaction gained from being an ED RN did not include salary or the fringe benefits of employment. Satisfaction was gained by meeting the professional practice goal of the ED RN. Being able to solve the mysteries presented in the ED, use the skills of an ED RN to provide good care and being appreciated for providing that care are experiences that make being an ED RN satisfying. Examples include having the knowledge that their actions saved a life, learning something new and having the satisfaction that they supported others in ways that only they, as nurses, could. Having personal satisfaction with what they do as a professional is a powerful motivator and source of satisfaction.

### Solving the Mystery

A particular draw to the ED for all the participants was the idea of mystery. Dealing with the unknown not only excited and drew the participants to the ED at the onset of their careers, but it was a source of eustress to keep them coming back to the department to practice nursing. Meeting the challenge of the mystery is a source of Being Satisfied.

Hazel's take on the theme of mystery was having the opportunity to figure out the patient's pathology. This opportunity far outweighed the dread of risk in contracting any contagion when her facial expression changed from one of worry and concern to one of childlike joy and wonder while discussing this aspect of being an ED RN. Connie echoed this situation when she expressed the thrill of being able to figure out what was

going on with each patient before her physician colleagues could come to the same conclusion. Carol even enjoyed the occasional competition to correctly assess the malady between members of the interdisciplinary team.

Therefore, the theme of mystery is twofold. First, there is the simple unknown of what pathologies will be presented to the nurse and second, there is the opportunity to unravel the mystery of each patient. The ED RN finds the challenge of skillfully using his or her intellect to be a positive stressor. As best stated by Hazel, “Patients don’t come in the door with a sign on them telling me what is wrong.”

### Using Skills

While the subtheme of using skills was far more prominent in the interview with one participant as it related to performing tasks, it was a major part of the motivation to be an ED RN for others as well. Using one’s intellectual skills was a great source of positive stress. Carol and Hazel both spoke of figuring out the source of a patient’s complaints. Ike spoke with delight about being able to perform tasks such as initiating intravenous access on patients. He spoke with frustration about the limitations placed on his role by not being able to perform tasks that he could perform as a Paramedic such as endotracheal intubation and external jugular intravenous access. Conversely, Carol spoke of being able to perform tasks as a source of motivation. She expressed enjoyment at being able to practice the “fundamental” tasks of nursing that she had been prevented from performing in her practice as a medical/surgical nurse where such direct patient care tasks of nursing are often relegated to the Certified Nursing Assistant. Using skills is a goal that is universal, yet the satisfaction derived from the

use of particular skills is specific to the individual RN. Being able to exercise what each ED RN deems to be an acceptable level of autonomy is paramount. Janet offered this when she spoke of initiating patient care activities that her assessment skills indicated would be needed to care for a patient.

So they have these little narrow parameters for orders. Well nothing...it would be even worse if we actually obeyed policy. So I've got to violate policy every time I want to use my own judgment and say, 'Well, look! (giggles) I'm going to go ahead and do enzymes and crap. Because they are going to order them.'

If they don't want to order them then they can always cancel them. You know; I just; I can't just sit here and do nothing while I'm waiting for; you know; everybody in there to decide they want to do something.

### Doing Good

Audrey summed up what it means to the ED RN by Doing Good by stating,

How do I get my fix? When I actually help someone who is sick. I mean actually help a true emergent case. Its rare to get a true emergency; sick person. You get people who are chronically sick. You are stabilizing chronically sick people. But every so often you get the STEMI or the person with the jaw that was broken in two from here to here (motions from left to right sides of her jaw) and it was just hanging down.

Always providing safe and effective care is a major tenant of what it is to be a professional registered nurse. Meeting this goal is synonymous with being a

professional. Evident from the responses of the participants was the eustress of giving the patients what they sought: good care. Connie voiced this most prominently when she stated that her greatest pleasure was to empower those she cared for in her role as an ED RN. She gained satisfaction from seeing her patients get better. She fulfilled the role of the ED RN by educating them on their diseases or injuries so they could care for themselves and this brought her satisfaction. When asked about her worst day in the ED, she recounted the story of an 18-year-old woman who died while in the care of her ED team from a pulmonary embolus two weeks after giving birth to her first child.

It seems that the young mother had delivered her child by caesarean section. Since the delivery, she had been complaining of increasing shortness of breath. She had complained to her regular care providers who seemingly had not listened to her complaints and had not evaluated her. Upon seeking care in the ED as a result of her worsening condition, her respiratory functions were compromised beyond her ability to compensate and the ED team was not able to reverse the condition. Connie's frustration and rage came not so much from the life cut short and the motherless child, but from the lack of empowerment that brought the situation to its tragic culmination. "No one listened to her [the patient]," lamented Connie. Connie's facial expression changed to what could be described as mournful with a touch of anger when she made this statement. As a result of the experience, Connie now coaches patients to be proactive and forceful. She likens the physicians to basic service providers by reminding her patients that, "they work for *you!*"

### Being Appreciated

Being thanked for caring for patients was a great source of satisfaction.

Expressions of appreciation were valued and interpreted as motivational. Janet stated, Um, there's all these secondary gains. And with the patient interaction you get immediate gratification with every patient, every interaction. I can't tell you how it feeds my soul when someone says, 'You helped me so much.' or 'You made me feel so much better.' or 'Thank you, I was never understood that before. No one ever told me that before.'

This experience was interpreted as being far more meaningful when coming from the patient or their family than it was when expressed by members of the health care team. But the instances of expressions of appreciation from colleagues do not go unnoticed. Connie cherishes a letter of appreciation that was written to her by a physician. It seems that Connie had to go to great lengths to convince the physician to reconsider a decision in patient care. Her persistent advocacy saved the life of the 5 year old with the transverse colon rupture who had previously been set for discharge. It was not so much that the letter was from a physician as it was the recognition and appreciation for being a good nurse that makes the letter valued by Connie. It is being acknowledged in such a positive manner for the work they do is vital to the wellbeing of the ED RN.

### *Summary of Being Satisfied*

As the ED RN meets the goal of professional practice, they experience satisfaction. They accomplish what they envision it is to be an ED RN and being what they envision fosters their love of the role. They like what they do. They have a healthy understanding of the contribution they have made to society. Connie expressed quite candidly that she gained personal satisfaction when she could enable people to care for themselves. Janet repeatedly expressed a sense of confusion when she relayed instances when her activities of caring were brought into question by others. Her simple response to peers was, "Why wouldn't I?" Janet had a strong feeling, as did Carol, that their duty was to provide good care simply because it was the right thing to do. This ethos of caring was woven through every story from every participant. Accomplishing the goal of practicing as a professional ED RN brought about satisfaction. When the ED RN is allowed to meet this goal, eustress is experienced.

### *Summary of Accomplishment*

The supporting subthemes of Being Satisfied and Being Dissatisfied serve to illustrate the varied situations in which the ED RN practices and strives to function as a professional. They make clear the idea that it is not the specific stimulus by itself that is stressful, but the overall contribution of the environment and its associated resources, the influence of interpersonal relations and the perceived possibilities of accomplishment that join together in the appraisal of stress by the ED RN. The

combinations of these factors create a very complex and highly interdependent response to the question of what the ED RN appraises to be stressful.

### *Interpersonal Relations*

As depicted in Figure 1, Interpersonal Relations influence both the Environment of the ED and the Accomplishment of the ED RN. Therefore, Interpersonal Relations not only stands as an independent theme, it also possesses tendrils that wheedle their way into the themes of the Environment and Accomplishment. Environment is influenced by practice that is efficient and cohesion of the interdisciplinary team. Accomplishment is also influenced by the level of cohesion of the team, which directly influences the ED RN's expectation of meeting his or her personal goal of professional practice. This dual influence on Interpersonal Relations is an important concept in order to fully appreciate its influence on goal attainment and stress. As a theme, Interpersonal Relations is supported by the following: 1) The Team, 2) Competence, 3) Administrative Support and 4) Getting Personal.

#### *The Team*

The team of the ED is the personification of the theme of Interpersonal Relations. In various ways, all the participants expressed the distress and eustress of working with other professionals. Participants expressed a close relationship with the Physicians, Nurse Practitioners and Physician Assistants on their ED staff. Ike expressed his inability to fathom how nurses outside of the ED functioned without such a close a relationship. Connie provided the example of being a valued member of the ED team

through her story of the 5 year old with the transverse colon rupture. But no participant expressed a dependence upon other team members as a result of the close proximity in which ED RNs work with medical providers. In fact, the close proximity fostered eustress because of the rapid communication, regular sharing of treatment decisions and the level of trust between the nurse and the medical provider. It was noted that being a respected and contributing member of the interdisciplinary team fostered a sense of professionalism that meets the practice goal of the ED RN.

In contrast, Audrey, Hazel, Ike and Connie all had stories to tell about working with persons who have either lost the skills required for safe, competent nursing practice or those who simply choose not to practice in a safe competent manner. In particular, Ike and Audrey offered the concept of the health care professional who is at the end of their career trajectory. When working with individuals such as these, they both found it difficult to care for their patients knowing that they did not have a teammate upon whom they could rely. "People who don't take responsibility for their jobs." was a statement made by Audrey in connection with doing the little things such as keeping critical supplies stocked in patient rooms was neglected. While Ike reserved his commentary to nursing and Janet expanded hers to include assistive personnel, Audrey voiced the expectation of professionalism to include medical providers. She found it distressful to work with members of the team who have sought out quiet little venues in which to finish their careers in the hopes that since the setting was remote and rural, they would not see the volume or acuity of patients typically cared for in larger settings.

Of course, the reality is that the likelihood of seeing high acuity patients in need of state of the art care still exists in the rural hospital setting. Audrey stated,

Taking care of cases with practitioners who...I am studying for my CEN. Its like, I don't ever do this stuff! But we get this stuff! What do you mean the best way to determine shock is the CVP?! Who does this? Maybe at Trauma Ones and Trauma Twos! Having to work with a doc who cannot help you with a situation that you don't know how to treat or how to handle.

Audrey's point was that she experienced distress when teamed with persons who did not contribute to the team simply because they had chosen to no longer be prepared to provide the care that might be required of a patient with critical needs and had instead attempted to hide in a small rural hospital setting. One could correctly classify this also as incompetent behavior. No matter what the classification, having an incompetent team member is negatively stressful.

### *Competence*

Working with members of the interdisciplinary team whom the ED RN considers to be inept or incompetent is distressful regardless of the activities in the department at any given moment. This stress is due to the perception that the teammate cannot be counted on when needed.

Hazel and Connie both indicated that working with individuals who do not maintain high professional standards was stressful. Connie clearly expressed her dread of taking over the care of a patient from another nurse. Hazel's tale of the nurse who discharged a motor vehicle crash victim without discovering the compound fracture of

his lower leg was disturbing. It was a profound statement not about working with incompetent individuals, but about working in an environment that compounded such unprofessional practice. Interestingly, Hazel defended the nurse as being a good nurse. In fact, she even stated that the nurse could take care of her or her family at any time. However, she sheepishly added the hopeful statement that it was “just really busy” the day the error was committed.

Janet spoke of a safety issue that also illustrated her frustration with a Charge Nurse who accepted a patient from an ambulance crew and then did not tell her (Janet) of the patient’s arrival or condition.

That's another day. I was so mad that day. I had um, it was quiet! It wasn't at all busy! So, I'm walking around helping other people; you know. How often do you get that chance? ‘I got two patients! Can I do something for ya?’ Blah, blah, blah...

So then I look out of the corner of my eye and see that one of my curtains are pulled. I'm like. ‘Oh! Well, OK, let me go in there and see what's going on.’ Side rails down, stretcher all the way up to the top, this guy who's like (snoring noise) totally out, lying in the middle of the bed. (Laughs) Shit!

Well, you know, pop the rails up, put the bed down and then I started trying to find out who this guy is. Hello! You know, and this was an ambulance dropped off my patient for me!

Janet was obviously distressed because she was working with an individual who acted in an incompetent manner thereby risking the safety of a patient. As it turned out,

the Charge Nurse had taken report from the ambulance crew and left the patient alone in a room without reporting to Janet. Additionally, Janet was distressed by the lack of administrative support shown by this incompetence.

### *Administrative Support*

Formal supervisors were seen to be either supportive or non-supportive of the ED in general and the RN in specific. When the ED RN perceived the supervisor to be unsupportive or not able to provide resources, negative stress was experienced. Administrative Support serves as another example of Interpersonal Relations and its effect upon the environment of the ED. Hazel spoke about the saga of higher administration and middle supervisors from outside the ED. She voiced as one of her major distresses her perception of the failure of some individuals in administration, who were unfamiliar with the ED environment, to understand or appreciate the workings of the ED. This was exemplified by her frustration with night time nursing supervision when she was instructed to simply leave the waiting room full of unseen (and thereby, untreated) patients as a result of the inability of the in-patient units to accept admitted ED patients in a timely manner. She expressed the frustrations she experienced when she could not readily transfer admitted patients to inpatient beds from the ED. She expressed compounded frustration when being caught in the situation of being unable to evaluate and treat newly arriving patients as a result of being backlogged with admitted patients waiting to be transferred to other units within her hospital. But the major source of distress in this scenario is the thought of a patient in the waiting room suffering from avoidable pain or injury as a result. While this may be a system issue, the

focus of Hazel's stress, perhaps erroneously, was tightly focused on the nursing supervisor. She stated,

If you had a manager or director that has no background in this, how could you possibly get any support? Because they have no idea what you are talking about. Um...

Because if you are ignorant, you're not going to give support. Or you can't unders...You don't KNOW how to give support.

Because you don't even know what's going on. If I present something to you; 'This is an issue because X, Y & Z.' How can you support something when you don't understand it? You would have to go and research it and unfortunately that won't happen.

Hazel's focus was on her goal of meeting the needs of others. Meeting those needs was a priority. Not meeting this goal resulted in distress. For example, both Ike and Carol expounded on the exploits of various Charge Nurses. Each told the story of single Charge Nurses in their respective departments who executed their duties in ways that differed from all the other Charge Nurses. Ike's Charge Nurse went to the Charge Nurse office, which is located far from the patient care portion of the department to do, "Charge Nurse things" rather than remain in the department to triage patients arriving via ambulance, as did all the other Charge Nurses.

In contrast, when supervisors supported the nurse in a given situation, positive stress was experienced and was found to be motivational. Carol expressed her sense of reassurance of being supported when she was challenged by a physician's statement of

being able to have her fired by boldly telling him to “Go for it!” because she knew her formal supervisors knew and valued her contributions to the department and would support her. The quasi-supervisory role of the Charge Nurse was also held to a standard of fairness, which was a theme not associated with intradepartmental or interdepartmental supervisors. Charge Nurses who varied from the department’s normal procedures were seen as unfair and this variance was negatively stressful for the ED RN.

The failure to meet expectations of professional practice served as a barrier to the goal of the individual ED RN and was therefore a source of distress in both instances.

### *Getting Personal*

If the ED RN does not socially mesh with another member of the team, negative stress is experienced independent of departmental demands. Most concerning with this subtheme is the potential negative impact on patient care and safety as expressed by Carol through two stories.

In her first exemplar, Carol shared her distressful interpersonal relations with a physician that negatively impacted their professional collaboration. Carol and another ED RN had a friendship outside of the ED. When the other nurse was fired from her position in the ED after being accused of prejudicial behavior towards a physician of a different ethnic heritage than her own, Carol found herself being treated differently by the physician than she had been treated previously. Instead of readily communicating and collaborating with Carol about patient assessments and treatment plans, the

physician stopped speaking to her. The physician opted to place nursing orders into the computer system without speaking to her and did not share the results of diagnostic studies or collaborate with her regarding ongoing nursing assessment findings and the condition of patients.

Carol defended the situation by suggesting that care was not compromised, but added that due to the poor communication efforts offered by the physician, neither was it optimized. While she considered the physician to be a good provider, the interpersonal friction experienced by Carol was distressful and had a negative impact on the working environment. The working relationship between Carol and the physician eventually became less than cordial to the point that it began to negatively affect patient care due to an extreme lack of communication and collaboration on patient care. When she could no longer tolerate the effect on patient care that the interpersonal relationship was having, Carol called in senior administration to mediate a resolution. While she and the physician now actively collaborate on patient care expressions of power continue to be present such as, "You know, I could have you fired." Comments such as these are a source of distress for Carol.

Carol's second example of impaired interpersonal relations was her observation of peer friction between an RN in her department and a particular Charge Nurse. The RN in her department had a habit of routinely refusing to solicit assistance from the Charge Nurse simply because the two do not care for one another. Part of the role of the Charge Nurse in Carol's department is to be a care resource for patients when the primary RN is busy dealing with other matters. But instead of using the resource as it is

offered, assistance is not accepted until Carol approaches the staff RN when (and if) she notes that he is floundering. By the time this happens, patient care has been delayed thus potentially leading to negative outcomes and increased negative stress and ultimately Carol's goals remain unmet. Another aspect of interpersonal relations can occur between the nurse and other persons present in the ED setting. Such persons can be patients, the family of patients or formal supervisors. Similar to the aforementioned subthemes, each of these has a dual nature that is highly dependent on the situation. For example, caring for a particularly demanding patient or family member may be thought of as a negative stressor simply because of the term "demanding." In contrast, as Janet flatly expressed,

I don't expect everybody to be cheerful all the time. And you know very few people; people are generally very easy to please if you just pay attention and kind of figure out what they want. 99% of the time you can help people and make them feel better.

Janet considered people coming into the ED acting this way to be acceptable and understandable, especially in light of being a patient or having a loved one as a patient in an ED. She considered the task of meeting the needs of these individuals as part of the role of the nurse.

### *Summary of Interpersonal Relations*

The theme of Interpersonal Relations is perhaps the most complex of the three main themes that have emerged in this study. It interacts with the Environment by shaping the appraisal of stress for the ED RN. Interpersonal Relations has the potential

to support great achievements yet disallow the simplest of tasks set forth for the ED RN to complete due to the interdependence of the members of the team and the team as a facet of the ED Environment.

As previously noted, the Stress Appraisal Triad (Figure 1) represents the possible major themes by which the ED RN holistically appraises his or her Lifeworld. This appraisal is conducted to determine not only the actual type and level of stress being experienced, but is also used to appraise the potential for stress in the near future. With a goal of professional practice, the ED RN considers the Environment with all of its contributing attributes, Interpersonal Relations and the affect they will have on the Environment and Accomplishments the ED RN.

### Tapestry of the Emergency Department

Each participant indicated through their story that their daily work as an ED RN is guided by personal goals for the shift that they are about to begin. For Hazel, a goal is to be a resource to others. Be they patients, peers or providers the nurse desires to meet the various needs of those with whom she will come in contact. For others, especially Ike, the goal may be to practice well-sharpened skills or to gain new ones. However, the concept of skill varies between participants. For Ike, it is primarily task oriented. For Connie, the skill is in the identification of the acuity of a situation and empowering others through education so that the learners might become self-sufficient. These learners need not necessarily be patients. They can be other nurses, physicians or family members of patients. The goals may be as varied as the persons who are ED nurses, but the importance of personal goals as identified in this study represents an

important aspect in the Lifeworld of the ED RN. It is from these goals that the stresses (both positive and negative) originate, duplicate and differentiate. It is these goals that can be thought of as threads in a great tapestry that represents the ED.

Equally interwoven into the tapestry of the ED are nurses like those who participated in this project. Each participant expressed a deep love for their work and their professional role. This love of the role is most likely the greatest motivating factor behind why nurses expose themselves to the highly stressful environment of the ED.

Janet voiced this most poignantly with the following statement during the interview:

At this point in time, yeah, I mean, if I had some big bills, I guess I could say the money. But right at this particular moment in time I don't really need to be working. I *need* to be working because I...I *need* that feedback, yeah.

It was not interpreted that any of the participants interviewed had any other primary reason to work in the ED other than a true love of the environment despite the expressions of negative stressors and the frustrations experienced on a day-to-day basis.

Another example of the expression of just how much these participants enjoy the work came from Hazel. As she was discussing the possibility of contracting a disease from a patient, her facial expression changed from one of near disgust, fear and loathing to one of childlike wonder when her focus moved to the opportunity to be a part of solving the mystery of what was causing a patient's complaint. She said, "I don't mind looking into what you've got. I'll investigate you with my full gear on..." Figuring out the puzzle of what is going on with each person who walks, limps, wheels or is dumped into

the ED was a motivating factor that was shared by all the participants of the study. To pit one's intellect against the unknown was expressed by each RN and even cited as being why they had returned after trying to escape the attraction of being an ED RN. Audrey expressed her sense of what it was like to her to *be* an ED RN with the expression that it both "tainted you" and "addicted you." Both are different concepts in the corporeal sense. Each of the participants expressed frustration with their addiction, but at the same time expressed profound joy in having the privilege to *be* an ED RN. Each participant rejected the suggestion that every nurse was the same as any nurse and subsequently all identified as *being* an emergency nurse as if it was a persona ingrained into the few individuals worthy of the calling to *be* an emergency nurse. While this robust self-image was interpreted as positive, the reader is encouraged to consider the negative result of having a self-image that is overly robust. Being too wrapped up in what one *is* prevents one from appreciating the circumstances, requirements and contributions of others. In the case of the ED RN, this may exacerbate the perception of being tainted.

The tapestry embodies the ED RN as an individual who is motivated by having the freedom to care for patients in a safe and efficient manner. The ED RN needs to have the equipment and supplies to perform their duties. The ED RN needs a team of professionals made up of all levels of experience. This includes the contagious youthful spirit of inquiry of the novice as well as the quiet wisdom and methodology of the experienced. The ED RN appreciates being thanked and respected while performing the most complicated or squalid of tasks. The ED RN is distracted by waste. The waste

of resources, time, money and effort are all sources of negative stress. Anything that jeopardizes the safety of the patient brings about feelings of stress to the ED RN. As barriers to meeting the goal of professional practice, factors such as inept co-workers, inadequate resources, being supervised by those who do not understand the unique flow of the ED and not understanding the needs of other hospital departments and roles are potential sources of stress for the ED RN.

The themes that have been interpreted from the materials provided by the participants of this study are tightly related and interwoven. Just as each thread of a tapestry blends into obscurity when one is viewing the whole, each thread is no less important. Each theme from the Lifeworld of the ED RN provides support, structure and meaning to every other theme in the overall experience. Many themes take on multiple meanings based on how they are situated in relation to other themes as well as by the individual who is experiencing the stimulus in question. An incident that may be negatively stressful given the influences of factors such as the make-up of the team or the relative availability of resources may very well be a positive experience with only a minor alteration such as a different support person, team leader, or availability of one piece of properly functioning equipment. The triad of stress as posited by Lazarus and Folkman (1984) is exemplified in the ED by this relational influence in addition to the elements of situation, environment and individual. While each of the ED RNs interviewed bring to their department their own goals and perceptions that tailor the stressors to the individual, the themes identified herein resonate as familiar and may be transferable.

## CHAPTER 5: DISCUSSION

What happens to a dream deferred?

Does it dry up  
like a raisin in the sun?  
Or fester like a sore--  
And then run?  
Does it stink like rotten meat?  
Or crust and sugar over--  
like a syrupy sweet?

Maybe it just sags  
like a heavy load.

*Or does it explode?*

*~Harlem (Hughes, 1951)*

As expected, materials provided by the participants yielded themes similar to, but not duplicative of the concepts found in the literature. Of greatest significance was the concept that ED RNs have the goal of practicing as a professional. Practicing as a professional ED RN is objectified by the delivery of safe and effective care to patients in the ED. The concept of the professional practice goal consists of three themes. These themes are Environment, Accomplishment and Interpersonal Relations. It is within these three themes that ED RNs appraise the quality of the stress experience as distressful or eustressful. When the Environment, Accomplishment or Interpersonal Relations support the professional practice Goal, the experience of the ED RN is eustressful. When the themes do not support the Goal, the experience of the ED RN is appraised to be distressful. The individual appraisal of stress in confluence with these themes is consistent with the research on stress and coping of Lazarus and Folkman (1984, 1987)

and adds to their model the specific details of what elements are considered by the ED RN to be stressors.

Having a desire to provide safe care in a way that one is ethically comfortable with can be considered a professional goal. When describing stress, participants frequently gave examples of barriers to meeting their personal goals of care. The significance of the goals of the ED RN and barriers to those goals can be likened to the reflections of the American poet, Langston Hughes (1951) who mused on the results of the stresses of having one's dreams prevented from coming true. The unmet goals of the ED RN are the "dreams deferred" that may "sag like a heavy load" and, over time, could "explode" as Burnout (Hughes, 1951; Freudenberger, 1974, 1975, 1977a, 1977b; Maslach et al., 1996), PTSD (American Psychiatric Association DSM-5 Development group, 2010) and an eventual abandonment of the role of ED RN.

Because stress has been implicated in nurse burnout (Gillespie & Melby, 2003), PTSD among ED workers (Ross-Adjie, et al., 2007) and nurses leaving the profession (Dwyer, 1996), and because the voices of ED nurses in describing the aspects of their practice that cause stress have not been heard, the orienting question of this dissertation is, "What experiences do you appraise to be stressful working in an ED setting?" Participants provided significant exemplars in response to this question that add to the existing literature. The work of Lazarus and Folkman (1984, 1987) on stress is applicable to the working environment of the ED. But otherwise, no themes unique to the ED setting as discovered in the interviews had been previously identified in the

literature. Therefore the findings relevant to nursing practice in the ED discussed in this chapter are considered to be new to the body of nursing knowledge.

This conclusion is supported by the fact that, with the exception of Cox (2004), the research reviewed for this study sought only to verify the hypotheses of the various researchers rather than seeking the insights of those who are most acquainted with the phenomenon of interest, stress as appraised by the ED RN (Adeb-Saeedi, 2002; McVicar, 2003; Scullion, 1994). Thus, the themes reported in these studies must be viewed with a high degree of skepticism. Despite this skepticism, the conclusions of previous studies may not be incorrect. The items cited may actually be stressful to the ED RN. Based upon the findings of this study, however, it is likely that the list of stressors from previous literature is incomplete. Identification of previously unidentified stressors is to be expected from a qualitative study such as this.

The remainder of this chapter will discuss the identified themes of Environment, Accomplishment and Interpersonal Relations. Each will be addressed in relation to the extant literature and the implications to nursing education, nursing practice and policy. The limitations of this study are discussed and recommendations for future research are presented.

## Discussion

The orienting question of this dissertation is, "What experiences do you appraise to be stressful working in an ED setting?" The succinct answer to this question is that factors that support the goal of professional practice are appraised to be eustressful and conversely, distress was expressed in the stories of experiences where that goal was

not supported. To further explicate the phenomena, a single factor such as basic resources or staffing, may induce either distress or eustress depending upon the combination of the individual, the environment and the situation. This is in agreement with Lazarus and Folkman (1984) who posit that the determination of what is and what is not stressful is determined not only by the individual, but also influenced by the setting in which a stimulus is presented and the stimulus itself. While the study did not set out to validate the Lazarus and Folkman model, the elements of that model are consistent with findings from this study. However, the findings of this study provide greater detail that is specifically related to the ED RN when appraising the environment and situation, as an individual in order to determine what stressors will be encountered.

To begin the discussion of the findings of this study, the following scenario, based upon the interpretation of materials provided by the study participants, is offered. When the typical ED RN walks into the department at the beginning of a work shift, they individually perform an environmental appraisal to assess the ability of the environment to support the accomplishing of their professional practice goals.

Questions related to the goals of that particular ED RN are silently reviewed and assessed. Questions might include: Who will I be working with today? Who is the physician on duty? Where is my assignment in the department? Do I have the right equipment? Does my equipment work? How many patients are in the department? How many patients are in the hospital? To sum up these questions, the ED RN is appraising whether or not the resources required to provide safe care for every patient who comes through the front doors with are readily available.

This appraisal examines each of the three components of the Stress Appraisal Triad (Figure 1) by addressing factors associated with both the relatively stable physical environment of the department itself as well as the dynamic changes to that environment that are associated with the make-up of the interdisciplinary team of the ED. By gaining an understanding of the Environment and the Interpersonal Relations that make up the resources for the shift, the ED RN is then able to plan how he or she will accomplish the goal of practicing as a professional ED RN. It is at this point when the experience of stress begins. If the ED RN assesses that the combination of the Environment and the Interpersonal Relations do not support the meeting of goals, distress is experienced. The opposite is true if the assessment suggests that goals will likely be met as a result of the support of the other two elements of the Stress Appraisal Triad (Figure 1).

The findings of this study show that there is an intricate interplay between the ED RN, the Environment of the ED, the Accomplishments of the ED RN and the influence of the Interpersonal Relations of the members of the ED team that determine the level and quality of stress experienced by the ED RN. No other literature was found that presents this information. Literature reviewed for this study has presented the stressors of the ED RN as either very broad categories of stressors or as stand alone instances of stress.

For comparison, McVicar's (2003) review of the literature from 1985 to 2003 reported broad categories of stressors for nurses in general such as workplace issues and dealing with families, death and workload. None of these categories were tied to the resources available to the ED RN as was found to be a contributing factor in this study

via the themes of the Environment and Interpersonal relations. In the research studies conducted by Adeb-Saeedi (2002) and Scullion (2004), subjects were asked to rank order preconceived stressors such as pain, suffering, decision making and other singular tasks associated with ED nursing. No inquiries were made of the subjects as to what contributed to their stress, nor did the authors hypothesize that stress was induced by anything other than specific situations that were not associated with the dynamic nature of the ED Environment, the Accomplishments of the ED RN or the Interpersonal Relations of a given ED department as was found in this study to be the major influences of the stress experience of the ED RN.

The most similar study found and reviewed for this study was the doctoral dissertation completed by Cox (2004). His qualitative approach was descriptive and sought to discover what psychological stresses nurses experienced as they practiced in the ED. However, his driving question addressed not what stressed the ED RN, but why nurses continued to practice in the ED despite being exposed to the high levels of stress found therein. As a result, his focus was less on what stressed the ED RN at the moment of working and more on why they chose to practice in such an environment and what extrinsic stressors affected their lives.

Cox (2004) used a structured interview of nine questions. Only one of these questions elicits the experiences associated with being an ED RN as it requests the participants to share their best and worst days in the ED. While Cox did ask facilitating questions to bring out more information from each participant, the interviews did not allow for significant deviation from the topic being investigated by the structured

interview. All other questions were related to either why they chose to work in the ED or general stressors and situations of life outside of the workplace such as family dynamics and personal sleeping patterns.

Cox's (2004) finding of the nurses being drawn to the exciting environment is the sole theme echoed in the findings of this study. Participants in this study presented information that was interpreted as excitement and satisfaction related to the mystery of each patient's pathology thus leading to feelings of accomplishment as a professional. The descriptions of excitement were of an egocentric nature as described by Cox in that he surmised that nurses who gravitated to the ED did so because they had a desire to be a part of the perceived excitement. Both Cox and participants of this study termed this concept, adrenaline junkie. His conclusion makes sense since his inquiry was more about stress in general as experienced by persons who were ED RNs and less on what stressors they holistically perceived as part of that role. Unlike the findings of this study, Cox (2004) did not describe the influence of having a goal for practice or the intricate interplay of the Environment and Interpersonal Relations.

As such, the findings of this study are unique as they put forth the idea that the stressors of the ED RN are not static situations that always or never induce stress but that the experience of stress for the ED RN is a dynamic interplay between the goals of Accomplishment of the ED RN, the Environment and the influences of Interpersonal Relations.

It must be stated that individuals make these assessments and therefore, while the themes may shift in their meaning based on an individual's interpretation, they are

none the less themes that all ED RNs may experience. Only the individual ED RN can state how specific instances are categorized for them as distressful or eustressful. It is possible, however, for suggestions to be made from the findings of this study that are vital to any effort to reduce negative stressors and increase positive stressors of the ED work environment. The remainder of this chapter will address the implications for nursing education, practice, policy and research.

Just as the themes of Environment, Accomplishment and Interpersonal Relations are bound together and intertwined with the concept of setting and meeting the goal of professional practice by the ED RN, the implications for education, practice and policy are also interwoven into a very complex pattern and build upon one another at multiple points. But the core of the implications is made up of a series of considerations beginning with the individual ED RN, passing through the ED team of caregivers and culminating with the ED as a whole. Implications for education are directed at the individual. Implications for practice address the group aspect of ED nursing. Implications for policy serve to guide the ED as a unit towards the reduction of negative stress, a promotion of positive stress and to meet the overall goal of providing safe, effective and efficient care to the emergency department patient.

### Implications for Nursing Education

Implications for education are directed at the individual. As an individual ED RN, one is responsible to attain the highest level of education required to support one's own practice and thereby support other members of the ED team. However, simply

possessing the knowledge needed to perform in a role does not address to what end the knowledge is used.

Education prepares the individual to function well in a given discipline. Of the three themes found in this study, Interpersonal Relations is perhaps the most influential when considering the implications for nursing education. Interpersonal Relations represents the abilities of individual members of the ED team to function effectively in their role. No matter what the role fulfilled by a team member, individuals must be fully educated in order to contribute completely to the team. The abilities and past accomplishments of an individual on the team serve as an indicator to other members of the team of how much stress they can expect from that individual. It was negatively stressful to be teamed with an individual who did not possess the education required to function well in the ED. Therefore; the individual team members must accomplish the professional practice goal of being fully educated for the role they are expected to fill on the team.

The conscious setting of specific goals improves individual performance in the workplace (Latham, 2004). Goal setting for the care of patients is already a learning objective of nursing education. A small shift to broaden educational focus to include goal setting for one's professional practice would require minimal innovation to nursing education. Nursing students as well as practicing ED RNs should therefore be taught and expected to guide their personal practice through the use of specific personal goals. Goals for practice as an ED RN could include improvement of a specific skill such as starting a large bore intravenous access or the ability to identify specific cardiac sounds.

A broader goal of professional practice might be to earn and maintain specialty certification such as Certified Emergency Nurse (CEN).

As relayed by the participants of this study, accomplishing these goals allows the ED RN to become a source of eustress in the department by becoming a dependable skill and knowledge resource for patients and for other members of the team. By accomplishing these goals, the ED RN also experiences reduced stress through self-confidence brought about by preparation and readiness. Department education efforts should also focus on meeting the educational needs of all staff of the department.

While improving the abilities of the ED RN through goal setting is important, synchronization of individual ED RN goals with the goals of the department is also an important aspect of goal setting when part of a team. Goal synchronization between the individual, team and department affect nursing practice and should be guided by departmental policy.

Based upon the findings of this study, education programs at the department level should assess the current knowledge level of each ED RN on the staff. From that assessment, plans should be crafted to increase the knowledge level of each ED RN to the point that they have a clear understanding of their role on the team. With that clarity, objective goals can be set by each ED RN that support the team and the goals of the department. Department leadership and educators should also formulate support systems to encourage appropriate continued education beyond what is minimally required by the individual facility. Examples of going beyond the minimum are to support attaining the Bachelor of Science in Nursing (BSN) degree and to attain and maintain

the specialty certification of Certified Emergency Nurse. Additionally, raising the minimum standards of education from having Advanced Cardiac Life Support (ACLS) training and Pediatric Advanced Life Support (PALS) training may also increase the value of the ED RN to the team. Requiring regular certifications such as Trauma Nurse Core Curriculum (TNCC) and Emergency Nurse Pediatric Course (ENPC) as regulated by the Emergency Nurse's Association are two examples of higher standards that should be sought by the ED RN and supported by their educators.

### Implications for Nursing Practice

Nursing practice in the ED Environment is also highly dependent upon Interpersonal Relations. The functionality of the personnel who make up the ED team have perhaps the greatest influence on the Environment and, by extension, the ability of the ED RN to accomplish the goal of professional practice. As found with the theme of Accomplishment, the meeting of one's goals is the determining factor of the quality of the stress experience. Each unique ED must become a place that not only recognizes the importance of each ED RN being able to meet his or her personal goals for practice, but also becomes a setting that actually facilitates such goals.

Every ED functions effectively based upon the team effort of the personnel employed there. Members of the team directly contribute to the efficiency of the ED to the point that the whole becomes greater than the sum of the parts. A significant consideration the ED RN makes when appraising the potential quality of stress (positive or negative) that might be present during a work shift is the make up of the ED staff. If the ED RN came to work to find they would be working with particular physicians,

physician assistants, nurse practitioners, nurses or ancillary staff they might experience either dread or elation based on this facet of the ED environment. This assessment by the individual ED RN is an example of how the combination of environment, individual and situation are key components to the identification of what ED RNs find to be positively or negatively stressful (Lazarus & Folkman, 1984).

Personnel working in an ED have an extremely wide spectrum of educational backgrounds, experiential backgrounds, role responsibilities, licensing requirements and abilities. Roles of members of the ED staff include unlicensed secretarial staff, unlicensed nursing assistive staff, emergency medical technician paramedics, professional registered nurses, physician assistants, advanced practice nurses and physicians. This listing is in order of authority in the department and the ED RN is situated in a position such that they are responsible for directing the actions of subordinates and acting according to the instructions of superiors at two progressive levels. Ultimately, all members of the team are responsible for the safe care of the patient, but the ED RN maintains the greatest amount of direct contact with the patient. The ED RN is responsible to supervise patient care as delivered by assistive personnel. The ED RN is also expected to contribute to the decision making process of the medical providers as well as to implement responsible care associated with those decisions. These responsibilities can only be met by maintaining open and effective communication among all members of the team as well as the patient and the patient's family.

The participants expressed distress when working with other ED RNs who did not perform the role of the ED RN effectively as evidenced by providing substandard or unsafe care. Communications with other members of the team were hampered either by previous accomplishments (or lack thereof) or by reputation of not being a fully collaborative member of the team. The aforementioned changes to the educational expectations of the ED RN, if acted upon will improve the overall level of accomplishment of each ED RN thereby making them a fully collaborative member of the team through accomplishment of providing safe and effective care on a routine basis.

According to Fernandez, Kozlowski, Shapiro and Salas (2008), groups of individuals with varied levels of education, skills and responsibilities who work together as a team must be able to function well together in order to achieve success. They classify the interdisciplinary team of providers in the ED as just such a team. Similar teams come from other high stakes settings such as aircrews and military command structures. Such teams are referred to as “Interdisciplinary Action Teams” (IAT) and the interdisciplinary team of the ED is considered to be an IAT (Fernandez, et al., 2008). Additionally, the success of such teams depends upon having common goals as well as individual goals that support the mission of the IAT. In order for the IAT to function as a unit and achieve success, all members of the team must be able to interact effectively to combine their resources and efforts. Interpersonal communication is at the center of these interactions.

The negative stress induced when the ED RN was not able to effectively communicate with other members of the ED IAT was clearly relayed by the participants of this study. No literature directly addressed the topic of the importance of communication among members of the ED team, but related literature does establish its importance in other areas of nursing. Garon (2011) conducted a study to explore the issues surrounding the ability of nurses to communicate with other team members, particularly physicians, in the acute care setting. The study was in agreement with the findings of this study that staff nurses believed they had the responsibility to communicate patient and workplace issues but that they were not always fully considered. In the Garon study, nurses in formal supervisory roles who took part in the study agreed that staff nurses should communicate, but the belief also existed among those same manager participants that there was a top down decision-making process which did not afford the input of the staff nurse to be considered. This is also in agreement with the findings of this study that administrative support being insufficient to meet the goal of professional practice of the ED RN is likely to induce negative stress. The cohesiveness of the ED team is of paramount importance. Therefore, nursing leadership must address the cohesiveness of the interdisciplinary team of the ED in order to reduce negative stress and deliver safe, effective and efficient care. As a matter of departmental practice, each member of the IAT must have the right to offer input for patient care planning and have that input seriously considered. But in order for that input to be pertinent, the ED RN must have sufficient knowledge base from which to speak as offered in the recommendations for educational change.

Fernandez, et al. (2008) also make this statement in their call for more research of this phenomenon, specifically in the area of the ED due to the nature of the IAT. They further posit that it is the combination of the resources brought to the team by each expert that either makes the team successful or unsuccessful. In the ED setting, success is the provision of safe care to all patients. Cohesive Interpersonal Relations support Accomplishment in the provision of that care.

This assessment insight is also reflected in the 2010 Institute of Medicine *Summary of the October 2009 Forum on the Future of Nursing: Acute Care*. Participants of the forum discussed the importance of a respectful and communicative health care workplace and noted that the issues of poor interdisciplinary relations are directly connected to poor patient outcomes. If any one of the members of the team fails to contribute to the overall functioning of the team, goals of practice can be thwarted and induce negative stress among the members of the team. Of course, the opposite should be true in that when all members of the ED team are contributing, communicating and performing the duties for which they are qualified in an effective and efficient manner, eustress abounds, the positive aspect of being an ED RN is experienced and patients experience better outcomes (Garon, 2011; IOM, 2010).

The concepts of working as a collaborative team are reflected by the International Council of Nurses' campaign to promote the improvement of the nursing workplace, the Positive Practice Environment Campaign, which was launched in 2006 (ICN, N.D.; Oulton, 2006). Among other items on the ICN's checklist for a positive practice environment are items that are supported by the findings of this study. Namely,

the importance of professional recognition, open communication among all members of the health care team, inclusion of staff in the departmental decision making process, the provision of support staff, equipment and supplies required to deliver care, thorough orienting of new staff and the adherence to staffing levels that are safe (ICN).

The American Association of Critical-Care Nurses (AACN) has adapted the ICN's campaign and launched a separate, but similar, effort for the promotion of healthy work environments. Both the ICN's and the AACN's campaigns to improve the workplace of nurses address themes interpreted in this study. Participants described the distressful environment in general and echoed points that are specifically related to stressors associated with the interdisciplinary team. The six standards outlined by the AACN to create a healthy work environment are skilled communication, true collaboration, effective decision-making, appropriate staffing, meaningful recognition and authentic leadership (Vollers, Hill, Roberts, Dambaugh & Brenner, 2009). All of these standards promote a cohesive team and reduce the negative stressors in the ED environment. Such a stable and supportive environment then promotes the accomplishment of the unique goals set by each ED RN.

The participants of this study clearly expressed throughout each interview their desires to be considered collaborative members of the IAT. They expected each ED RN with whom they worked to meet the goal of being a professional and to bring that professionalism to the IAT and to the patient. They expressed distress when other members of the IAT discounted their input. They expressed eustress when, no matter

the outcome of the patient, the IAT functioned well and provided everything the patient needed. Truly being a valued member of the IAT is a significant eustress for the ED RN.

### Implications for Policy

The day-to-day functions of the ED are regulated by policies of each individual facility. It is recognized that these policies are in place to assure compliance with the regulatory demands of government and certification entities and therefore are of a high level nature and common among all facilities. But none of these regulatory driven policies addresses the stressors of the ED RN. It is up to the individual department leadership to create and implement policies at the department level to address the specific needs to optimize the stress levels in the ED.

In keeping with the themes of Environment, Accomplishment and Interpersonal Relations, the policies of the ED should be focused on building and maintaining an efficient and effective IAT. Each member of the IAT must possess sufficient knowledge to perform his or her role on the IAT. Nursing practice must be goal driven in order to function with purpose other than to simply take on what it is given in the form of each patient's pathologies. Having departmental performance goals as noted in the findings of this study is a good beginning, but those departmental goals must recognize the professional qualification of the ED RN to amend those goals based on the higher standard of providing patient centered care in every instance.

As previously noted, Latham (2004) reported that workplace performance of the individual improved with the setting of goals. In a meta-analysis that reviewed research on Goal Setting Theory, Kleingeld, van Mierlo and Arends (2011) found that the

performance of a work team also improved with formally set goals. Additionally, they posited that the goals of the individual worker must be in support of the group's goals, and vice versa, in order for both the goals of the individual and the group to be attained.

In order to create goals that are synchronized between the goals of the individual and the goals of the department, departmental policies for work performance and patient care should support the goals of the members of the IAT. From the departmental policy standpoint, the routine review of the personal practice goals of each ED RN (and progress toward meeting them) should be a part of employee review process to ensure support of the department's goals as well as to inform leadership any needs to adjust department goals to ensure synchronicity.

Formal goal setting theories and practices are primarily related to business and industrial psychology (Kleingeld, et al., 2011). The theories related to goal setting in such workplace settings may or may not be applicable to the ED due to the varied qualifications and roles of the ED team members. But the setting of individual goals in cooperation with departmental goals matches the highly intricate interweaving of the individual, team and environment as seen in the ED. Therefore, it is recommended that further investigation of this implication be completed in the ED setting.

The findings of this study also indicate that there is a need to inform department leadership of the existence of incivility between members of the IAT when it occurs. This incivility reaches across the boundaries of role within the IAT as noted from both the participants of this study and the discussions documented by the IOM (2010). Writing policy to support the ED RN's goal of being able to practice professionally should be

written into explicit and enforceable policy by which all members of the ED team, not just the nursing staff, must abide. The Joint Commission (2008, 2009) specifically addresses the importance of policy enforcement by leadership to ensure safe patient care and a healthy work environment. Such policies are directed by The Joint Commission to apply to all persons associated with the hospital without prejudice to influence or station within the organization.

### Recommendations for Future Research

#### *Replication of this Study*

Replication of this study would further validate and possibly expand our knowledge of the sources of stress for the ED RN. A quota sampling method could be considered to assure future researchers of a representative sample without otherwise changing the study methodology. Since the experience of the individual is shaped by their personal perspective, a more representative approximation of the ED RN population make up of race, gender, ED types and work history (from minimal ED experience to several years' experience) might offer different perceptions of the stress experience. Specific study sites should also be sought in order to gain the perspective of the ED RN in the academic or trauma center setting. What is considered to be stressful by the highly experienced ED RN may be very different than what is considered to be stressful by the less experienced ED RN. Including these adjustments will increase the transferability of results of studies regarding the stress experience of the ED RN.

It was remarkable that no participants discussed stresses that had been included in some of the quantitative studies reviewed for this research such as a patient death or code calls. Although this study sought out the more regularly experienced stresses and purposefully avoided the rarely occurring events such as mass casualties and disasters, the absence of such stories being spontaneously offered by the participants could indicate that such events may very well be an area for a more focused phenomenological investigation. However, it is recognized that these rare events simply may not be considered to be important by the participants and therefore were not considered to be stressful. It is recognized, however, that the absence of such stories being offered by the participants could represent an incomplete expression of the stresses experienced by the ED RN.

### *Future Expansion on the Investigation of ED Stressors*

#### *Team Members*

Another extension of the research could be to include nurses in the ED who have roles other than those represented here. The perspective of nurses who function in supervisory, managerial and administrative roles may be different in terms of their stress experience in the ED. Advanced practice nurses such as Clinical Nurse Specialists, Advanced Registered Nurse Practitioners and ED specific Nurse Educators could also be studied. Likewise, Physicians and Physician Assistants should be included in any study looking to gather data regarding the stresses of functioning in the ED. Such stories may shed valuable light on the theme of interdisciplinary relations

since they are on the other side of the relationship and communication equation. Similarly, non-licensed clinical and department support personnel may also have valuable input to be considered when seeking to bring about an understanding of the complex environment of the ED.

### *The ED Environment as a Subculture*

Expansion of knowledge of this topic may also come from an ethnographic methodology which would allow a researcher to explore the stressors of individuals in all roles of the interdisciplinary team of the ED in a natural setting, thus potentially building upon and gaining greater insight into the highly interwoven themes discovered in this work. Given that so many of the themes are entwined with the environment and the team, an ethnographic inquiry might yield a greater appreciation for the ED as a subculture nested within nursing and the hospital organization and the stressors associated with that subculture (Mallidou, Cummings, Estabrooks, & Giovannetti, 2010).

### *Quantitative Studies*

The natural progression of research supports building upon the qualitative themes discovered here to quantitatively investigate critical factors that may contribute to employee turnover, nursing staff Burnout, inefficient practice commonalities and patient care errors. Intervention simulations can be designed to assist the ED RN to manage the distressful experiences and capitalize on the eustressful aspects of the Lifeworld of the ED RN. Quantitative study tools can be designed based on the

framework provided by qualitative investigations and a continued review of new literature from nursing, psychology and organizational dynamics.

### Limitations of the Study

Although the Snowball method of sampling did allow for the recruitment and subsequent participation of sufficient participants, it did not result in a heterogeneous sample. Of the six persons who participated, five were women and all were Caucasian. All participants were experienced professionals with at least three years of experience in nursing. The sole participant with only three years as a nurse had been a paramedic for well over a decade and all the other participants had at least 14 years as a nurse in either the ED or another nursing setting. None of the participants were younger than 30 years of age. These demographics indicate that this study does not provide an understanding of stress as experienced by the younger, less experienced ED RN. Participants were from three different small community hospitals located in three different central Florida counties, but none were designated as trauma centers. Experiences of ED RNs actively practicing in settings such as designated trauma centers or teaching hospitals were therefore not included.

The remaining possible study limitation is the fact that the primary researcher is a practicing ED Nurse Practitioner with ties to the community from which some of the participants practice. While the researcher had no relationship with any participant beyond being part of the larger professional circle of ED RNs in the area, it is not unreasonable to consider that the responses of the participants may have been either positively or negatively tailored as a result of the professional associations with peers of

the participants. However this possible limitation is balanced by the possibility that the researcher being an ED ARNP may have enhanced the openness of the participants. This is perfectly exemplified by the many questions posed by Janet at the beginning of her interview that focused on the researcher's qualifications to be investigating the Lifeworld of the ED RN. It is also possible, although conscious efforts were made to the contrary, that the biases of the researcher affected the interviews and the interpretations of the study materials.

### Conclusions

The stress experience of being an ED RN is shaped by the perception of those who have lived it. Commonalities of that experience have been shared in this work. As previously stated, no matter what the image of *being* an ED RN is to someone, the ED RN strives to provide the care according to personal knowledge, abilities and goals. The goals for practice of the ED RN are manifest by this effort. Eustress and distress are a direct result of being supported in accomplishing one's goals or being barred from accomplishing them. Implications for education, policy and practice of nursing must support the notion that the ED RN must be able to possess a sense of fulfillment in order to be able to shoulder the burdens that the patient is unable to bear alone.

Even though the goals of the ED RN were not always associated with specific endpoints of measurable achievement, they were no less important. Situations, environments and stimuli that blocked the ED RN from meeting a goal were appraised to be negative stressors. Likewise, situations, environments and stimuli that either

facilitated or did not impede the meeting of a goal were appraised to be positive stressors.

Specific barriers and facilitators appeared to be closely tied to the resources available to the ED RN during a shift in the department. Resources that were inadequate for the situation nurtured negatively stressful situations because they directly affected the ED RNs ability to: spend adequate time with a patient, depend on other nurses for support, depend on physicians to promote efficient diagnostics and/or treatments, depend on administration to provide more resources, and/or depend on the availability of functioning equipment. Not being able to depend on any one of these factors added stress and potentially prevented the ED RN from accomplishing the goal of delivering safe care.

When the ED RN had control over the workplace and had the proper resources available, a sense of accomplishment was fostered. This is in agreement with the demand/control model posited by Karasek (1979). Being able to meet the goals set forth by the individual encouraged continued practice as an ED RN.

### Summary

This research examined the Lifeworld of the ED RN in order to discover what nurses who regularly practice in the ED setting assess to be stressful. What evolved was an exploration of what they described as distressful or eustressful. The materials provided by the study participants did not support themes from the literature such as the stress of dealing with violence, death, pain and being a witness to tragedy. But participants did provide new insight into the Lifeworld of the ED RN by sharing stories

that expressed their stresses about themes that heretofore had not been documented. These themes included the stresses associated with personal practice goals of the ED RN and the associated facilitating and preventative factors of the ED practice environment.

The major theme previously unknown was that of having goals. From this theme stems the interpretation of varied stimuli as being distressful or eustressful based on whether the environment hinders or facilitates meeting the goal of the individual ED RN. It is not the stimulus by itself that is or is not stressful, but a complex interwoven set of circumstances from which each individual ED RN assesses the stress level of each moment they are working in the ED.

Nursing leadership must address the major theme of the work environment with all of its subthemes in order to allow the ED RN to assess the individual workplace as conducive to meeting the set goals. Failure to recognize the need for a well matched team of professionals in sufficient numbers who are equipped with the tools and supplies required to meet the needs of patients in an effective, efficient and safe manner will result in negative outcomes of poor patient care and increased staff Burnout and turnover.

## APPENDIX A: PARTICIPATION SOLICITATION FLYER

# Emergency Nursing Research

## Participate in a study about being an Emergency Department Registered Nurse!

### **Study Description**

The purpose of this study is to explore the perceptions of stress as experienced by ED nurses at the bedside.

A confidential interview will be completed to discuss what experiences nurses feel have impacted them while caring for patients.

### **Who should participate?**

Active Emergency Department Registered Nurses who provide direct patient care on a regular basis.

### **Who is doing the study?**

This study is being conducted by Stephen Heglund, MSN, ARNP as the dissertation project for a PhD degree in Nursing from the College of Nursing at the University of Central Florida.

### **Participation is confidential.**

If you would like to tell your stories about experiences in Emergency Nursing and participate in this project, please contact me.

**Steve Heglund**

**E-Mail [sheglund@knights.ucf.edu](mailto:sheglund@knights.ucf.edu)**

**(772) 538-xxxx (Cell) or (321) 433-7858 (Office)**

## APPENDIX B: INFORMED CONSENT

**Stressors Experienced by Emergency Department Registered Nurses at the  
Bedside: A Phenomenological Study**

**Informed Consent**

Principal Investigator: Stephen D. Heglund, MSN, ARNP  
Faculty Supervisors: Diane Wink Ed.D., ARNP  
Diane R. Andrews, Ph.D., RN

**Introduction:**

Researchers at the University of Central Florida (UCF) study many topics. To do this we need the help of people who agree to take part in a research study. You are being invited to take part in a research study, which will include about 10 people from the central Florida area. You have been asked to take part in this research study because you are a Registered Nurse (RN) who works or has worked full time in an Emergency Department (ED) in the past year. You must be 18 years of age or older to be included in the research study.

The person doing this research is Stephen Heglund of the College of Nursing at the University of Central Florida. Because the researcher is a graduate student, Diane Wink and Diane Andrews, UCF Faculty supervisors in the College of Nursing, are guiding him.

**What you should know about a research study:**

- Someone will explain this research to you.
- A research study is something you volunteer for.
- Whether or not you take part is up to you.
- You should take part in this study only because you want to.
- You can choose not to take part in the research study.
- You can agree to take part now and later change your mind.
- Whatever you decide it will not be held against you.
- Feel free to ask all the questions you want to before you decide.

**Purpose of the research study:**

The purpose of this study is to explore the perceptions of stress as experienced by ED nurses at the bedside. Previous research studies have been completed that ask nurses how stressful they believe certain things to be, but there have not been any studies that have asked nurses in the emergency department what they think is

stressful. By discovering directly from nurses who work in the Emergency Department what is stressful, further research can be conducted to improve the emergency department as a workplace for nurses.

**What you will be asked to do in the study:**

If you agree to participate in the study, you will be asked to complete a survey that will ask you things about yourself such as how long you have been a nurse, how long you specialized in emergency care, your gender, your age, your education, etc. In addition to the survey, you will participate in a private interview with the primary researcher to talk about your daily life as an Emergency Department Registered Nurse. You do not have to answer every question. You will not lose any benefits if you skip questions.

**Location:**

You may come to a UCF Campus or select a public place to meet the researcher for the interview that is not too distracting to hold a private conversation. A follow up interview to clarify topics discussed in the first interview may or may not be needed.

**Time required:**

The survey should take about 10 minutes and the interview should take about an hour. The follow up interview should take much less time.

**Audio recording:**

You will be audio recorded during this study. If you do not want to be audio recorded, you will not be able to be in the study. Discuss this with the researcher or a research team member. If you are audio recorded, the recording will be kept in a locked, safe place. The recording will be erased after the researcher has transcribed it.

**Risks:**

There are no reasonably foreseeable physical risks or discomforts involved in taking part in this study. However, the interview process may remind you of unpleasant experiences that you have had while working as a nurse in the emergency department which may be upsetting or uncomfortable. If you find that our discussion has brought up such emotions and desire assistance, the following agencies are qualified to evaluate and assist you.

Indian River County  
The Behavioral Health Center at Indian River Medical Center  
1000 36<sup>th</sup> Street

Vero Beach, FL 32960  
772-563-4666 or 800-226-4764

#### Brevard County

Circles of Care – North Area  
6700 South Washington Ave.  
Titusville, FL 32780  
321-269-4590

Circles of Care – Central Area  
1770 Cedar Street  
Rockledge, FL 32955  
321-890-1500

Circles of Care – South Area  
2020 Commerce Drive  
Melbourne, FL 32904  
321-952-6000

#### General Referral Services

Mental Health Association of Central Florida  
407-898-0110

Additionally, the Employee Assistance Program (EAP) maintained by your employer is may be an excellent resource to obtain assistance with unpleasant experiences that you have had while working as a nurse in the emergency department of that organization.

A breach of confidentiality might negatively impact employability, insurability and/or criminal and civil liability. If topics are discussed having to do with illegal acts or reportable conditions, the researcher may be required to disclose the information in accordance with Florida law.

#### **Compensation or payment:**

There is no compensation or other payment to you for taking part in this study.

#### **Confidentiality:**

We will limit your personal data collected in this study to people who have a need to review this information. We cannot promise complete secrecy, but it is expected that only Stephen Heglund will see your individual name. Organizations that may inspect and copy your information include the Institutional Review Board (IRB) and other representatives of UCF. If information is disclosed that reveals illegal activity or

reportable conditions, the researcher may be required to disclose the information in accordance with Florida law.

**Study contact for questions about the study or to report a problem:**

If you have questions, concerns, or complaints, or think the research has hurt you, talk to Stephen Heglund, Graduate Student, Ph.D. Program, College of Nursing, (407) 823-1170 or Dr. Diane Wink or Dr. Diane Andrews, Faculty Supervisors, College of Nursing at (407) 823-2744 or by email at [Diane.Wink@ucf.edu](mailto:Diane.Wink@ucf.edu) or [Diane.Andrews@ucf.edu](mailto:Diane.Andrews@ucf.edu).

**IRB contact about your rights in the study or to report a complaint:**

Research at the University of Central Florida involving human participants is carried out under the oversight of the UCF IRB. This research has been reviewed and approved by the IRB. For information about the rights of people who take part in research, please contact: Institutional Review Board, University of Central Florida, Office of Research & Commercialization, 12201 Research Parkway, Suite 501, Orlando, FL 32826-3246 or by telephone at (407) 823-2901. You may also talk to them for any of the following:

- Your questions, concerns, or complaints are not being answered by the research team.
- You cannot reach the research team.
- You want to talk to someone besides the research team.
- You want to get information or provide input about this research.

## APPENDIX C: INTERVIEW GUIDE

### ***Demographics***

1. How long have you been a nurse?
  - a. *Number of years estimate is adequate.*
2. What types of nursing have you practiced?
3. How long have you been in the Emergency Department as an RN?
4. What educational level and certifications do you hold as an RN?

### ***Influence & Satisfaction Overview***

5. What influenced you to work in the Emergency Department as a Registered Nurse?
  - a. Pause to allow voluntary information to flow.
6. Overall, do you enjoy your work?
  - a. *A “Yes” or “No” response is expected.*
    - i. *Pause to allow for voluntary information to flow.*
    - ii. *Follow the path offered by the participant first.*
    - iii. *When it is sensed that the participant has shared sufficiently in the positive or negative, turn the conversation to the opposite area. (If they first offer why they love the work, then move to why they do not love it or vice versa.)*
    - iv. *If a story does not flow, encourage the participant verbally.*
  - b. To follow the “Yes” response
    - i. Please tell me about what you love or enjoy about working in the Emergency Department.

- ii. What is your favorite assignment area to work?
    - iii. What was your best day ever?
      - 1. Why?
  - c. To follow the “No” response.
    - i. Please tell me about what you hate or do not enjoy about working in the Emergency Department.
    - ii. What is your least favorite assignment area to work?
    - iii. What was the worst day ever?
      - 1. Why?
- 7. What would you change about your work at the bedside in the Emergency Department?
- 8. What would you keep from changing about your work at the bedside in the Emergency Department?
- 9. What do you see as the five greatest barriers to you that keep you from providing great care to your patients?
- 10. What are your five greatest sources of stress in your work in the Emergency Department?
- 11. What do you see as the five greatest facilitators that help you provide the greatest care possible to your patients?
- Error Associations – will use only as follow up questions.***
- 12. Please describe for me a situation in which you think a nurse would be most likely to have an error occur.

13. Can you recall a day in the Emergency Department when you witnessed, caught after the fact, prevented or made an error?

- a. What kind of day was it up until the error occurred?
- b. Can you recall what the stress level was...
  - i. ...of the nurse who made or nearly made the error?
  - ii. ...that you were experiencing at the time?

14. If you had the power to prevent your worst Emergency Department fear from happening, what four things would you change?

- a. This can include anything associated with your work in the Emergency Department.

**Closure**

15. Would you like to add anything to our discussion?

- a. Follow up questions as needed to investigate themes not previously thought of by the researcher or brought to the discussion by the participant.

## APPENDIX D: INSTITUTIONAL REVIEW BOARD APPROVAL



University of Central Florida Institutional Review Board  
Office of Research & Commercialization  
12201 Research Parkway, Suite 501  
Orlando, Florida 32826-3246  
Telephone: 407-823-2901 or 407-882-2276  
[www.research.ucf.edu/compliance/irb.html](http://www.research.ucf.edu/compliance/irb.html)

### Approval of Human Research

From: **UCF Institutional Review Board #1  
FWA00000351, IRB00001138**

To: **Stephen D. Heglund**

Date: **September 28, 2011**

Dear Researcher:

On 9/28/2011, the IRB approved the following human participant research until 9/27/2012 inclusive:

Type of Review: UCF Initial Review Submission Form  
Project Title: Stressors Experienced by Emergency Department Registered  
Nurses at the Bedside: A Phenomenological Study  
Investigator: Stephen D Heglund  
IRB Number: SBE-11-07871  
Funding Agency:  
Grant Title:  
Research ID: N/A

The Continuing Review Application must be submitted 30days prior to the expiration date for studies that were previously expedited, and 60 days prior to the expiration date for research that was previously reviewed at a convened meeting. Do not make changes to the study (i.e., protocol, methodology, consent form, personnel, site, etc.) before obtaining IRB approval. A Modification Form **cannot** be used to extend the approval period of a study. All forms may be completed and submitted online at <https://iris.research.ucf.edu>.

If continuing review approval is not granted before the expiration date of 9/27/2012, approval of this research expires on that date. When you have completed your research, please submit a Study Closure request in iRIS so that IRB records will be accurate.

Use of the approved, stamped consent document(s) is required. The new form supersedes all previous versions, which are now invalid for further use. Only approved investigators (or other approved key study personnel) may solicit consent for research participation. Participants or their representatives must receive a copy of the consent form(s).

In the conduct of this research, you are responsible to follow the requirements of the Investigator Manual.

On behalf of Sophia Dziegielewski, Ph.D., L.C.S.W., CF IRB Chair, this letter is signed by:

Signature applied by Joanne Muratori on 09/28/2011 01:40:31 PM EDT

IRB Coordinator

## APPENDIX E: LIST OF PSEUDONYMS

Carol

Ike

Hazel

Gustav

Connie

Felix

Janet

Dean

Audrey

Stan

Donna

Dennis

Carla

Ivan

Hattie

Charley

Flora

Juan

Dora

Fabian

Hilda

Keith

Betsy

Lenny

Inez

Floyd

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