NURSES’ EXPERIENCES OF CARING FOR THE OLDER ADULT
IN THE EMERGENCY DEPARTMENT

by

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A THESIS SUBMITTED IN PARTIAL FULLFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
Master of Science
in
THE COLLEGE OF GRADUATE STUDIES
(Nursing)

THE UNIVERSITY OF BRITISH COLUMBIA
(Okanagan)

June 2013
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Abstract

The population of those over the age of 65 continues to grow. This cohort is one of the largest consumers of health care and presents with some unique needs and challenges. In a health care environment with fewer family physicians and careful resource allocation many older adults must seek health care in the emergency department (ED). Compared to younger cohorts older adults spend more time in the ED, require more diagnostic tests and are more often admitted and held in the ED until an inpatient bed becomes available. This changing demographic has an impact on ED nurses who must straddle care for incoming emergency patients and boarded inpatients.

As the older adult population continues to grow it is important to understand nurses’ experiences of caring for the older adult in this unique venue. This ethnographic study used semi-structured interviews and non-participant observation, to understand nurses’ experiences of caring for older adults in the ED. Seven registered nurses participated in the interview process and detailed their experiences of caring for the older adult in the ED.

Interviews were conducted at locations of the nurse’s choice. Data was transcribed verbatim and analyzed thematically. Three themes emerged from the findings: the culture of the ED which focused on priority setting and throughput of patients, fit and lack of fit between the older adult and the ED, and managing lack of fit. Nurses relied on a default orientation of priority setting but recognized this put the older adult at risk of ‘under care’, prolonged length of stay in hospital, and increased risk of mortality and morbidity.
The findings of this study have implications for nursing practice, education, and research. ED nurses need to be aware of the needs and the challenges of caring for the older adult in the ED. ED nurses need education on the atypical presentation of older adults to the department. Further research is needed to investigate and develop innovative models for health care delivery for the older adult in the ED. Health care administration needs to look at different models of care delivery for the older adult in the ED.
Preface

This science was conducted as a requirement for completion of my Degree in Masters of Science in Nursing. Data collection was completed by Bonny Taylor with guidance from committee members. Analysis of the data was completed collaboratively with my Committee Supervisor, Kathy Rush and Committee member, Carole Robinson. Kathy Rush is listed as the principal investigator as required by UBC Okanagan Research Ethics Board.

The writing of this research was done in collaboration with Kathy Rush and Carole Robinson. Documentation was reviewed by committee members, Kathy Rush, Carole Robinson, and Janice Stanbury. Ethics review and approval by UBC-Okanagan [H10-02253 ] and Interior Health, [2010-036 ] was obtained prior to beginning this study.
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Acknowledgements

I wish to express my thanks to all those people who have encouraged and supported me while I have engaged in this marathon endeavor. Special thanks to the members of my committee for keeping me on course.

- To Dr. Kathy Rush, my supervisor, who was always there with words of encouragement and was always willing to be my sounding board.
- To Dr. Carole Robinson, for willingly joining my committee after so many changes, for helping clarify my thinking and my writing, often pointing me in directions that were unexpected but fruitful.
- To Janice Stanbury for her encouragement to get this finished and all her help with the APA formatting.
- To my husband, Philip, for putting up with my many moods and muttering, as well as the piles of paper throughout the house.
- To my son Jason for always being willing to listen and critique my work and who reminds me constantly to keep it simple.
- To my sons, Darby and Riley, for your encouragement, for listening when I talk about this even though you have no interest in the topic, and for letting me play with my grandchildren who provided so much laughter and hugs to keep me going.
- To Mary Kjorven who gave me encouragement and reminded me often how important this work is.
• To Shannon Paul-Jost who shares my interest in older adults and has shared so much of her knowledge and time with me.

• A special thank you to the nurses who agreed to participate in this study and for sharing all your experiences with me. A thank you as well to those nurses with whom I have worked in the emergency department. Your ability to carry on in difficult circumstances and still smile at the end of the day shows me what an amazing group of nurses you are.
Dedication

This work is dedicated to my grandparents from whom I have learned so much. I count myself blessed to have known these wonderful people during my formative years. To my great grandpapa "Mac" who carried me on his shoulders when I was a small girl and he was in his 90's. To my grandmother, Helen Pearl Wilkerson, who taught me how to crochet, knit, cheat at cards, and was a role model as a nurse. To my grandmother, Esther Caroline Young, who taught me by example to laugh and to have the courage to try new things no matter how scary they were. To my grandfather, Walter Clinton Young, who taught me the value of a good argument and to stand up for my beliefs. To my grandfather, Wallace Wilkerson, who taught me the peace of digging in the dirt and the joy that comes from growing things and seeing them thrive under your care. Thank you for all the time and love.
Chapter 1: Introduction

Background to the Study

It was a weekday in the Emergency department (ED) and I was on triage. All the beds were full, there were already six patients in the hallway and by midmorning the ambulances were lined up waiting to offload their patients. Yet another ambulance crew came through the door. The stretcher held an older man wrapped in a blanket. It was hard not to notice him as he was shouting quite loudly. The ambulance attendant stated “I’ve got a live one for you today.” The ambulance attendant told me they had been called by the patient’s wife who stated that the patient had been increasingly confused over the past three days. She would not have called but he had begun threatening her with his cane.

After talking with the ambulance crew I went to talk to the patient and his wife. The patient was cooperative when I asked if I could do his vital signs and ask him a few questions. While I took his vital signs he told me he was “a little miffed”- after all he had not agreed to be in this movie. When I asked him where he was he told me on a movie set. “Don’t you see all the cameras there?” he said, pointing to the monitoring screens. Then he looked closely at me and told me that I was very good in that movie he and his wife had watched last week.

There was no bed to place this man in for assessment. He stayed on the ambulance stretcher for several hours. I started some basic diagnostic tests to see if the source of his delirium could be pinpointed. When his blood work came back it indicated that this patient had suffered a heart attack and required admission to the hospital.
After four hours of waiting this patient was placed in a bed and his treatment initiated. Unfortunately the general chaos and noise only exacerbated his delirium. He repeatedly tried to leave the department and threatened staff with his cane when they tried to intervene. Although we moved him to a quieter area and got a one-to-one caregiver for him his behaviour escalated to the point where he required sedation.

When I left the hospital that evening this gentleman was finally sleeping. I hoped that by the morning he would not be in the ED but in a bed on a medical ward. It was a hope not to be realized. This patient stayed in the ED for four days. After the third day he was designated an alternate level of care (ALC) patient. This meant that while he did not require further specialized medical care in hospital, he could not be discharged home. But there were no beds available in an alternative level of care facility and the admitting department did not want someone deemed ALC taking an acute care bed. After much discussion, he was moved to a medical ward. I saw his wife about a month later. She told me that he was better but so weak now he could not walk. The doctors had recommended placement in a long term care facility.

**Exploration of the Problem**

The problem this study addressed was nursing care of the older adult in the ED. I have worked as an ED nurse for more than fifteen years. The incident recounted above occurred shortly after I attended a workshop known as the Geriatric Emergency Network Initiative. This workshop brought ED nurses together to address caring for the increasing numbers of older adults in the ED. This particular
workshop focused on the recognition of delirium in older adults. Seeing a patient present with delirium immediately afterwards brought sharply into focus many of the problems I had seen time and again in the ED: the lack of recognition of delirium in the older adult, the myth that older adults always end up with confusion, the excessive stimulation and stress of the ED environment on older adults, and the increasing time older adults were spending in the ED. I was concerned that we were not providing the best care possible for older adults. In fact I observed that keeping the older adult in the ED for extended periods of time often worsened their health, as with the gentleman in my story, whose delirium was exacerbated by the noise and chaos of the ED. I began to wonder if other ED nurses experienced these same concerns and issues related to caring for older adults in the department. This incident evoked questions that provided the impetus to begin the research I undertook.

The ED in which I practice and in which the research was conducted is a tertiary care facility in an urban center in the interior of British Columbia. In 2007 approximately 45,000 patients attended this ED with the figure rising steadily to 59,000 ED visits in 2012 (Interior Health Authority- Facility Profile 2007, 2013). Older adults comprised 25% of all ED patient visits, and over time, patients were staying longer in the ED prior to discharge or transfer (Meditech DAD ABS database, 2009). Almost 60% of the patients admitted to inpatient beds were admitted through the ED. While 60% of the patients admitted from the ED were transferred to an inpatient bed in less than 10 hours the other 40% waited a minimum of 24 hours with some waiting for as long as 162 hours or more than 6 days. Of the patients waiting
more than 24 hours for an inpatient bed the majority were older adults. Evidence supported my observations that the ED where the study was conducted was progressively busier, with increasing numbers of older adults presenting, and who were staying longer.

Indeed, multiple international studies (American, Australian, British, Canadian, Hong Kong, and Italian) document increased use of the ED by those 65 years and over (Arendts and Howard, 2010; Claver and Levy-Storm, 2010; Fealy et al., 2012; Han et al., 2007; Hodgins & Wuest, 2007; Li et al., 2007; Lowthian et al., 2012; Markham and Graudins, 2011; McCusker, Bellavance et al., 2000; Parsons & Boling, 2007; Pines et al., 2013; Platts- Mills et al., 2010; Schull, Mamdani & Fang, 2005; Smith, et al. 2005; Tang et al., 2010; Wilson & Truman, 2005). Evidence reveals that as the older adult’s age increases, so does use of the ED (Hwang & Morrison, 2007) leaving older adults overrepresented in ED utilization (Aminzadeh & Dalziel, 2002; Li et al., 2007). A range in utilization patterns have been reported from a low of 12% of all ED encounters accounted for by older adults (Aminzadeh & Dalziel, 2002) to a high of 73% among those 75 years and older (Li et al., 2007). Although such numbers may seem high, the use of the ED by the older adult is appropriate and most have accessed an alternate source of health care prior to their presentation in the ED (Grief, 2003; Han et al., 2007; Ionescu-Ittu et al., 2007; Wolinsky et al., 2008). More recent studies on older adults’ utilization of the ED, from 2009 onwards, show continuing increases in the use of the ED as well as some changing trends in utilization patterns. Chi et al. (2009) found that since 2001, community dwelling older adults have been three times more likely to access the ED.
at least once per year. Vegda et al. (2009) and Xu et al. (2009) discovered that increasing numbers of older adults accessing the ED were women, over the age of 80, and had at least seven comorbid conditions on presentation. As in previous studies Caterino et al. (2009) confirmed that older adults presented with serious illnesses, were four times more likely to require admission, (Lowthian et al., 2012; Pines et al., 2013) and with higher risk of mortality.

Nevertheless, there is some evidence that older adults are being labeled the problem in the system. For example, in 2008 George Abbott, then the Health Minister for British Columbia, stated that the aging population of British Columbia was causing both cancelled surgeries and delays in emergency rooms (CBC News.ca, March 18, 2008). This inevitably contributes to tensions in caring for older adults in the ED. Several studies (Derlet & Richards, 2000; Guo & Harstall, 2006; Kawano et al., 2013; Knapman & Bonner, 2010) have established that older adults do have an effect on overcrowding. Indeed, wait times for other less urgent patients increased in proportion to the number of older adults within the ED. As older adults access the ED for care and are admitted many will remain in the ED to receive that care. Hodgins et al. (2010) discovered that being female and over the age of 65 increased the likelihood of remaining in the ED. Studies of patients being held, or boarded, in the ED have shown that these patients are at increased risk of serious complications or mortality (Gilligan et al., 2008; Singer et al., 2011; Zhou et al., 2012).

Where the ED historically operated to quickly treat acute, urgent health care needs (Adams & Gerson, 2003) it has now become a holding station for people
awaiting inpatient beds, many of whom are older adults. The changing face and environment of the ED has created a major culture shift for nurses working in the ED (Schriver et al., 2003; Taylor et al., 2004), requiring them to provide care for two subsets of patients: outpatients and inpatients. Although the nature of nursing work in the ED has changed we know little about nurses’ experiences of caring for the particularly vulnerable population of older adults. With those 85 and over being the fastest growing population cohort in Canada and the ED (Statistics Canada, 2006), it is expected the older adults’ use of the ED will continue to increase (McCusker, Bellavance, et al., 2000). Therefore, the challenges nurses face in caring for the older adult in the ED are likely to intensify as well and this merits investigation. The question my study addressed is: what is the experience of ED nurses caring for older adults? This question is both relevant and significant to nursing given the national trends of increasing numbers of patients presenting to EDs, high proportion of patients being older adults (Li et al., 2007), increasing patient acuity (Lowthian et al., 2012; Pines et al., 2013), and continuing overcrowding (Knapman & Bonner, 2010). An ethnographic approach was chosen to account for the unique environment and changing culture of the ED in which nurses’ work is constructed.

Operating definitions for key aspects of the research are provided below.

**Culture of the ED**

Culture is multidimensional concept. Morse and Richards (2002) described ethnography as a means by which culture may be explored. These authors further defined culture as “beliefs, behaviours, norms, attitudes, social arrangements, and forms of expression that form describable patterns in lives of members of a
community or institution” (p. 48). The purpose of this research is to explore some of these multiple facets and look for describable patterns in relation to nurses care of the older adult within the ED.

Older Adult

For the purpose of this study the older adult was defined as an individual who was a minimum of 75 years of age. Although many studies define the older adult as anyone over the age of 65 there are a number of reasons for setting the benchmark at 75. The most pressing is that as the age of the older adult increases so too does the incidence of chronic disease and frailty, increasing the need for older adults to access the services of the ED. With the fastest growing cohort in the Canadian population being those over the age of 85 (Statistics Canada, 2006) it is likely that these individuals will seek care in the ED. Choice of the study site where those aged 75 and older comprise 37% of all ED admissions (Meditech DAD ABS database, 2009), provides a unique snapshot of how the older adult and ED will look across the country in twenty years time when the proportion of Canada’s older adult population reaches that found in the study community.

ED Nurse

For the purpose of this study, an ED nurse was defined as any registered nurse working in the department who had a minimum of three years of ED experience. This ensured that these nurses were well versed in the daily routines of the unit and had some experience caring for the older adult in the ED.

The aim of this research was to enhance understanding of the experience of nurses caring for older patients in the context of the ED as well as the factors that
influence that practice. It is my hope that this will lead to better policies and practices for providing care for the older adult within the ED.
Chapter 2: Literature Review

This chapter reports on the selected review of literature conducted in relation to the older adult in the ED. Searches were carried out on the PubMed, CINAHL, and Medline databases. The search terms used were emergency department/ED, older adult, elderly, aged, and nursing care. The literature surrounding the ED and the older adult fell into three categories: culture of overcrowding in the ED, ED utilization by the older adult, and nurses’ experiences of caring for older adults in the ED.

Culture of overcrowding in the ED

The ED is an example of an environment within health care that has been subject to a great deal of change in the past ten years. The culture of the ED is different from other areas within the hospital setting. ED nurses require specialized education over and above basic nursing education. The workload is often unpredictable and not easily controlled. Nurses in this setting need to be prepared to deal with any clinical problem that presents to the door regardless of the level of acuity. Patients in the ED range from very young to very old with a variety of medical, surgical, psychiatric, or traumatic presentations (Schriver et al., 2003).

Overcrowding is an international issue. Schneider et al. (2001) and Schull et al. (2002) indicate that overcrowding continues to plague most Canadian ED’s. As ED utilization has escalated, so too has ED overcrowding. In simple terms, overcrowding occurs when the demand for ED services exceeds the ability to provide quality care (Canadian Association of Emergency Physicians, 2002; Ospina, et al., 2007; Schull et al., 2002; Steele & Kiss, 2007). Similar problems have been
reported in the United States, Taiwan, Great Britain, Germany, and Australia. It has been estimated that between 10 and 30 percent of all ED’s in the United States experience daily overcrowding (Schneider et al., 2001). The Canadian Association of Emergency Physicians (CAEP) (2001) describes overcrowding as a chronic condition, a position supported by Schull et al. (2002). In the Canadian context, the problem of overcrowding can be traced back to the health cuts of the 1990’s that followed the Barer-Stoddart Report (Beck & Thomson, 2006). This report indicated that the physician group in Canada was too large and overused hospitals for their own convenience adding to the ever increasing costs of health care. As a result, cuts were recommended in relation to the number of physicians being educated, as well to the number of acute care beds funded, with more money allocated for less costly home care services. Unfortunately the funding given to home care was not substantial enough to offset the closure of the acute care beds. Between population growth, population aging, and a diminished supply of physicians the public was, therefore, forced to seek care in the ED.

While it is easy to determine that ED overcrowding exists, it is not so straightforward to determine why it occurs and there is lack of agreement among experts about the contributing factors. Among the leading factors influencing overcrowding are numbers of staffed acute care beds, numbers of patients being held in the ED awaiting bed placement, the percentage of time the ED remains overcapacity, and the time from ward bed availability to actual transfer from the ED to that bed (Ospina et al., 2007; Schneider et al., 2001; Schull et al., 2002; Steele & Kiss, 2007).
Hoot and Aronsky (2008) conducted a systematic review focused on the causes and effects of overcrowding, as well as solutions for overcrowding. They reviewed 93 articles and categorized the causes of overcrowding in three ways: as those that interfered with input, throughput or output. Input interferences included non-urgent patients and lack of primary care for patients. Throughput bottlenecks arose due to lack of adequate ED staff to provide patient care. Output was affected by the inability of other care areas to accept the ED patient because of hospital bed shortages, which resulted in inpatient boarding (the holding of patients indefinitely in the ED). They also found that most patients would have exchanged a visit to the ED for a follow-up appointment with their primary care provider if it was available within 72 hours.

The problem of patient flow in the ED has led to an increasing frequency of patients being boarded in the ED until inpatient beds become available (Braitberg, 2007; Freeman, 2007; Krochmal & Riley, 1994; Ospina et al., 2007; and Steele & Kiss, 2007). The majority of older adults who require admission to hospital have serious and urgent cardiovascular, respiratory, or neurological conditions, or preexisting terminal illness (Aminzadeh & Dalziel, 2002; Bridges et al., 1999; Caterino et al., 2009; Fealy et al., 2012; Grief, 2003; Li et al., 2007; McCusker et al., 2007). However, they often wait in the ED until an inpatient bed is available.

Given that diagnosis of an older adult’s presenting problem is often complicated, several hours may elapse before there is a decision to admit to an inpatient unit, which can mean a minimum 24-hour stay in the ED prior to bed placement (Hodgins et al., 2011). No longer is quick throughput the norm. Indeed,
at the hospital where the current study occurred, 42% of patients waited more than the 10-hour benchmark set by the Ministry of Health to be moved to an inpatient bed (Meditech DAD ABS, August 2010). More recent studies (Derlet & Richards, 2000; Guo & Harstall, 2006; Hoot & Aronsky, 2008; Knapman & Bonner, 2010) have taken a closer look at the factors behind overcrowding. The presence of older adults in the ED has been identified as the cause for delayed wait times for others in the department due to the complexity and comorbidities present in the older adult population (Derlet & Richards, 2000; Guo & Harstall, 2006; Knapman & Bonner, 2010). These multiple comorbid conditions contributed to difficulty with diagnosis, evaluation and disposition of the older adult and this was apparent whether the older adult was admitted as an inpatient or discharged home from the ED (Kawano et al., 2013; Lowthian et al., 2012). However, there was a significant increase in overcrowding as the mean age of the patients increased. Recent research has considered a more nuanced exploration of overcrowding in the ED including who was more likely to be held longer in the ED, outcomes of overcrowding, solutions to overcrowding, and the relationship between the time of accessing the ED and the likelihood that a patient would remain boarded in the ED awaiting an inpatient bed (Hodgins et al., 2010; Hoot & Aronsky, 2008; Schilling et al., 2010; Ye et al., 2012). All of these researchers found that overcrowding led to a variety of adverse outcomes for both patients and providers. For older patients’ adverse outcomes such as increased mortality, risk of complications, reduced quality of care, delays in treatment, and impaired access to care were found. For care providers adverse outcomes consisted of monetary losses and decreased job satisfaction.
When Hodgins et al. (2010) examined length of patient boarding in the ED they found that older adults, and in particular, older adult females, were likely to be boarded for the longest time. They also found that time of day and week was influential in whether a patient was boarded. In general, patients admitted on a weekday, during a night shift, with a medical condition, especially congestive heart failure or pneumonia, were most likely to be boarded in the ED (Fealy et al., 2012; Hodgins et al., 2010; Lowthian et al., 2012).

**ED utilization by the older adult**

Pines et al. (2013) found a 24.5% increase in older adults presenting to the ED from 2001 to 2009. Older adults present more frequently to the ED than younger adults with medical conditions, such as cardiovascular disease, respiratory disease, infections (e.g., pneumonia, urinary tract), or neurological problems (Caterino et al., 2009; Hastings et al., 2005). Moss et al. (2002) ranked the following conditions for approximately 2500 older adult patients seen by their ED care coordination team: “respiratory, 17.5%, cardiac, 12.2 %, musculoskeletal, 10%, neurological 7.5%, and abdominal 8.5%” (p.428). The health problems reported by older patients are frequently complicated by a number of co-morbid conditions. Complexity and comorbidity often obscure the ability of health care professionals to diagnose the older adult’s problem, which means an increased number of diagnostic procedures and longer waiting times in the ED for both test results and inpatient admission (Aminzadeh & Dalziel, 2002; Moons et al., 2003; Salvi et al., 2007; Smith et al., 2005). Additionally Caterino et al. (2009) found that the older adult, presenting with suspected infection, had an increasing risk of mortality. This risk of mortality ranged
from 0.51% when there was a single accompanying comorbid condition to 47% with three or more conditions.

Older adults presenting to the ED are usually more acutely ill with conditions classed as urgent, and more likely to require hospitalization than younger adults (Aminzadeh & Dalziel, 2002; Moons et al., 2003; Robinson & Mercer, 2007; Salvi et al., 2007). Existing studies estimate that from 25% to 68% of older adults will require hospitalization on their presentation to the ED (Aminzadeh & Dalziel, 2002; Grief, 2003; Hastings et al., 2005; McCusker, Bellavance, et al., 2000; Robinson & Mercer, 2007). Further, it has been estimated that the older adult presenting to the ED is five times as likely to require admission if over the age of 70 and to have a length of stay up to seven times longer than a younger patient (Stuck et al., 1995). Older adults are also 130% more likely to require an admission to intensive care services than their younger counterparts (Hwang & Morrison, 2007; Lowthian et al., 2012; Wilber & Gerson, 2003). A high demand for both intensive care and medical beds within most hospital services results in the older adult waiting significant periods of time in the ED for a bed on the required service.

Older adults are less likely than younger adults to have their presenting complaint resolved (Moons et al., 2003) due to the complexity of co-morbid conditions and atypical presentations. Researchers have found that the presenting complaint of the older adult was often misdiagnosed (due to atypical presentation, geriatric syndromes) and they were then discharged with unrecognized and untreated problems (Caterino et al., 2012; Grief, 2003; Khan et al., 1996; Nemec et al., 2010; Parke et al., 2012; Rutschmann et al. 2005). This partially accounts for
the high rate of return of older adults to the ED that occurs within a few days to a few weeks of discharge (Aminzadeh & Dalziel., 2002; Grief, 2003; Hastings et al., 2005; Hwang & Morrison, 2007; McCusker et al., 2000). Evidence shows that of older adults presenting to the ED with ‘no specific complaint’ between 25% (Rutschmann et al., 2005) and 59% (Nemec et al., 2010) were diagnosed with a serious illness within 30 days of the ED visit. Several authors have studied factors predictive of the older adults’ return to ED. These factors include previous or recent ED visit or hospitalization, advanced age, living alone and lack of social support (Aminzadeh & Dalziel, 2002; McCusker, Bellavance et al., 2000).

**Nursing Care and Older Adult in the ED**

Although there were multiple international studies on both ED utilization and interventions for prevention of older adults returning to the ED there were few studies that actually explored nurses’ experiences of working with the older adult in the ED, which was the focus of the current study. Understanding nurses’ experiences is especially important given the changes in the context of the ED, that of having to care for both incoming emergency patients and boarded inpatients, that has occurred in the ED. Yet, there has been no study of the impact of this shift on nurses’ ability to give care. Only three studies with a focus similar to that of the current study were found. The first was a Swedish qualitative study (Kilhgren et al., 2005) that explored ED nurses’ beliefs about what constituted ‘good care’ for older adult patients in the ED. The findings elucidated several themes in the care of the older adult that focused on the necessity of being knowledgeable, understanding the
patient situation, and being responsible for providing good care. However, the overriding theme that emerged was the barriers that interfered with good care.

For the nurses in Kihlgren et al.’s (2005) study, what was valuable in their practice was medically based ‘knowledge’ that allowed them to recognize either improvement or deterioration in their patient’s condition. This allowed them to react appropriately when emergency situations arose. These nurses also valued the ability to organize their time, which enabled them to take a more ‘active’ role in patient care. The second theme for these nurses was the ability to ‘understand the older adult’s situation.’ This meant having sensitivity to waiting being a tiring process and the older adult needing reassurance in the strange environment of the ED. The nurses also felt that sensitivity to the ‘little things’ was important for the older adult. Nurses believed it was important to listen to the older adult patient, meet the older adult’s expressed needs, and to keep in mind that the older adult was powerless in the ED environment. The third theme that arose as a hallmark of good care for older adults was that of ‘being responsible.’ For these nurses ‘being responsible’ was described as having the courage to stay and take the time to be with the older adult even if the situation was difficult, for example having to impart bad news. It meant not shying away from the older adult and making independent decisions to spend whatever time was necessary. The final theme was barriers to provision of good care. The nurses in this study agreed that it was difficult to provide good care when there was not enough time to do so. Many nurses felt that medical care and practical skills were prioritized above nursing care. Other nurses felt that being good at the technical aspects of nursing made them less adept at the basic
nursing care portion of their practice. Nurses in this study described being good at
the acute nursing portion of their jobs and that other nursing care, described as
fluffing pillows, did not come automatically to mind. Aside from workload, nurses
believed that physician’s time to decision (for admission to hospital), documentation,
and difficult and emotionally draining experiences also created barriers to provision
of good care.

The second study was an American study undertaken by Robinson and
Mercer (2007) that used the Geriatric Institutional Assessment Profile to survey ED
nurses about their perceptions about care of the older adult, as well as their
knowledge of best practices in geriatric care. Again, obstacles to care proved to be
an important finding. The three most common barriers identified by the nurses were:
lack of time, resources, and continuity of care. The survey was completed by 37%
of nurses in the ED who had a mean length of 12 years of ED experience. The
survey asked questions about the nurses’ perceptions of satisfaction with geriatric
care, and the appropriateness of treatment for a variety of situations such as pain
management, use of restraints, use of urinary catheters, and pressure ulcer
prevention. The nurses rated the appropriateness of pressure ulcer treatment
lowest and appropriate use of mechanical restraints highest. Nurses described
obstacles to their ability to provide good care: lack of knowledge, economic
pressures that limited treatment or lengthened stay, staff shortages and time
constraints, communication difficulties with geriatric patients and families, nurses’
confusion about decision makers, lack of transportation to or from nursing homes,
and bed unavailability for older adults waiting in the ED. These nurses rated staff
shortages and time constraints as the biggest obstacles to providing care. Interestingly when asked what proportion of patients in the ED were older adults, the nurses responded with more than 50%.

The final study by Boltz et al. (2013) was an American qualitative endeavor undertaken to identify what nurses felt were the most important issues for care of the older adult in the ED. One thousand one hundred and ninety one ED nurses from 49 acute care hospitals in the United States were administered the Geriatric Institutional Profile. The narrative portion of this survey was then analyzed to determine issues identified by the respondents. The majority of nurses responding were white, female, staff nurses with a mean age of 42.7 years. These nurses had an average of 15.8 years of nursing experience. The five themes, which arose centered on a lack of older person - ED environment fit. The first theme was that of respect for the older adult and their caregivers. Respect was considered crucial to the patient and family but four areas were identified that demonstrated a lack of fit with older adults: poor communication, especially attitudes of ageism and lack of compassion, lack of information regarding treatment and medication and discharge teaching, inadequate support for decision making, especially inclusion of the older adult in discussions about care and their treatment wishes, and lack of acknowledgement of families and caregivers.

Secondly, nurses believed that lack of older adult and ED fit related to lags in the ED’s adoption of evidence-based practice in relation to care of the older adult. Despite acknowledging that traditional practices increased older adults’ risk for the occurrence of common geriatric syndromes (e.g. delirium or urinary tract infections),
nurses expressed frustrations in changing the situation. Nurses were also concerned with the inefficiency with which the older adult was treated in the department, citing prolonged triage and lengthy times for throughput as putting the older adult at risk for delays and miscommunication on transfer or discharge.

Thirdly, nurses identified a lack of fit between the older adult’s unique, complex and multisystem needs and required time and manpower the ED did not have. Nurses experienced many competing demands for their time with documentation requirements and other patients who were sicker often leading them to prioritize acute medical problems over preventive care such as mobilization or skin care. Nurses also reported a shortfall in the knowledge of care of the older adult that compounded the inability to care for the complex needs of the older adult.

Theme four related to transitions. Nurses felt there was a lack of fit around use of the ED by the older adult. ED nurses felt that older adults misused the ED when other venues of care transferred the older adult either too early or too late in dealing with certain problems, such as urinary tract infections or pneumonia. ED nurses felt that other venues of care either sent the older adult to the ED when the presenting problem could have been dealt with by the general practitioner or waited to send the older adult until they were gravely ill. Nurses also felt that the older adult was sent home unsafely with poor referral to support such as home care or social work. The last problem with transitions was often ineffective handoffs from nursing homes to the ED, including inadequate information about the older adult in terms of activities of daily living, advance directives, mobility, and cognition.
Finally, nurses observed that the ED environment did not match older adults’ need for physical safety. Nurses described the noisy, hectic environment of the ED and lack of proper equipment (e.g. high stretchers, pressure relieving mattresses, toileting facilities) that compromised the older adults’ safety and well-being. Nurses in this study also offered solutions to the problems they perceived in the care of the older adult. These ranged from equipment, such as stretchers and mattresses, social work presence in the ED, development of clinical practice guidelines, reliable tools for handoffs, reliable transportation, and proper supplies to care for nutritional and personal care needs.

While these studies are similar to the current study there are some important differences. The first is that the current research explored nurses’ personal accounts of their care of older adults. The second is that this study accounted for the cultural influence in the changes of both the care of older adults and nursing within the ED. The last is that the previously noted studies took place in Sweden and the United States while the current research was undertaken in Canada, and more specifically in Canada’s oldest census metropolitan area of the country (Statistics Canada, 2006). Given the dearth of research focused on nurses’ experiences of caring for older adults in the ED, and the vulnerability of this population to poor health outcomes within the current culture of ED care, the current study is relevant and timely.
Chapter 3: Research Methodology

This study used a focused ethnographic approach in order to explore and understand nurses’ experiences of caring for the older adult in the changing culture of the ED. This chapter describes my research methodology, beginning with my positioning as a researcher. I discuss the methods of my study including the design (research tradition), site, sample selection, data collection, data analysis, ethical considerations, and issues of trustworthiness of the findings presented.

My Positioning - Pragmatism

To begin this section I first give a short explanation about the philosophy behind pragmatism and will then describe how this philosophy has influenced my own position as a researcher. There are four tenets within the philosophy of pragmatism that fit well with my values and beliefs. These tenets influenced my decision to engage in research and influenced how I looked at, and interpreted, the research that I have undertaken.

The core of the pragmatic approach is the pragmatist maxim; a rule for clarification of an idea that scrutinizes the practical consequences of the idea (Stanford Encyclopedia of Philosophy, August, 2008). This was referred to by James (1907) as the ‘cash value of an idea.’ It was this author’s assertion that developing an idea was well and good but how an idea was applied was as important as the idea itself.

For me this closely aligns with another pragmatist maxim and that is the ‘good’ that will come from this action. For James, ‘good’ leads us to consistency of thought and human interaction. If we cannot remove human contributions to our
actions we must take them into account. As James asserts, it is this human component that leads us into conceptual areas that ask the questions of right and wrong. The question then becomes, ‘What do I expect from this research and what value will it provide?’ I have long been an advocate for older adults in the ED. I wanted to know if other nurses felt, as I did, that older adults were often disadvantaged during their stays in the ED. Perhaps by adding to the knowledge that was already present about older adults in the ED I could also work to improve the care they received.

Another central tenet to pragmatism is what is often termed the ‘primacy of practice’ (Stanford Encyclopedia of Philosophy, August, 2008). This is the intersection where theory and practice come together. It was James’ (1907) belief that thought was needed to guide action and intelligent thought guided informed practice. This is very similar to the concept of praxis in nursing. It is important to actually put practice into action; however it is equally important that critical reflection about what has occurred in practice also occur. Lipman (2007) describes this critical thinking as not only looking at our thoughts but making corrections to them as we go along. I had questions about my practice as an ED nurse looking after older adults in this environment. Unless I examined my thinking and the practice I saw occurring I was not in a position to evaluate or improve it. Further, this offered support for systematically examining the thoughts and practice of other nurses in the research context.

James (1907) believed that experience was the ultimate test of an idea and that experience needed to be understood. Understanding of experience is no simple
matter. James described concrete personal experiences as being “multitudinous beyond imagination, tangled, muddy, painful and perplexed” (pg. 8-9). This brings forward the last tenet of pragmatism; that of pluralism. The principle behind pluralism is that knowledge comes from multiple sources. I know that my knowledge comes from my own practice, from theory I have studied, and from my personal experiences. I have my own ideas about the care of older adults in the ED. The research study enabled me to expand my perspective through including others’ experiences of caring for older adults in the ED.

James (1907) described pragmatism as the mediator between the ‘tough and the tender minded.’ The ‘tough minded’ part of my perspective is my awareness of the economic and practical aspects of my profession: the cost of care for the older adult; recognition that prolonged stays in the ED result in extended hospital stays; and that large numbers of admitted patients held in the ED may compromise care for incoming patients. If there are too many patients in the department awaiting inpatient beds, we may not have the human or financial resources to meet the needs of the next patient arriving at the door. In the end all of this costs our health care system more money, which is always in scarcity.

On the other hand my ‘tender minded’ side is aware of the injustice of vulnerable patients being cared for in an inappropriate environment. While these two perspectives seem diametrically opposed, they offer an understanding of my world and its complexity. That there is always more than one source of knowledge makes sense to me. That we need to appreciate and accept multiple sources of knowledge also makes sense. Exploration of the literature around the ED, the culture of the ED,
overcrowding, and the older adult’s place within the ED was one source of knowledge. Another source of knowledge that had not been tapped was that of ED nurses and their experiences of caring for older adults. That we try to learn from multiple sources and apply what we have learned for the betterment of all concerned is a necessity. It was the concept of pluralism inherent in the pragmatic approach that allowed me to step back from the assumptions I had made about nurses caring for the older adult in the ED and approach this problem with an eye to exploring it more thoroughly.

From a pragmatic perspective, it is important to explain what will be done with this research. For Creswell (2007) and Angen (2000) pragmatism occurs with the examination of the consequences of the research in which we engage. The pragmatist should engage in a systematic approach to spell out possible consequences and the practical value of the research endeavor. One practical value of the research is that it adds to the body of knowledge about nurses’ experiences of caring for the older adult in the ED, especially as this has not been studied in depth or from the cultural perspective of the ED. The second value is that the findings may inform nursing practice with older adults in the ED. It is my hope that managers will look at the findings of this research and consider alternatives for care of the older adult in this setting.

**Research Tradition: Focused Ethnography**

My research used qualitative inquiry. Creswell (2007), and Morse and Field (1995) have described the use of a qualitative research design as appropriate in a variety of situations. Appropriate situations include: times when little is known about
a situation or subject, when exploration and complex understanding of a situation is required, when there is a need to understand context, when seeking an understanding of relationships, and when seeking the reasons why situations are occurring. In the case of this research, a variety of these factors led to my decision to use qualitative methodology. As this topic, nurses’ experiences of caring for the older adult within the ED, had not been considered in depth, qualitative inquiry proved to be a useful first step. As well, qualitative inquiry allowed exploration of situation complexities and relationships, for example, the changing context of the ED, how care for increasing numbers of older adults was provided within this changing context, and the relationships between the ED environment, the older adult, and the ED nurse.

This research was conducted as a focused ethnography. Ethnography is the study, description, and interpretation of cultural behaviours (Polit & Beck, 2006). Hammersley and Atkinson (1995) further describe ethnography as a naturalistic technique that seats research in the participants’ own environment, thus allowing the researcher to provide a description of what is occurring in the environment and how persons in the environment view their actions and the actions of others. The underlying assumption of ethnography is that each human group eventually evolves a culture, which both guides and structures the members’ view of the world. Such cultures and the structures which guide them are not static entities. They change and evolve over time. These ideas of group norms and of change over time made ethnography an ideal method for the group in question.
Morse and Richards (2002) describe focused ethnography as research carried out to elicit data on a special subject or to study certain aspects of a given field (Knoblauch, 2005). This type of study has the ability to look at specific activities and actions and allows the researcher to focus on the particular rather than the general. Nursing care of older adults in the ED is a focused area of study. Using focused ethnography makes the assumption that the ED and the nurses working within the ED espouse a particular culture. Focused ethnography allowed for narrowing of the focus of exploration to the experiences of ED nurses in relation to their experiences of caring for older adults. The focused ethnography approach also allowed for exploration of the culture in relation to nurses’ care of older adults.

Focused ethnography was an ideal approach for the study of ED nurses’ experiences of caring for older adults as outlined by Knoblauch (2005). First, and foremost, focused ethnography assumes that the researcher will have extensive knowledge of the area being studied. I have over 15 years experience as an ED nurse. My intimate knowledge of the setting eliminated the problem of strangeness and the need for me to spend time acclimatizing to the study setting. Knowledge of the study group and setting also meant that the existing relationships added to the trust between me and participants allowing for easier access to the study setting and participants.

The second advantage of using a focused ethnography was that it tempered the extensive knowledge of the ED that I, as a researcher, brought to this project. Knoblauch (2005) argues that rather than controlling or disposing of this knowledge, the extensive knowledge that researchers bring to projects can be viewed in terms of
'alterity,’ whereby the researcher examines familiar objects or contexts from new vantage points. One advantage of this, Knoblauch suggests, is that looking at familiar practices from new perspectives can in fact reveal alternative dimensions to the data collected. In terms of this focused ethnography, data was examined from the novel viewpoints of participant nurses, which revealed three central themes that will be discussed later.

Thirdly, Knoblauch (2005) points out that focused ethnography lends itself to intensive data collection techniques within a short time frame. This intensive collection of data is augmented by the use of recording tools. Digital recording of interviews allowed for focus on hearing the nuances of each participant’s expressions. It also allowed me, as the researcher, to let the conversation flow while taking notes and jotting down questions to direct the interview, return to salient issues, and probe further in some cases. Knoblauch contended that digital recording can also contribute to ‘alterity’ for researchers by increasing objectivity with the removal of some of the personal perspective which accompanies the process of insider ethnography. Digital recording allowed for a third person verification and an audit trail open to other members of the research committee.

Study Site

The site for this research study was the ED of a tertiary care hospital and regional trauma center in Western Canada with over 300 inpatient beds, providing care to medical, surgical, intensive care, psychiatric, maternity, rehabilitation, and paediatric patients. The ED staff included 10 physicians, 50 registered nurses, 10 licenced practical nurses, three care/ward aides and several unit clerks. In reports
for the year 2009, this ED had more than 50,000 patient visits per year of which 16%, or approximately 8,000, were adults over the age of 75. Nineteen percent of the patients from these visits were admitted to hospital and 4.5% spent part of their stay in the ED awaiting inpatient beds (Meditech DAD ABS database, 2009).

This ED was comprised of twenty beds including two trauma beds. This department had eleven monitored beds, four medical observation beds, two treatment beds for suturing, four beds attached to the rapid assessment area and four beds in the minor treatment area. Nurses were assigned to a variety of areas and cared for anywhere from one to ten patients at any given time. On average each nurse had an assignment of four patients but some assignments included the need to float from one area in the department to another to help provide patient care.

The physical environment of this ED was challenging for staff and patients alike. Space was very limited; in a hospital where the ED and inpatient units run over 100% capacity on a daily basis there was little room for movement of equipment in halls crowded with the stretchers of overflow patients. These overflow patients were waiting to be seen by a physician, being treated in the ED and awaiting discharge, or waiting to be transferred to an inpatient bed. The nurses who worked in this department continually moved patients from space to space whether for diagnostics, higher level of care (either to a monitored bed, to the trauma bay, or to a placement for procedural sedation and suturing), or to accommodate those new patients entering the department who needed initial assessment and treatment.

The nurses in the study ED fulfilled a variety of roles including, the patient care coordinator, who worked closely with the physicians; and triage nurses and
staff nurses who determined patient placement within the department. Triage nurses worked closely with the patient care coordinator on appropriate patient placement and often initiated the discussion on patient movement. Staff nurses covered a variety of bed/stretcher assignments from trauma, to the rapid assessment zone, and minor treatment. Predetermined requirements needed to be met to send a patient either to the minor treatment or rapid assessment zone. Patients in these zones were required to be stable and, for the most part, ambulatory. This meant that the older adults were usually assigned to a stretcher within the department. The nursing assignment ratio for these stretchers was usually four patients to one nurse. A diagram of the physical layout of the department is included to aid in establishing position and movement of patients and nurses within the department (Appendix A, Figure 1).

**Sampling**

A convenience sample of seven nurses participated in this study, including six women and one man. The inclusion criteria for this study were: being a Registered Nurse with three or more years of ED nursing experience working in the study ED, English speaking and having cared for an older adult patient within the six months prior to the interview. These inclusion criteria were intended to achieve a sample with maximum variability and ensure a range of perspectives that would provide a comprehensive understanding of nurses’ experiences of caring for older adults in the ED.

Recruitment of participants occurred using a number of methods. The clinical educator for the department first presented the nature of the study and general
information to ED staff at a regularly scheduled staff meeting (see Appendix B). This was to decrease any perception of coercion resulting from the previous working relationship between myself and the other ED nurses. Pamphlets (see Appendix C) describing the study and my contact information were subsequently distributed at a scheduled monthly staff meeting and were available through the clinical educator’s office. These pamphlets were also placed on the nursing unit for the information of those nurses unable to participate in the staff meeting. Posters reminding nurses about the study were placed in the staff room along with additional pamphlets and a drop box for consent to contact information, which was checked periodically. The use of the drop box and inclusion of researcher contact data ensured the confidentiality of interested staff members. Despite these measures there was continuing difficulty recruiting participants for the study. In an effort to encourage more participation the nursing educator for the unit sent a follow-up email to all the department nurses reminding them of the study and of the drop box, location of pamphlets, and the ability to contact the researcher directly. At the end of the seven month recruitment and interview phase, seven nurses had agreed to participate in the study.

Data Collection

When interested nurses contacted me, either by phone or email, they were given additional information about the study. This included the need for consent, the completion of a demographic information form, the possibility of being followed in the ED during non-participant observation, choosing a time and place for an interview, and an outline of the possible follow up process. Data collection consisted of
demographic information (Appendix D, Table 1), semi-structured interviews (Interview Guide, Appendix E) and hand written notes of follow-up interviews, non-participant observation (Observation Guide, Appendix F) and field notes.

Prior to data collection, consent was obtained (Appendix G). Participants were told they could withdraw from the interview/research process at any time. Participants were also advised that confidentiality for both themselves and any patients they might mention during the interviews would be maintained. Participants were asked not to mention patients by name but could refer to the presenting diagnosis, age of the patient, or pertinent details that applied to the research question. Further, participants were assured that no information that could identify them would be used in any dissemination of the research findings. The consent process also involved discussing details with participants about the observational component of the study and their comfort in being observed while they worked in the department. All participants agreed to be observed if mutually convenient scheduling could be achieved.

Demographic information (Appendix D) was collected from those nurses agreeing to participate in this study. This information included age, sex, years of nursing experience, and years of ED experience. The collection of demographic data was important to obtain a description of the sample of participants. This allows other researchers to determine the transferability of the study findings in terms of other nurse groups.

Participants were provided with a copy of the signed consent form. Participants were also assured that when the findings are shared or published that
there would be no identifying information from the interviews or observation sessions. I emphasized my role as a researcher rather than as a staff nurse colleague, and the ethical responsibilities associated with being a researcher.

**Semi-structured individual interviews and follow up interviews.**

Semi-structured interviews were used as part of the data collection process. Mack, Woodsong, MacQueen, Guest & Namey (2005) indicated that interviews for ethnography are semi-structured at most. This allowed for a free flowing interview in which the researcher guided the interview and focused on participant experience. Questions that were used in the semi-structured interviews may be found in the Interview Guide (Appendix E). Examples of these questions include: 1) Tell me about your work as an ED nurse; 2) Tell me how care for the older adult has changed over time; 3) Talk about a time when you felt that you gave the best possible care to an older adult; 4) Talk about a time when you felt you were unable to give the best possible care to an older adult.

Each participant was interviewed once. The focus of the study allowed nurses to address their experiences in a single session. Interviews lasted between 45 to 60 minutes and were digitally audio recorded. Interviews occurred in a variety of locations, chosen by the participant to maximize their comfort. When they chose a public place such as a restaurant, the interview took place in a quiet and more secluded area.

Follow up clarification of the interview data was required for four participants. The process of consent and the interview process were negotiated between me and the participant on an ongoing basis, especially during the follow up interviews that
occurred (Ramcharan & Cutcliffe, 2001). If a follow up interview was necessary I reminded the participant that they did not have to participate unless they felt comfortable doing so and that they could withdraw from the process at any point.

While these participants had already signed a consent form I felt it was ethically important to determine if they still wished to continue with the research process and, therefore, obtained a verbal consent. Clarification of information occurred for such things as acronyms the participant had used, questions that I had written down but forgot to return to at the time of the interview, and for new questions that surfaced as I listened to the interviews and read the transcripts that required further probing. Follow up interviews occurred by telephone at a time convenient for the participants. These conversations lasted between 15 and 20 minutes during which I took verbatim notes.

**Non-participant observation.**

Non-participant observation was another tool used to gather data. As a nurse working in this department I was well versed in the daily function of the unit. Non-participant observation allowed me to remain more distant from the busyness of the unit and to focus on observing and documenting patterns of behavior that arose from the nursing actions rather than a simple documentation of the actions with which I was already familiar. Non-participant observation takes more of ‘a fly on the wall’ approach than does participant observation (Katz, 2009). It allowed me to take a step back from the day-to-day workings of the unit and gain a fresh perspective on the physical, social and cultural context and activities, which could not have occurred had I chosen to participate. This type of observation also allowed me to observe
more closely the nurses’ work life in relation to the older adults in the department and obtain feedback from the nurses immediately after their interactions with the older adults. This added depth to the interview data I had collected with the participants on their day-to-day activities. Taking the step back to non-participant observation and obtaining a fresh perspective of the work life of participant nurses with older adults added to the sense of ‘alterity’ I was trying to obtain as an insider doing ethnography.

This non-participant observation occurred with four nurses in the department, was scheduled at different times during the day and evening, up to eleven pm, and lasted between two and four hours each, for a total of twelve hours. These sessions took place with only four of the seven participants because of relocation and scheduling difficulties. To maintain my non-participant status I wore street clothes, avoided active participation in nursing clinical discussions or problem solving, and stayed away from performing actual ‘hands on’ nursing care. A semi-structured observational guide was used (Appendix F).

The non-participant observations consisted of general observations related to the ED department and specific observations related to nurses caring for older adults in the ED. General observations included the total number of patients in the department during the observation period and the number of patients awaiting an inpatient bed. To protect the privacy and confidentiality of older adults, ED nurses not involved in the study, or other health care professionals working in the ED, very limited and specific observations occurred. Specific observations included the bed placement of older adults, the length of time that older adults waited on ambulance
stretchers, and the times and places of movement that occurred for older adults (e.g., movement to diagnostics or movement from a curtained area to the hallway).

The interactions between older adults and nurses involved in the study were not directly observed due to ethical constraints. For this reason, non-participant observations were supplemented with discussion and question and answer with the participant nurses. When arriving for the observation session I checked in with the participant nurse, reminded them of points of interest, such as patient age, tasks carried out for, or with, the older adult, and amount of time they felt was devoted within the observation period to care of the older adult, all of which would be discussed during the debriefing process. A conversation between the researcher and the participating nurse occurred after the care of an older adult was finished or at the end of the observation session. This conversation involved general discussion only about the type of interaction that occurred with the older adult, for example delivery of personal care. The length and number of interactions with older adults was also recorded with a view towards gauging the amount of time spent in the care of older adults. The same type of process occurred if the nurse being observed had interactions with other health professionals caring for an older adult, for example, the length of time needed to receive a care report from the ambulance crew. Care was taken to ensure that no information that could identify either the older adult patient or health care providers was collected or used. General information only, such as job title, for example - registered nurse, was used.

Non-participant observation proved to be challenging for me and for the nurses within the department. Many of the nurses in the unit had to be reminded that
I was in the department in the capacity of researcher and therefore could not participate in any care. After the first couple of observation sessions they stopped asking if I was going to put on a uniform and help out. I worried that the nurses might feel uncomfortable with my presence in the ED in this role but all proved supportive of the process. The nurses’ comfort with my presence seemed natural and no noticeable changes in behaviour were apparent during my observation periods. I made efforts to ensure that I maintained confidentiality of the participants by making notes and not approaching them for further information until the end of the session. I ensured that any questions I had for clarification were asked in a setting that provided them with confidentiality, usually this meant meeting in the manager’s office. Additionally it was difficult for me not to help out when a nurse asked advice or worse when the department was extremely busy and I appeared to be sitting there watching everyone work. I did expound on this in my journal and realized just how much my identity as a nurse was bound up with this unit and these nurses I call my colleagues.

**Field Notes.**

The last data collection tool was my field notes. These notes were taken shorthand, both during the semi-structured interviews and non-participant observation sessions. They were written up immediately after an interview or observational period to aid with memory. These field notes were used to augment the other data sources. Data in the field notes included information such as setting of the interview, nuances of expression (facial or hand gestures), colloquial terms used by the participant, and notes on ideas that arose during the interview that I incorporated at
an appropriate time during the interview process. Notes about the setting of the interview provided a contrasting backdrop especially when changes in a participant's demeanor were noted both in the notes and the voice changes that occurred as the interviews progressed.

Data Analysis.

To support early immersion in the data and the analytic process (Bird, 2005) I transcribed the first two interviews and then utilized a transcription service for the final five interviews. After receiving the transcribed interviews I listened to the interview while reviewing the transcript to ensure accuracy. Turning the interviews over to a transcription service allowed me to concentrate on the content of interviews as I listened to them and made more notes for tone of voice, expressions used, and any questions which came to mind, to augment my field notes. Nuances of expression were easily detected as I listened to the recorded interviews because I was present at the interview.

After the interviews were transcribed, interview data were analyzed using thematic analysis. Braun and Clarke (2006) describe some of the advantages of thematic analysis. It is firstly, a very flexible method that may be adapted to many qualitative research projects. In the case of this project it was congruent with the pragmatic philosophy approach and ethnographic method used in the study. Thematic analysis looks to describe patterns across the data set of the research project (Creswell, 2007). Ethnography also looks for patterns in behaviours and attitudes; thus the two approaches aligned. Thematic analysis was also congruent
with a pragmatic or practical approach and allowed for emerging themes to provide a practical basis for solutions to care of the older adult in this challenging environment.

Saldana (2009) offers a standard four step procedure for beginning qualitative analysis. This procedure begins with reading the data for overall understanding, identifying meaning units, extracting the contents of the meaning units, and then summarizing the importance of the units. I began this process with the first interview transcriptions.

As I started to read transcripts for meaning units I made notes in the margins of the transcripts with generalist codes. These codes consisted both of generalist similarities, like overcrowding, and colloquialisms provided by the participant, like “the MI wins.” Saldana (2009, pg. 8) describes codifying as arranging things in a “systematic order.” It is Saldana’s suggestion that this process allows data to be separated and then regrouped to consolidate the meaning behind it. After I had coded the data I began grouping codes according to themes where codes shared similarities or were antonyms to the themes. Where ever possible I tried to use the participants’ own terms, especially if these were consistent across the interview transcripts. Interviews were also independently coded by members of my thesis committee and then results compared to ensure that the coding of the data were similar. Codes and themes were further refined throughout the process until three central themes were developed.

Agar (2006) and Hammersley (1990) assert that every ethnography undertaken is a distinct entity and that two ethnographers looking at the same event will probably have two different, but equally valid, interpretations.
themes were identified and refined this information was returned to three of the participants, who wished to be involved in the process and who had agreed at the outset of the research to review the themes developed. These participants were in agreement that the identified categories and underlying codes accurately represented their experience.

Observations, field notes, and follow up interviews were coded in a similar manner to the interview transcripts. As follow-up interviews had been transcribed verbatim as they occurred I read them first for understanding and then looked for meaning units and application of codes. The observations also consisted of a fair amount of text from the discussions that occurred after the session with the participant and this was coded in the same way as the interview transcripts. This data also supported much of what participants described in relation to moving patients multiple times and advocating for the patient best suited to a move to the hall. Observations also supported the amount of time that personal care took in the care of the older adult.

**Trustworthiness.**

One validation criterion set out by Angen (2000) is substantive validation, which is defined as the procedures used to validate the findings. This is echoed by Lincoln and Denzin (2000), Morse and Richards (2002), Creswell (2007), Lincoln and Guba (2004), Charmaz (2004), and Lincoln (1995). Although given different names by each of these authors, common procedures emerge that contribute to the trustworthiness of research. I used a number of strategies to ensure trustworthiness of the current research. To provide rich description of the study site I have described
the nurses’ roles in the ED and provided an accompanying diagram of the
department in Appendix A where the roles were enacted. Earlier in this chapter I
outlined my pragmatic stance to provide theoretical candor. For triangulation I used
semi-structured interviews, follow-up interviews, and non-participant observation to
ensure multiple data sources.

One very important element in ensuring trustworthiness of this research was
the involvement of my supervisory committee. The committee members are
experienced qualitative researchers who helped guide all aspects of the research
process, especially the data analysis stage. Two committee members read
transcripts and reviewed the coding to ensure that there was agreement about the
development of themes. After the themes were developed and refined they were
taken back to participants for validation. An external audit trail was developed as I
took notes during committee meetings. These notes were transcribed into a
computer file. The final strategy is the transferability of the findings of this study.
Although there has been limited research in this area some of the findings presented
in chapter four and discussed in chapter five show similarities with themes found in
other studies.

I further ensured trustworthiness through reflexivity, which is the process of
thinking about and clarifying one’s stances and beliefs. Archer (2010) describes
reflexivity as ‘the conversation that one holds with their own soul.’ (pg.1). Fine et al.
(2000), Morrow (2005), and Shenton (2004), all recommend the use of reflexivity
during the entire research process to account for the influence that a researcher has
on the research being conducted. Dwyer and Buckle (2009) asserted that there can
be no neutrality in research only a greater awareness of one’s own biases. Use of reflexivity enabled me to illuminate and filter out some preconceptions and reach what these authors describe as a clearer interpretation of the phenomenon.

Therefore, secondly, I engaged in reflexivity about my own thoughts during the research process to try and separate my thoughts and ideas from those of the participants. The journaling process helped remind me when I was taking on the persona of ED nurse versus researcher and assisted me to take a step back and consider the data with a more objective eye. Reflexivity helped me to maintain the ‘alterity’ stance that I sought to achieve.

Ethnography is historically done by researchers as outsiders to an environment. In this study, this researcher was an insider, an ED nurse with over 15 years of experience in the setting being studied. As an insider some of the tasks for negotiation of entry, recruiting participants and acclimatization to the routines were less problematic than might have been the case for an outsider. On the other hand as an insider I was aware that the status of insider and long acquaintance with the environment clouded some issues, for both me and for participants. I was inured to some aspects of the environment that were part of the research in question. This made distinction of embedded practices and behaviours more difficult. Participants also shared this feeling of embedded practice and initially would not expound on examples, assuming that I would know what they were referring to due to my familiarity with the setting (Asselin, 2003; Kanuha, 2000). Kanuha and Asselin point out the necessity of being aware of this ‘expected knowledge’ and continually guarding against role confusion by ‘observing myself as a researcher’ and keeping
detailed notes on the interactive process that occurred during the interviews and observational processes. This was very true in the case of this research. I often found myself hearing the words “Well you know how it is.” I had to reinforce that my ideas were not the ones of interest and that I wished to know what each nurse thought. This caused some moments of uneasiness which I tried to diffuse either through laughter or introduction of a different question. This allowed my participants to relax. After the first interviews I began by asking the nurses what life as an emergency nurse was like for them. This allowed an opening that was more personal and made easier segues into their personal experience of caring for the older adult. Through the use of reflexivity I was able to clarify my thoughts, separate them out from participants’ thoughts and interpret data from the participants’ perspective and increase the trustworthiness of my interpretation.

Thirdly, before undertaking this research, I clarified my own philosophical positioning to be aware of all the reasons I was engaging in this research. Aside from clarification of my philosophical bent which was presented at the beginning of the chapter it is often useful to also clarify a researcher’s critical stances (Lincoln and Denzin, 2000). For me this allies closely with my pragmatic leanings. Creswell (2009) described the pragmatic viewpoint as having a large social justice component because research always occurs in social and historical contexts. From my viewpoint the older adult is a member of a vulnerable population and as such, health care professionals need to be more aware of how and in what contexts the older adult is being cared for.
Ethics

Angen (2000) presented another concept for research validation as ethical validation. Ethical validation is more than just the use of informed consent. It is a combination of the moral motivation for engaging in research as well as the development of ethical relationships with research participants. Much of qualitative research occurs in the relationship developed between the researcher and the participant. Any ethical concerns, such as participant vulnerability, confidentiality, and voice, were addressed on a continuing basis, such as during the follow up interviews and the member checking process, and were negotiated to the mutual satisfaction of both researcher and participant. For example, when I set up meetings for my participants I asked them to choose the meeting place. It was my hope that the participant would be more comfortable in a neutral setting such as a quiet coffee shop rather than my home, their home or the hospital. If the interviews took place in a public venue, such as a coffee shop, we seated ourselves away from other customers and chose a time to frequent the coffee shop when there were fewer people present. In addition, I reminded participants of the need for confidentiality and to use little defining information when describing an older adult. As well I ensured that they had a good understanding of the consent process and the ability to withdraw at any time they might choose.

Prior to undertaking this research ethical approval was obtained through both the Interior Health Authority Research Ethics Board and the University of British Columbia-Okanagan Research Ethics Board. A number of measures were used to protect participants’ identities. The recordings and transcribed interviews were kept
in a locked cabinet, made available only to members of the research committee, and will be destroyed in 5 years. The transcribed interviews were identified by participant code numbers and all personal identifiers were removed during transcription. All documents were identified only by code number and kept in a locked filing cabinet. The information provided by participants will be shared with others who study and work with older adult patients, especially in the ED, and be communicated in written papers or oral presentations, but will have no information which could lead to revealing the participants’ identities.

Another piece of Angen’s (2000) ethical validity, which resonates with Lincoln’s (1995) criteria for validity, is the process of fairness and reciprocity. While this was partially achieved through an open and democratic process, as described above, the process also relies on the concept of relationship building during the research endeavor. Building of rapport and trust between researcher and participant leads to more open sharing of information and an increased depth to both the interview and observation process. For me the foundation for the research relationship was pre-existing. Having worked with the participant nurses in the past I already had a level of rapport and trust that I could build on for my research project.

Ultimately though, as Denzin (1998) indicates, the researcher must make an interpretation of the data collected. If researchers seek to represent the voices of others and their communities, then they must be aware of the need to base their interpretations within historical, contextual, and cultural mediums in which they occur. Charmaz and Mitchell (1997) again stipulate that no voice is neutral but that voice can be improved by increased sensitivity to extensive portrayal of the
phenomenon under scrutiny. Researchers strive to portray slices of the human experience but the only way to capture this is through the use of multiple participant statements and observations. Through reflexivity and with constant thought as to why this research was being undertaken as well as the other methods presented I endeavoured to offer an interpretation representative of the participants’ experiences.

**Summary**

Focused ethnography was chosen for this study because of the salience of the ED culture to the focus of inquiry. A convenience sample of seven ED nurses participated. Data were collected via semi-structured interviews, brief follow-up interviews, and non-participant observation. Data were analysed thematically and themes were confirmed with participants. Study findings are presented in the following chapter.
Chapter 4: Findings

In this study I examined nurses’ experiences of caring for the older adult in the emergency department (ED) of a 300 bed tertiary care hospital in an urban center in British Columbia, Canada. To begin this chapter I first give a brief description of the participants’ demographic information, followed by an explanation of the themes that emerged from the analysis of data collected from the interviews and observations carried out during the study. Findings will be presented in relation to three themes. The first theme is the culture of the emergency department, which provided the foundation for all of the nurses’ descriptions of caring for the older adult. The second theme is problems in caring for the older adult that resulted from fit or lack of fit between the older adult and the culture of the ED. The third theme is how nurses managed care of older adults in the ED, particularly in the circumstance of lack of fit. Direct quotes from the participants are used to exemplify my interpretation of the interviews and observations.

Demographic Information of Research Participants

This study included seven nurse participants. They ranged in age from 35 to 58. Two of these nurses were in their 30’s, two were in their 40’s, and three were in their 50’s. All of the nurses in this study were Caucasian. Six female and one male nurse participated and all were English speaking. Four worked on a full time basis and three on a part time basis in the ED.

The number of years that these nurses had practiced varied from seven to thirty eight years. All had a minimum of three years working as ED nurses with the
number of years ranging from three to twenty. Each of these nurses had worked in other areas prior to coming to work in the study ED. Three had worked in medicine, two had worked in surgery, and two had worked in a variety of settings prior to beginning work within emergency medicine. The experience of the seven nurses also included a variety of specialty areas such as telemetry, neurosurgery, and intensive care.

Three of the participants were diploma prepared nurses while the other four had obtained a Bachelor of Science in Nursing. Two of these nurses were pursuing courses at a master’s level at the time of the interviews. When asked about education in the care of the older adult one participant had completed a neuro-geriatric course, one had some education as part of a critical care course, and one had taken some workshop style courses in the care of older adults. The other four participants stated that they had received no ‘extra’ education on the care of older adults beyond their entry to practice preparation. When asked how many older adults each of these nurses cared for on a given shift, answers ranged from 50 to 80% of the patients of their assigned case load. In the following sections I begin by describing the culture within which these nurses provided care.

**The Culture of the ED**

The culture of the ED involved effectively determining and juggling changing and competing priorities in a time pressured environment, while always anticipating the next life threatening emergency. These life threatening problems were always given priority over any other activities. The difficulty was that the change in the ED was continuous, rapid, and unpredictable. This meant that priorities were
continuously subject to change. As new life threatening situations presented
anything of lesser importance dropped in priority, which meant that care, even
important care, suffered.

[O]bvously somebody must have gone in to help her because when I came
out an hour later she was gone. But obviously you are constantly getting
pulled away and these kinds of things always …come second. They always
seem to happen and they are not going to be properly cared for. I think it’s
kind of… it’s a real shame at just how this kind of care gets done. (Participant
2)

Nurse participants also contrasted the differences in the priority setting they
engaged in within the ED to the priority setting that occurred on the wards.
Descriptions of the ED priority setting conveyed the urgency that was felt with the
changes that occurred in patient care and acuity.

Okay, I’m going to get towels, I’m going to get basins, I’m going to do my
assessments but then I have a new patient coming in that is not quite the
same I don’t think as an admission upstairs where you can just say “well I’ll
get there when I get there.” No, the new person coming in is a level 2,
somebody with shortness of breath or chest pain and so then you launch on
this whole other road of caring for this person and taking care of their acute
needs and doing the assessment and communicating with the physician and
so on and so forth, and now you’re all down a different road and you’ve
forgotten, or you don’t feel that you can go back and continue getting those
basins. (Participant 3)

The environment in which priority setting occurred was time pressured.
These nurses were required to efficiently, accurately, and rapidly assess and
intervene with each patient to get them home or to an inpatient bed. This was
extremely challenging because of the constantly changing picture as new more
seriously ill patients arrived and priorities needed to be adjusted. One participant
described this in terms of ‘pressured care’:

‘Pressured’, I guess would be an overall generic term; in terms of pressure to
get things done, pressure in that we don’t have a…I don’t feel that it’s a
stable environment for patients. What I mean by ‘stable environment’ is that there is pressure to turn beds; there is pressure to move patients; there is pressure to treat them and get them out quickly. So there is a high pressure for a nurse to treat. (Participant 5)

The pressure these nurses constantly felt was evident in their voices during the interviews. Participants’ speech became staccato, rapid, and the pitch of their voices became higher even though they were not in the work environment. This demand to work quickly and efficiently was clearly internalized for these participants regardless of their position or duration of employment within the ED.

Priority setting in a context of rapid change and time pressured care was complicated by two factors: access issues and space constraints. The nurses reported increasing numbers of people seeking health care in the ED and the requirement that no one be turned away, which meant there was relatively unlimited access to the ED and its services. Most nurses in this study believed that patients saw the ED as either a ‘fall back’ or the only option for accessing health care. The nurses described the ED as a “gateway to care” for many people. They stated that there had been an increase in all types of patients presenting to the department, whether for mental health, medical, or social issues. One of the most experienced participants explained it this way:

[There has been a] general increase in all types of emergency patients…. demands are up. The volume of patients coming through seems to be increasing. The acuity of the patients is increasing... the number of social situations-type patients seems to be increasing... It seems to me that all services are becoming more prevalent. (Participant 1)

While the increasing numbers of patients utilizing the ED was for a wide variety of services, the nurse participants also thought that much of the increase occurred because patients had nowhere else to go. This was described by nurse participants
as a “general lack of resources [in the health care system] that all came back to the
emergency room.”

Nurse participants reported that the increase in demands for ED services
changed their ability to work together. Opportunities to help other nurses or spend
time with the patients presenting to the department rarely existed. Even times that
previously would have been spent reorganizing or restocking, such as night shift,
were now so busy that such action could no longer occur. One experienced
participant described the change quite clearly:

… we used to have an ambulance that would come in at night and you would
assign the bed and everyone would get together and get this patient all sorted
out. See the doctor, get the doctor if need be…. Now they’re so busy doing
everything else that they are not always there to help each other. (Participant 6)

Some participants explained that the ‘unlimited access to care’ issue was
heightened by Canadians' knowledge and expectations of the ED. They stated that
patients knew the ED was there and always available. Patients accessed the ED
when they could not see their own family physician or get diagnostics done in what
they felt was a timely manner. It was the participants’ belief that the ED was being
used as back door access to health care.

So they come in to emerg’ and expect ‘well, I just came in here. I know that
this is the back entrance. I know if I say that I have a headache for one
month, you’re going to do a CT on me. I know that if I say I’ve been hurting
all over and I’ve got pain in my bones and I don’t want to go back home and
no one can take care of me at home, that likely transition is going to get
involved and likely I’ll get to go to an MRI significantly faster than if I am
waiting in the community.’ It is a conversation I have every single 12 hour shift
I’m in. Because they know… Canadians know how the system works. You
have a healthcare system that offers many things to the general public it’s just
incredibly backlogged. (Participant7)
The volume of patients presenting to the ED, who could not be turned away, along with lack of inpatient beds in the hospital contributed to the second factor that complicated priority setting - space constraints. All patients needed to be accommodated in a facility that was built to serve a much smaller population, thereby ramping up the pressure the participant nurses felt to quickly and efficiently move patients through the ED. However, inability to move patients out of the ED to inpatient beds, in concert with the already identified continuous influx of new patients created a 'log jam' and serious difficulties with space, exemplified by patients on stretchers in hallways awaiting inpatient beds. Overcrowding was by far the biggest factor influencing these nurses' ability to provide care to older adults on a daily basis. For these participants overcrowding was not a new problem in this or other EDs in which they had practiced. One participant described her experience with overcrowding as a “[d]ifferent space; different province; same concerns.” Another participant’s description was more detailed:

I worked at […] and we had the overcrowding and I floated. So I would come in and I would end up taking a room that we used to keep our stretchers in. When we were overcrowded … there would be five patients in there, no oxygen, no suction. Me and five patients to look after in one little room…. Or we had a three bed room that we did suturing in, for our walking wounded, for our minor treatment area. That room would have five patients in there. So there were three stretchers in there and then they would slam three more stretchers in there. You might have some portable monitors ‘cause there was oxygen in that room. There was suction in that room. So you would have your five patients in there that you were looking after and it was the same kind… way back then, and this was probably in the 80s….. It was the same kind of thing that we do now with our hallway patients. Plus we had hallway patients then too. We called it “the alley.” We had them lined up on one side. We had beds on the other side and we would bring them in and out to examine them. And then we had a ten bed holding area in our emerg’ and then sometimes we would have these other ten in these little rooms. (Participant 6)
When inpatient beds were not available, patients were held or ‘boarded’ in the ED until a bed became available. Sometimes this meant that patients could be kept in the ED for days - if not their entire stay. Accommodation of new patients was the priority and this meant moving patients already in the department to make room for newcomers. While all participant nurses reported that they were involved in making choices about which patients to move into the hallways, these were choices they made reluctantly and only by necessity. For these nurses these choices became a determination of “the best of the worst.” While all felt that no one should be moved to the hallway, each nurse had a specific criterion for which patient they would choose to move; some felt that only ambulatory patients should be placed in the hall, others opted for non-ambulatory patients, and still others expressed the need for this choice to be made on an individual patient basis.

Several of the nurses contrasted the rapid movement and patient changes that occurred in the ED with the other units they had worked on. This is exemplified in the following quote.

Now having the experience of working upstairs on a floor, everybody stays in the same bed; you know who is in what bed, what they need, and so forth. And you actually even get to know their names. That’s even better. That’s even better. (Participant 3).

Inevitably, holding a large number of patients awaiting inpatient beds heightened the pressure on setting priorities, especially if the need was to accommodate a more seriously ill patient. Observational data confirmed that patients awaiting inpatient beds were moved frequently during their stay within the department: it was not uncommon for these patients to begin in one bed assignment,
to be moved to the cast room holding area for the night and then moved back again
to the ED hallway in the early morning.

For the participant nurses, priority setting, time pressured care, access
issues, and overcrowding continually interacted, which resulted in continuous
reorganization of existing priorities with the addition of new ones. Working in a
culture of pressured care and priority setting where more seriously ill, incoming
patients were given highest priority meant lower priority needs of persons being held
in the ED for placement elsewhere were continuously displaced. It was within this
complex culture of time pressured care, priority setting, and overcrowding that the
nurses explained their experiences of caring for the older adult in the ED.

**Fit and Lack of Fit between the Older Adult and the ED**

In this section I will discuss the difficulties that the participant nurses
described in caring for the older adult in the ED. These difficulties often arose for
participant nurses because older adults did not fit easily into the culture of the ED.
Participants described two circumstances of older adult care: times when there was
a fit between the older adult and the culture of the ED, and times when there was a
lack of fit. ‘Lack of fit’ also captures how the ED nurses felt about the type of nursing
that they often engaged in while caring for older adults because it did not align with
their expectations of ED nursing. This section also describes the consequences in
nursing care for the older adult that arose in the circumstances of lack of fit.

**Fit.**

Participant nurses described only rare times when the older adult fit easily
with the culture of the ED. The rare occasions occurred as a result of either patient
centered factors or emergency department factors. Good fit occurred as a result of patient centered factors: i) when older adults clearly presented as emergencies and ii) when older adults were independent and could look after themselves. Older adults presenting as emergencies aligned with the ED nurses’ expectations of patients they should be caring for in the department. They required the quick intervention that ED nurses were ready to deliver. This was particularly true if the older adult presented in an emergency situation with signs and symptoms that were easily recognized rather than an atypical presentation. One example of this occurred during an observation session when three older adults, ranging in age from 79 to 84, presented to the ED with chest pain. Each of these patients was diagnosed as being in the process of having a heart attack. These patients were treated quickly with medication and sent to the heart catheterization lab for angioplasty and stenting. As the last one was leaving the department, one participant commented “this is what we are here for. Today we were a real ED.”

Good fit also occurred when older adults were ambulatory and independent. This allowed nurses to provide the care that the older adult required even if it wasn’t emergency care. They could give holistic care that included mental and emotional support as well as physical care (but not too much physical care because the patients were self-sufficient).

[If] they are an ambulatory, more independent geriatric person, I think that helps in that you give more mental, how would you say… more mental support than you would do physical support. If you have somebody that is a geriatric that requires psychological, mental and physical support, it requires more of your time, more of your energy, and if you have five patients you’re not giving that kind of care as well. So, in terms of your question, I’ve given somebody pretty good care, geriatric-wise, if they are ambulatory, if they are compos mentis, and if they require not as much treatment. (Participant 5)
Good fit also occurred when factors within the emergency department fit with the older adult: i) when there were “ideal” conditions – for example, when the ED was quieter than usual; or ii) when staffing levels enabled nurses to work as a team.

Participants described infrequent circumstances within the ED that allowed them to provide care for the older adult in ways they felt the older adult deserved. Most of these times of good fit related to time factors within the ED that worked to relieve the pressure to move patients through the department and enabled nurses to devote more time to older adult patients.

[I]t was relatively quiet. My patient was elderly and palliative and she had come in because family wasn’t managing well at home. Patient needed pain control. Basically just needed care and admission and because of the fact that I had the time to do it I was able to give the attention that this patient deserved, and I think that’s a really important word...They deserve good care; and they certainly require it. They actually deserve it as well. I was able to, you know, nurse from that other perspective. I was able to provide comfort. I was able to provide attention. I was able to spend time with the patient. You know looking after the physical needs. Seeing that she was turned and that she got up to the commode and that she had mouth care. Mouth care, how often do you think mouth care occurs in the emergency department? It doesn’t occur very often. Unless you have the time. That’s the sort of thing I mean. You know patients can be in there two and three days and never have their mouth cleaned out. I mean you or I couldn’t stand that but those are the standards considered...well maybe they are not considered okay but that is what is happening. (Participant 2)

Participant 1 discussed the need for team work and how without this, much important care would have been missed.

I was lucky that my partners that day were good partners and were able to offer assistance when I needed it, because it was a very demanding day and it would have been difficult on my own. I couldn’t have done it on my own. Two of the four were total care. They needed assistance to turn them. To do everything, to do anything. So I couldn’t have done it on my own. I had two helpers. Good helpers. (Participant 1)
Lack of Fit.

While there were occasions when the participant nurses described good fit between older patients and the ED, enabling them to provide the care the older adult required, all recognized that this was not the case in the majority of situations. Every participant discussed occasions when the older adult did not fit with the culture of the ED. Participants described the older adult as being ‘out of synch’ with the ED in a number of ways. Lack of fit in these cases occurred in relation to i) patient-centered factors; and the ii) ED nurses’ expectations.

**Patient-centered factors.** The first way in which the nurses described lack of fit related to capabilities of older adult patients themselves. Participant nurses described older adult patients as slower moving in a department geared to rapid action and intervention. Everything about the speed of these patients differed from other patients: their movement, speech, and thought processes all conflicted with the nurses’ need to rapidly accomplish the required tasks of assessment, intervention, discharge, and movement to the next patient. It was difficult for these nurses to slow their pace to match their older patients’ speed as the nurse continued to feel the pressure to move rapidly from one patient and task to the next. Participants described the difference that occurred in working with older adults in the ED in terms of assessment and intervention:

With the elderly patient…. They don’t answer as fast, they don’t walk as fast, they’re slow to transfer, they’re slow to sit up for a respiratory assessment, they’re slow to lay down, they’re slow for everything. So it is, I would say, if it takes me 5-8 minutes to walk someone in, and at the same time as they’re walking and talking and undressing them, I’m assessing them I’m going to say it doesn’t take me any longer than 5-8 minutes. But it will take me sometimes 20 minutes to do a thorough [assessment] on an elderly patient. (Participant 7)
Another of the participants put this much more succinctly by stating “you want them… need them to go faster, and they just can’t.” (Participant 3)

In addition to the speed of these patients, the nurses caring for the older adult also discussed how the presentation and level of complexity often seen in the older adult did not fit with the rapid priority setting and throughput culture of the ED. Participant nurses discussed how the often atypical presentations of older adults was further complicated by the multiple comorbid conditions frequently experienced by the older adult.

These factors combined so that the older adult was frequently unable to give a clear history and this became a puzzle the nurse had to work through. In a department focused on rapid movement of patients, the time needed to solve the puzzle was not always available. The nurses felt pressured to move these patients through and often focused on more overt problems without looking for the less obvious problem that may have brought the patient in. If the patient was weak or confused the nurses simply attributed this to an inability to care for themselves rather than one of the common geriatric syndromes that may underlie this presentation. Participant 2 described this very situation:

It’s not uncommon to see a family member bringing an elderly loved one in and they are basically just saying there is a decrease in their ability to look after themselves and we are not able to do it anymore. We are not able to adequately look after my mom or my dad anymore. They present with increased confusion. They present with urinary retention, so all of those physical things. They present with mini strokes. They present with strokes. They present with, like I mentioned before, the decline in daily living. They’ll come from... you know they’ll just stop eating and drinking some times. So, you know, those are the things that are a little different than the younger group that come in, but the heart attacks, you know, they’ve got the chest pains and the shortness of breath, you know. All of those things that younger patients come in with but on top of that very often they, they’re just getting to
that point in life where they can’t look after themselves and their families can’t cope or manage.  (Participant 2)

Other participants also described this puzzle solving in a department geared to quick thinking and obvious problems. Many nurses described thinking that the older adult was coming in for one problem and finding during the assessment other more serious issues that needed to be dealt with. For example, Participant 1 discussed one patient brought in with what was assumed to be ‘degenerative disc disease,’ who was in pain and unable to move. The participant described this patient as,

spending his time curled up in a foetal position, lying on his bed…. He can’t urinate, bowels aren’t working. We catheterized him. And this is when it dawns on us that he is all rhabdoed. …He had red pee and then we start to notice the pressure markings on him.

In the case of this patient, 'rhabdoed' refers to rhabdomyolysis. This is a condition which occurs when tissue is broken down rapidly. Tissue breakdown releases large myoglobin (protein) molecules which needs immediate treatment to prevent the development of kidney failure. This man was acutely ill but the ED nurse who described this situation did not initially recognize the severity of this older adult’s condition, because this was not the initial focus that brought this patient to the ED.

Nurses’ Expectations. Lack of fit was heightened for these nurses when the older patients remained in the department. When older patients remained in the department, often awaiting an inpatient bed, the focus of these nurses’ care changed from acute to basic needs. This separation of focus was captured well by Participant 2 who contrasted assessment of an older adult’s basic needs with the patient presenting with “real physical symptoms.”
Many of these nurses discussed the inordinate amount of work and time that older adults required for personal care. This need to provide basic personal care and include it in their list of priority activities interfered with the ‘ABC’ (airway, breathing, circulation) emergency priority setting of many of the nurses interviewed. It was difficult for many of these nurses to switch gears to the basic care they knew many older adults required.

Dealing with basic care did not fit with the expectations participant nurses had regarding what it was to practice as an ED nurse. All spoke about basic care needs of the older adult not falling into the realm of emergency nursing. Participant 4 put it most succinctly when she said:

Some of the things [personal care] I find more challenging simply because they don’t challenge me I suppose, and don’t make me think quite so hard, is just generally taking care of patients when they are there for long periods of time and doing the things that we don’t think that we should be doing in an emergency department such as changing pads; such as helping people get cleaned up; doing things like that for a 12 hour day when you do it. Little bits of that… that’s all right. But when you have to do it all day, every day, in an assignment I don’t think I like that quite so much. To be honest, that’s probably the hard part of my job. (Participant 4)

Participant 1 was able to very clearly delineate the difference in expectations between being an ED nurse and other nurses. This participant thought that the differences truly came down to how the nurse was thinking. It was this participant’s opinion that:

When you get nurses who are thinking one way and having to act another it’s difficult for a lot of nurses to possibly provide the care that is needed. They’re not interested. I mean I’ve had my days where the last thing I wanted to see was another 85 year old who can’t get out of the bed. Cause I know it’s going to be work for me. It’s a lot of work.
Consequences of Lack of Fit

Participants were clear that the consequences of lack of fit arose from the need to continually reset priorities and accommodate the seriously ill incoming patient. While these nurses struggled with giving the kind of care older adults required especially because of longer older adult stays in the ED, participants also articulated how the lack of fit impacted important care needs for the older adult. The nurse participants communicated a wide variety of problems that they witnessed in the care of the older adult which Participant 5 labelled ‘under care.’

All of the participants gave examples of care that was compromised by both the priority setting and the pressured care culture of the ED. While they labelled these events differently as “under care,” “missed care,” “undignified care,” and “unsafe care,” each label showed what participants agreed was poor quality care for the older adult. This under care was associated most frequently with those patients who were moved from place to place within the department to accommodate new more acutely ill ED patients, those who spent long periods of time in the ED, or whose nurse was pulled away to care for a patient deemed to be more acutely ill. This was illustrated on numerous occasions during the interview process.

He was initially in respiratory distress but much more stable and was being acutely treated for acute onset CHF [congestive heart failure]. We moved him suddenly because we had somebody that had a heart rate of 30. So being that that was probably the only monitored bed that we could shift, I put my 89-year-old with CHF into the hallway. So, little did I know that later on, he needed to be irrigated. His catheter I had put in needed to be irrigated probably for prostate problems, so there he is getting irrigated in the hallway. (Participant 5)
Each of the examples given by the ED nurses showed an awareness of the problems inherent in the department, which arose because of the ED culture of priority setting and pressured care. The participant nurses gave a multitude of different examples of ‘under care.’ Each participant recognized that this type of care was neither the care they wished to provide nor the care older adults deserved. This recognition of ‘under care’ was accompanied by a sense of distress. One participant was eloquent in describing the personal struggle that arose with being unable to provide good care:

That is one of my one thing that I’ve really struggled with as an emerg nurse and I’ve gone through some extreme struggles with that where I have just felt like I couldn’t stay there anymore because it was too hard to go home at the end of the day and feel like I hadn’t provided adequate care to my patients: that it wasn’t safe; that it wasn’t proper; that people were being left on stretchers for far too long; that they were getting pressure sores; that they were getting more confused because they were being held in a place where the lights never went out and the noise never stopped. It was like a real crisis for me for a while there in my nursing career that was affecting my personal life even. I just thought I can’t do this anymore. This is nuts. This isn’t what I went into nursing to do. I feel like I’m torturing these people, I don’t feel like I’m actually doing anything to help them get better. (Participant 3)

Managing Lack of Fit

This section describes the variety of ways in which participants dealt with lack of fit. While all of the participants described feelings of unease or distress at the ‘under care’ that older adults sometimes received, participants had a variety of means for dealing with their distress. Managing lack of fit fell into four categories; i) switching the focus of care away from ED nursing, ii) choosing one piece of care they incorporated into the ED routines, iii) putting tasks on hold and returning to them when able or involving team members in care, and iv) rationalizing the ‘under care’ they witnessed and participated in.
As nurses worked through the problem of how to deal with the ‘under care’ they had administered, several of them described shifting the expectations and focus of their nursing care. The nurses shifted the focus away from throughput and priority setting to the needs of the older adult remaining in the department. Participant 4 described this change in focus for her practice well. This nurse reported beginning her day by saying to herself:

This is not going to be an ED day - when you come on you have 2-3 sometimes your whole assignment, you’re taking care of admitted patients a lot of times, and then I ‘refocus’ myself. In that case, then, I refocus myself and say ‘Okay… take a breather… this is what my day is going to involve.’ That’s how I try to deal with it as opposed to seeing my day as an emergency day, I think like, ‘okay, this is how I need to take care of this person’ as opposed to maybe running to this, that and the other thing. (Participant 4)

Other participants recognized that they could not alleviate all of the ‘under care’ that was occurring but chose within their own practices to try small things that would alleviate some of the distress and indignity that the older adult patients experienced. Nurses spoke about needing to increase awareness of each patient’s needs and making it more of a priority to see that things like morning care were done. For some nurses, there was also an aspect of putting tasks on hold temporarily, or finding other team members who might be able to help with the care that each patient needed. One participant also described the influence of a particular nurse who she regarded as a role model:

I’ve learned from [that nurse]… to be honest I, not that long ago, …. I sort of made it more of a focus to be honest to make sure that my patient got washed up in the morning, and to be sure I changed their bed and done that because I’d seen one particular nurse there who does that every morning and it’s quite impressive that she does that every morning. So, but watching her, I kind of thought I should be a little more attentive to that. Um… and so this particular person kind of like made me aware of it every day and that’s what she does. (Participant 4)
Other nurses made choices to change their care as well. Some chose to nurse from selected aspects of care. Aware that they were not able to meet each and every care need, participants chose one that they could meet while still maintaining the priority setting and throughput needed in the department.

And I just made sure that across the board from left to right, she was getting up to toilet. So, it doesn't sound like a lot, but it gives them dignity and you know, if you can teach someone to take little sips of water, it's just as accurate if not better than IV hydration. It's great for gastro and to teach her that, 'You know what? You too can do this. I know that you're older than me, I understand that, but with a little bit of help you'll get over this.' And to conquer that fear was all she needed. So afterwards, I was pretty proud, I set up things for her to go back home. I reminded her that she does need to use her walker and that if in fact it's too heavy for her husband, then maybe we should be putting some community services in place. So that was 12 hours of one of the five or six patients that I had in [rooms] 12 to 15 and it's not a great example but it's one that I felt confident in after a long shift. (Participant 7)

While this was a choice made during a shift, other nurses felt that they could not meet a patient's needs unless they stayed past the end of their scheduled shift.

Participant 3 found a patient who had been in the department for two days dressed, ready to go home, and sitting out in the waiting room. When this nurse checked, she found that this patient had not been discharged so she escorted her back to the department. She described the incident this way:

The shift changed. My job was over and I went, no. So I took this lady, I said 'You need to come into the bathroom with me; we have to get you changed back into a gown.' I can't remember who the hallway nurse was but they were saying you know 'Oh, you don't have to do that. You don't have to stay. Your job is done.' I think it was about 8 o'clock by this time and I said 'No, you know what? I do; I need to stay. I need to make sure I get her tucked in and I get her something to eat that she likes.' So that was a time that I left the hospital feeling that I had given really good care to an elderly person. (Participant 3)
For this nurse the choice to nurse came from the relationship that she had built with this patient while she had been in the department. It allowed her to look more closely at who this woman was and address what she needed from the nurses in the ED.

Despite all of the ways in which participant nurses tried to manage the lack of fit, they repeatedly fell back on the need for priority setting and throughput. While recognizing the levels of ‘under care’ that occurred, participants rationalized much of this in statements made about the competing needs that existed in their nursing practices and the requirements of practicing in an ED setting. All participants chose to care for the most acutely ill patient first while recognizing that this choice placed other important care as a lower priority. Participants described these choices as privileging “life and death” situations. Participant 2 described it best with the following statement.

Absolutely because the truth of the matter is that when these, when you got these, like I say, the MI come in. The MI is going to “win” so to speak. It is. You’re not going to bother to turn that patient who may have been laying on their back for how many hours. Or do their mouth care. Or take the time to figure out what they are trying to relay to you. You are going to be looking after the MI. (Participant2)

Summary

Participant nurses working in the ED were influenced by a number of factors while they provided care to older adults. The most prominent of these factors was the culture of the ED. This culture consisted of two components: priority setting and pressured care. Priority setting meant that these nurses always chose to care for the sickest patient first. For these nurses priorities were constantly being reset and
juggled to include the pressured care: the need to constantly and rapidly move patients through the system.

Participant nurses recognized that there was often lack of fit between the culture of the ED and the older adult. Only on rare occasions did the culture of the ED and the older adult mesh. This good fit occurred due to patient factors or environmental factors within the ED. If patients were more acute with overt presentations and could be treated rapidly the older adult fit well with the culture of the ED. If the older adult patient was more independent and required less physical care they also fit well with the ED culture. The final circumstance in which good fit occurred was when the pressure for throughput in the ED lessened and the ED nurse had the time to engage in the care they wished to provide.

Participants struggled with lack of fit between the ED culture and the older adult. Nurses described attributes of the older adult, such as their pace of walking and speech, as conflicting with the nurses’ need to accomplish a variety of tasks in rapid succession. There was a common belief that this was not the type of nursing they had signed up for. Lastly these nurses recognized that care the older adult often received within the ED was substandard.

The final theme which emerged in this study was how participants managed the lack of fit they recognized in the care of the older adult. Nurses chose a variety of ways to manage both the lack of fit and ‘under care’ in the ED. Some nurses chose to change the focus of their nursing care to “not being an ED day.” Others chose to incorporate small changes into their practice to meet the needs of the older adult patient. Still others put tasks on hold till they could return to them or sought
help from team members to accomplish basic care tasks for the older adult. In spite of the variety of ways in which these nurses tried to incorporate changes into their practice all rationalized the ‘under care’ by citing the basic premise of ED nursing-acuity comes first.
Chapter 5: Discussion, Implications, and Conclusions

In this chapter I will consider the findings from my study in relation to the existing literature and will show how they contribute to knowledge about the care of the older adult within the ED. This chapter will begin with a synopsis of findings, discuss the findings in relation to the culture of the ED, lack of fit, managing fit and proceed to the implications of the findings for ED nursing practice, education, and research.

Synopsis of findings

The purpose of this focused ethnography was to explore the experiences of nurses caring for the older adult in the ED and to account for the influence of culture in the ED. A total of seven nurses (six women; one man) participated in the interview process. Three major themes arose from the analysis of the data: the culture of the ED nurses, ‘fit and lack of fit’ between the ED and the older adult, and how nurses ‘managed lack of fit.’

The culture of the ED revolved around continually juggling priorities in which the most seriously ill patient always took precedence. This meant that basic care for the older adult, even though important, was often relegated to lower levels of priority. The continual setting and resetting of priorities was compounded by the need to move patients through the department to make room for incoming patients and those deemed to be more seriously ill. Priority setting and ‘throughput’ were complicated by unlimited access to the ED and chronic overcrowding within the ED and the hospital.
Working in this ‘pressured care’ environment gave rise to the other two themes, those of ‘fit and lack of fit’ and ‘managing lack of fit.’ ED nurses recounted only rare situations when there was a fit between the older adults and the ED, and when they felt that the best possible care had been given to older adults. These were tied to ideal situations within the department: when it was quieter than usual and times when the nurses were able to work together to provide care as a team. There were also patient factors that supported best care. These were when the older adult presented with overt, easily recognized symptoms that needed rapid emergency intervention, or when the older adult was more physically independent, which allowed the nurse to give holistic care that included mental and emotional support.

On many occasions the older adult did not fit with the culture of the ED. This lack of fit revolved around patient centered factors and the ED nurses’ expectations. The ED nurses described the older adult patient as being ‘slow moving’ in an environment where everything was expected to move at a faster pace. The typically complex presentation of the older adult also did not fit with the rapid pace of the ED environment because of the time required to unravel the complex, interrelated problems.

Lack of fit also occurred because of the ED nurses’ own expectations of their practice in the department. Their expectations were focused on attending to ‘true’ emergencies characterized by life and death outcomes. Nurses discussed the amount of time needed to provide the personal care that the dependent older adult often required and contrasted this with nursing a patient with life and death
symptoms. Many felt that basic personal care did not fall into the legitimate realm of emergency nursing practice. Instead, participants felt that basic care should be provided elsewhere, for example, on the inpatient wards.

All participants recognized the consequences of lack of fit. This resulted in ‘under care’ of older patients relegated to stretchers in the hallway, which created a daily moral struggle for many of the participant nurses. Recognizing ‘under care’ and the distress it caused the participant nurses gave rise to the last category of ‘managing lack of fit.’ Nurses used a variety of ways to ‘manage lack of fit,’ including rationalizing the ‘under care’ which they observed or participated in, changing the focus of their care from ED care to basic care, choosing one piece of basic care that could be incorporated into the ED care routines, and putting some tasks on hold then returning to them after the more urgent tasks were taken care of.

**Culture of ED**

ED’s were first developed in the early 1960’s to quickly treat acute, urgent health care needs (Adams & Gerson, 2003), especially trauma. Over time the specialty of emergency medicine has evolved, with increasing specialization and use of technology. Suter (2012) discussed the goals of emergency medical care set out by the World Health Organization in 2007. These goals aim to safeguard access for all persons to receive emergency and trauma care and ensure that an essential set of emergency medical services are available to all people requiring them. Kobusingye et al. (2005) as well as Razzak and Kellermann (2002) described the purpose of emergency medical care as stabilization of patients with life or limb threatening injuries or illnesses. Further, these authors described ED’s as needing
to address assorted diseases from communicable infection, chronic disease in acute states, to trauma. For these authors the focus of ED care was comprised of two major components: medical decision making and the completion of actions to prevent death or disability in time sensitive problems. This premise of providing emergency medical or trauma care for all those who may need urgent care in a time sensitive situation forms the basis of the culture that I observed during my study.

The overall culture of the ED and how it influences the practice of healthcare professionals who work there has not been studied extensively. Research studies that address aspects of ED culture include: exploration of patients’ experiences of care in the ED (Grief, 2003; Kihlgren et al., 2004; Lyons & Paterson, 2009; Way et al., 2008; Wellswood et al., 2005;), the nursing beliefs of ED triage nurses (Fry, 2011), and how ED clinicians manage patient flow in the ED (Nugus et al., 2011). In the current study the culture of the ED had two components: ongoing priority setting and creation of throughput for incoming patients in a constantly changing environment. Other researchers have had similar findings. For example, Cole & Crichton (2006), Fry, (2011), Nugus et al., (2011) and Nystrom (2002) all described the ED as a dynamic entity that responds quickly to changes, especially acute patient changes. Nugus et al. described ED clinicians, both physicians and nurses, as having to “prioritize patient momentum” (pg. 1047) and to “actively construct patient flow” (pg. 1048). Although the terms used are different these concepts are very similar to what was described by the participants in the current study. While Nugus et al. focused on work pressure and patient flow, for the nurse participants in the current study the need for ongoing priority setting was their default
practice orientation. If a choice needed to be made in the participants’ practice they always chose the sickest or most acutely ill patient over all other patients.

Further, the Nugus et al. (2011) study described ED clinicians as interdependent and responsive to the environment around them. These clinicians were influenced by the environment and by each other. The nurses in the current study showed this same solidarity of thought when viewing their practice in the ED regardless of their years of ED experience. Nugus et al. described the outside pressures on the ED to manage all the demands imposed upon it, whether it be the continuing arrival of patients, the needs of the community in which the ED was situated, the political and managerial expectations, or dealing with ongoing overcrowding and lack of resources. In the case of the ED where the current study occurred, the expectations of a tertiary care trauma center had to be met. In addition, this tertiary care center is the only hospital serving a community of over 100,000 people (Statistics Canada, 2006). Tactics such as ambulance diversion to other hospitals in times of excessive crowding is not an option for this facility. This department must care for all patients presenting to its doors.

The other portion of the culture of the ED was the creation of throughput. For the nurses in the current study this meant moving patients through the department, either to an inpatient bed or discharging them home. Nugus et al. (2011) defined patient flow as the “passage of multiple patients through complex intricate processes with the aim of delivering high quality care… across the department and the hospital” (pg. 1046), especially in conditions of overcrowding and access block. These processes were described in terms of assessment, assignment to appropriate
portions of the ED, diagnosis, treatment, and negotiation about admission to hospital or potential follow up. This work pressure and managing the flow was described as a ‘living entity’ that needed to be constructed. My study participants were very clear about the need, in fact the pressure, to move patients through the department and out the door. One finding of the Nugus et al. study focused on the effort that ED clinicians made to actively get control of patient flow in those times when it got out of control. ED clinicians were described as managing the boundaries of the ED and sharing the patient load by not assigning multiple patients to the same area or moving patients to the emergency medical unit within the ED. This was a challenge for participants in my study. Considering that the participant nurses worked in a hospital in which inpatient capacity was chronically over 100% they faced additional pressures to accommodate ED patients because there were often no inpatient beds to allow for transfer. They accommodated the pressure of incoming patients by moving other patients to the hallway or to an area adjacent to the ED after regular hours. They emphasized their careful problem solving in choosing appropriate hallway candidates and advocated when possible to put less vulnerable patients in these areas. They gave input about which patients should be sent to wards and which should be kept in the department based on the possibilities of discharge home. While other researchers have looked at ED nurses’ decision making in triage there has been little research into other areas of emergency nurses’ decision making.

Rapid throughput was further complicated by political and managerial expectations for the nurses in my study related to patient-focused funding that had
been initiated by the Province of British Columbia. Under patient-focused funding, hospitals receive financial incentives for delivering acute-care services in a competitive manner. In the case of emergency care, funding is provided by meeting care times set by the government. If a patient is to be admitted and reaches an inpatient bed within ten hours then the hospital receives a financial reward. Likewise if a patient at triage levels three, four and five is seen and discharged from the department in either two to four hours the hospital will also receive financial reward. So strong is this incentive that the hospital has created a ‘flow nurse’ position. It is this nurse’s job to help find ways of meeting these target times.

**Fit and Lack of Fit**

Jelinek et al. (2013) and Boltz et al. (2013) described a focus on priority setting as a ‘competition with emergencies’ in their studies of nurses’ care of palliative care patients and issues for the older adult in the ED. This ‘competition with emergencies’ gave rise to both the theme ‘lack of fit’ and ‘managing lack of fit’ in the current study. Lack of fit between the older adult and the ED is a relatively new finding. Boltz et al. and Jelinek et al. indicate a tension between the ED and certain types of patients. Boltz et al. discussed tensions with older adults while Jelinek et al. described these same tensions with palliative care patients who tend to be older adults. Indeed, Boltz et al. described the lack of fit between the ED and older adults as the most pressing issue nurse stakeholders identified in relation to care of older adults in the ED. This lack of fit occurred in relation to (a) respect for the older adult and carers, (b) correct and best procedures and treatment, (c) time and staff to do things right, (d) transitions, and (e) a safe and enabling environment. Findings in the
current study concurred with the themes presented by Boltz et al., especially the theme of not having either the time or the staff to do things right. Participants described having to leave older adults in order to deal with other patients deemed more acute. The problems recognized by participant nurses were labeled ‘under care’ and included older adults not receiving: basic care (skin care, mouth care), nutrition, mobilization, safe equipment to use, or privacy. Further, they were moved so frequently within the department that it was difficult to know what care and treatment had occurred for the older adult. Like the findings in Boltz et al.’s study participants in the current study all discussed lack of respect for the older adult and how the older adult deserved better care than they often received.

Participant nurses were aware of the need to make choices in whether they cared for incoming patients or those who were there awaiting inpatient beds. These nurses were also aware that the choices they made often compromised the care that the older adult received. Similar to Boltz et al. (2013) study and Jelinek et al. (2013), the nurses in my study recognized the competition between the older adult and incoming patients who were deemed more emergent than the older adult, but who often was seriously ill. The participant nurses in my study, while always choosing to care for the most obviously emergent patient, were also very aware of the risks that this posed for the older adult. Khan et al., (1996), Nemec et al., (2010), and Rutschmann et al., (2005) who examined atypical symptoms and presentations in the older adult in the ED, labelled these presentations as non-specific complaints.

These atypical presentations by the older adult revealed that ED nurses had to change the way they worked with the older adult. If the older adult presented with
overt symptoms this presented no difficulty for the nurses; however when the older adult presented with atypical symptoms then the nurses often could not act quickly to intervene. The atypical presentation of older adults required that nurses in the current study piece together disparate aspects of the clinical picture, similar to solving a puzzle. Although there is recognition of presentation with atypical symptoms this need to engage in puzzling out or problem solving is a finding not currently reported in the literature. When the ED nurse was required to solve the puzzle of atypical presentations the culture of rapid throughput often overrode the needs of the older adult patient and put increased pressure on the ED nurse. Indeed everything about the older adults in these atypical cases required that the ED nurse slow down. With no easily recognizable overt symptoms there was a need to dig through a multitude of information to try and determine what was occurring with the older adult. It is evident that for the older adult, atypical symptoms placed in the context of priority setting and creation of throughput make timely and accurate diagnosis difficult. While Nugus et al. (2011) described the need for ED clinicians to reconcile the tension between urgency and complexity of patients it would seem that the need for urgency often overrides the complexity leaving the older adult at risk of adverse outcomes. Caterino et al. (2012); Khan et al. (1996); Nemec et al. (2010); Parke et al.(2012); and Rutschmann et al. (2005), in discussing atypical symptoms and presentations of the older adult discovered that between 25% and 59% of these patients were later diagnosed with a serious illness.

The nurses in the current study valued the highly technical and fast pace of the ED, which exacerbated the lack of fit they experienced between the older adult
and the ED. Nurse participants did not view basic care of older adults as an ED practice priority. In fact most believed that the older adult was less acutely ill and required more basic care than other patients. Nystrom (2002) also found that a group of ED nurses valued the technical competence and practical skills of ED nursing. In Nystrom’s study, which involved both registered nurses and care aides, there proved to be a high division of labor between the registered nurses and the care aides. Nystrom found that as soon as the more technical aspects of the medical care were done, the more basic care was turned over to the care aides who felt that the care they provided was less valued than the more technical medical care provided by the registered nurse. There was a common theme among the participant nurses in the current study that there was nothing exciting or interesting about looking after the older adult. In fact, many of the participant nurses described having to change their expectations for the day, away from that of emergency care to accommodate the care of the older adult. However they were also very clear that they did not wish to provide this type of care on a frequent basis.

This is similar to findings from other ethnographic studies that have explored the views of nurses who work in specialty areas, such as the intensive care (Scott & Pollock, 2006) or the ED (Cole & Crichton, 2006). It was evident in both these studies that these nurses valued the highly technological and skill based aspects of their practice and focused on the clinical management of the sickest patients within their practices. Similarly nurses in the current study expressed a preference for caring for the sickest patients. In the Scott and Pollock study the notion of caring for the sickest patient was a measure of the nurses’ competence in what was
considered an elite environment. The nurses in the current study were fine with caring for older adults as long as the older adult was overtly ill and fit what the nurse saw as the legitimate scope of ED practice but, as already discussed, they did not always recognize that older adults were very sick.

Similar findings regarding lack of fit and priority setting also arose from a study conducted by Margaret Fry (2011). Fry interviewed triage nurses in four metropolitan Australian ED’s. Fry described the nurses in her study as being resentful of any patients who were viewed as wasting the time and resources of the ED because this placed the sicker patients they should be caring for at risk of poor outcomes. This was especially true for those patients who presented with either minor or chronic problems that could be cared for in another venue, such as a family physician’s office. Nurses in the current study did not imply that the older adult was a waste of time in the ED but made no apologies for setting the most gravely ill patient as their priority patient or for resetting these priorities as things changed in the ED.

**Managing Lack of fit**

Managing the lack of fit between the ED and the older adult was negotiated in a variety of ways by the nurses within the current study. The nurses all described the ‘under care’ that arose because of the lack of fit between the ED and the older adult. For the nurses in the current study handling this lack of fit varied depending on the nurse. Many of the nurses aligned themselves strongly with the priority setting and throughput aspects of the culture and rationalized the ‘under care’ that occurred with the older adult as a necessary occurrence given the circumstances. In
fact rationalization seemed to be a protective component for these nurses. This close alignment with the culture removed the need to slow down and think about the appropriateness of the care that was being provided. Interestingly, it was the more experienced nurses who aligned themselves very closely with this viewpoint. The nurses who had spent the bulk of their careers in the ED were very ‘matter of fact’ about the alignment with priority setting and throughput and often expressed this as “this is the ED. Life and death and all of that come into play.” The less experienced nurses were the nurses who expressed the most moral distress at the care they saw occurring. They were also the nurses who tried to make adjustments in their own practices to deal with the ‘under care’ they experienced. This gives some evidence that there may be beginning culture shifts occurring among some nurses in practice to meet increasing environmental demands.

In order to juggle the needs of a department that managed everything from trauma to childhood ailments to the ailments of the older adult, especially in conditions of chronic overcrowding and access block, the default practice orientation of priority setting and managing throughput may be a survival mechanism for the nurses in my study. Similarly, Scott and Pollock (2008) found that pediatric intensive care nurses learned not to fight the culture and to survive using solidarity with the culture of the unit. This included rejecting activities that did not fit with the culture. For the nurses in the current study it may have been less distressing to align with the culture, especially when the work was busy and chaotic. It may have been difficult to include the elements of care that the older adult required if this was not accepted by other members of the culture.
While some nurses aligned themselves with the culture in a way that seemed to buffer them from distress, others did suffer distress associated with the ‘under care’ that was occurring. Participant nurses described instances of ‘under care’ for older adults including lack of privacy, lack of dignity, lack of proper equipment (such as stretchers or commodes), lack of nutritional choices, and lack of facilities for hygiene. However, many participants felt that they had no choice about this ‘under care.’ Kilcoyne & Dowling (2008) detailed similar findings for nurses working in a crowded Australian ED. The nurses in this Australian study defined situations, termed ‘elusive care’ that mirrored the ‘under care’ described by the nurses in the current study. Likewise the nurses in Kilcoyne and Dowling’s study expressed feelings of frustration and powerlessness at being caught up in a situation they felt could not be changed and had grown to be the ‘norm’ for practice in the ED.

In a survey study of 374 nurses from a variety of healthcare settings throughout the province of British Columbia, Varcoe et al. (2012) found that nurses did respond to moral distress, however, Varcoe et al. described the nurses’ response as a focus on changing the system that was causing the distress. The current study is unique in that it documents individual changes that nurses made within their own practice to change a situation they found distressing. Some nurses who identified ‘under care’ for older adults in the ED as a problem, made attempts to straddle or counter the culture of the ED by providing elements of care that they felt were important for the older adult. Benner (1994) described engaged nurses as having ‘an ethic of attentiveness and responsiveness.’ Benner described this ‘ethic of responsiveness’ as a practical form of knowledge in which nurses respond to the
concerns, needs, preferences and tendencies of their patients. It was Benner’s contention that when understanding of patients’ needs broke down caring practices suffered. It was nurses’ attentiveness and response to the needs of the older patient that kept them engaged with practice. The nurses in the current study were struggling to maintain that attentiveness and responsiveness by altering their caring practices to partially, but importantly, meet the needs of the older adult patient. By changing the expectations of their day away from ‘an ED day’ and doing the small things that improved care for the older adult the nurses in the current study were able to alleviate some of the distress they experienced in the care of the older adult.

Despite the efforts made by these nurses to instill changes in their practice often the pressure exerted for throughput and the need to keep updating priorities overrode the nurses’ ability to provide counter culture care. For some nurses the moral distress suffered in relation to the care they provided to the older adult made it necessary to actually leave practice in the ED.

Implications for Practice

Much of the time, the older adult and the culture of the ED do not mesh. Alternative ways of providing emergency care to older adults need to be explored. Salvi et al. (2008) studied the differences between a geriatric ED and a conventional ED. Although the 30 day and six month return rate for the geriatric ED was similar to the conventional ED, the geriatric ED cared for frailer patients and showed a lower mortality rate. This is one potential model to address the problem of lack of fit between the ED and older patients and to support more positive health outcomes for older patients.
If older adults do not have the option to be cared for in a geriatric ED there are other means to improve their care within the conventional ED. Sandecki (2007) and Splinter-Flynn et al. (2010) argue the benefits of a nurse within the ED who is specifically educated to assess and intervene in relation to the needs of older adults. Not only could these nurses recognize problems in the care of the older adult but they could act as mentors and educators for other ED nurses to increase knowledge around the specific care needs of the older adult in the ED. This would be of benefit to address and support some of the counter cultural elements that the nurses in my study tried to incorporate into their practice.

**Implications for Research**

There are many implications for follow up research that arise from this study. It would be beneficial to repeat this study with ED nurses in other hospitals to see if their experience of caring for older adults is similar to that of the nurses in the current study. Given that the priority setting and throughput aspects of this culture is long standing and unlikely to change; that increasing numbers of older adults will be seeking care in the ED as numbers of older adults in the population rises; and that ‘under care’ of the older adults often occurs in the ED setting, it is important to explore specifics of how ED nurses manage to straddle the demands of both emergent and boarded patients under conditions of overcrowding. While this study examined only registered nurses to obtain their experiences of caring for the older adult in the ED it would be worthwhile to broaden this research to include other health care professionals who practice in the ED to better understand their experiences of caring for the older adult. The last research implication I would like to
suggest is the attitudes of ED nurses in relation to older adults with a focus on ageism. Fry (2011) found that ED nurses did not wish patients to waste the valuable time of the ED and the clinicians who work there, especially for those patients who are frequent users of the ED. It would be interesting to look at this question in relation to how older adults are perceived as being frequent users of the ED in a Canadian study.

**Implications for Education**

The implications for nursing education are clear. ED nurses need more information on the special needs of older adults. Perhaps this can be incorporated more into nursing school curricula. Nurses should be encouraged to continue study of the geriatric component of nursing especially in specialty areas. The incorporation of a geriatric emergency nurse could provide both a role model and serve an educational leadership role within the ED. Lastly given the evidence from other research (Khan et al., 1996; Nemec et al., 2010; Parke et al., 2012; and Rutschmann et al., 2005) education on atypical symptoms and presentations need to be included in ED nurses’ education. An appropriate place to house this piece of education might be within the current ED certification courses, in the Trauma nursing core course (TNCC) (although this is not an ideal fit), or as a separate entity after beginning work in the ED. Like the TNCC this should be a requirement to work in the ED.

**Limitations**

There are a number of limitations to this study. The first is that only seven nurses agreed to participate in this study resulting in a very small sample size. The
group of nurses who participated in this research also represented nurses who were particularly interested in the care of older adults. Replication of the study with larger more ethnically diverse sample would be appropriate. In addition this study was conducted in a mid-size tertiary care hospital and results obtained here may not be transferrable to other ED’s. Another limitation of this study has to do with the observational piece of the ethnography. Due to ethical constraints, permission to observe the nurses’ interactions with the older adult was not possible. More extensive supportive data from the observational piece of this study would have strengthened the findings.

**Conclusions**

The findings in this study indicate that the priority setting and throughput culture of the ED and older adults does not mesh well. The culture of priority setting and throughput is the default practice orientation for ED nurses, which places the older adult at risk of poorer outcomes. Given that this culture is longstanding, will be slow to change, and that older adults will continue to seek health care in the ED in increasing numbers, consideration needs to be given to how to better meet the needs of the older adult in the ED setting. Consideration needs to be given to the development of more geriatric emergency departments or other innovative strategies to meet the needs of this population.
References


Appendices

Appendix A: Diagram of ED and Nurses’ Roles

Nurses’ Roles.

The study site for this research was the ED of a tertiary care hospital in Western Canada with over 300 inpatient beds. This hospital is the designated trauma center for the region it serves. The designated inpatient beds provide care to medical, surgical, intensive care, psychiatric, maternity, rehabilitation, and paediatric patients. The ED in this hospital has a staff consisting of 10 physicians, 50 registered nurses, 10 licenced practical nurses, three care/ward aides and several unit clerks.

These nurses work in a twenty bed emergency department which includes two trauma rooms. This department has eleven monitored beds, four medical observation beds, two treatment rooms for suturing, four beds attached to the rapid assessment area and a four stretcher minor treatment area. Nurses here are assigned to a variety of areas and can care for any where from one to ten patients at any given time. The average number of patients is four. Certain assignments include the need to float from one area in the department to another to help provide patient care.

The physical environment of this ED is challenging for staff and patients alike. Space is very limited; there is little room for movement of equipment in halls crowded with the stretchers of overflow patients. The nurses who work in this department continually move patients from space to space whether for diagnostics,
higher level of care (either to a monitored bed, to the trauma bay, or to a placement 
for procedural sedation and suturing), or to accommodate those new patients 
entering the department who need initial assessment and treatment.

This department has nine registered nurses who work on each day shift. They 
are joined later in the day by three more nurses who are assigned to areas where 
the patient load increases during the day. Additionally, there are licenced practical 
nurses who act as the emergency practical nurse, overflow nurse for admitted 
patients, and the minor treatment nurse. One registered nurse is assigned as the 
trauma nurse and they care for the patients assigned to the trauma room. If there 
are no patients in the trauma bays this nurse floats and helps with other aspects of 
patient care. Another nurse is assigned to rooms’ three to six. These are monitored 
beds and house mostly patients with suspected cardiorespiratory problems. The 
next assignment includes bed seven and minor treatment. As this nurse has only 
one monitored bed to his/her assignment he/she is designated to help with any extra 
needed care (E.G. intravenous antibiotics) that might arise in the minor treatment 
area; alternatively, the nurse in this assignment would be the first pulled to the 
trauma room in the case of an unstable patient requiring rapid intervention from 
more than one care giver.

The rapid treatment zone has rooms eight to eleven assigned to the zone. 
Patients do not stay in a bed in this zone but rather in chairs. Patients are moved in 
and out of the rooms as they are assessed by both the nurses and physicians and 
wait in the chairs for diagnostics to occur. In order to be assigned to this area
patients must meet a certain criteria; they must have stable vital signs, have the ability to sit, and be ambulatory to walk in and out of the assessment rooms. As many patients are assigned to this area, a second nurse is assigned here from mid-morning on. Because these patients are considered stable this second nurse may be pulled, as well, to help in the event of a trauma where the patient requires more than a single care giver.

The next assignment is bed twelve to fifteen. This five bed assignment holds mostly medical patients and is frequently where the older adults who present are placed. This assignment is paired with beds sixteen, seventeen, twenty two, and twenty three. Beds sixteen to twenty three are a combination of monitored beds and where a lot of patient movement occurs; as these beds are near to the nursing station, patients who require closer observation are often placed here. The problem occurs after these patients have been assessed and stabilized as they are frequently moved to accommodate a newer patient who might require closer observation such as a seizure patient or someone who is confused.

The last nurse with a bed assignment is the nurse who cares for rooms nineteen, twenty, and the seclusion room. Included in this assignment are any patients who are sequestered in the hallway, often several at a time. As this is often the case there is usually a licenced practical nurse who is also assigned here who helps to care for the admitted patients in the hallway. Two other nurses are assigned to the triage duties in the department. Each of these nurses works a twelve hour shift, one beginning at the early morning start time and one beginning mid-morning. The nurse
beginning mid-morning is often assigned to triage the patients brought by ambulance and can also be pulled from this assignment to go to the trauma room or care for another acute patient, should this be necessary.

Lastly each shift, both days and nights is covered by a patient care coordinator. This nurse is responsible for the assignment of nurses to the various work areas, placement of patients within the main department, and overseeing the general flow of patients through the department. This nurse works closely with the physicians, respiratory therapists, the staff nurses, the transition nurse, and the admitting department to try and ensure patient safety and movement. As the work load increases during the day another nurse comes on in the afternoon to either take over a patient assignment or to act as a float nurse for the department.

Similar numbers of nurses are seen on the night shift, with the exception of a second triage nurse and a second rapid assessment nurse. Several nurses finish their respective shifts between 2100 and 2300 hours resulting in a shifting of nurses to cover what are considered the basic minimum assignments. Another exception for night shift is that admitted patients are moved to the adjacent cast room and its adjoining waiting room for the night. To ensure patient care in this area there are usually two licenced practical nurses.
Figure A: 1
Appendix B: Information for Staff Meeting

Bonny Taylor asked that I (XXX) attend this staff meeting to provide the staff of the XXX Emergency department with information packages regarding a research study that she is conducting in partial fulfillment for her Master's in Nursing degree.

It was decided by Bonny, in conjunction with her research committee that she should not attend in person because her presence may be interpreted as coercion, and she is committed to abiding by ethical principles.

As many of you know, care of the older adult while in the emergency department has been an interest of Bonny’s for quite some time, and she is especially interested in hearing from ED nursing staff (RNs with three or more years of experience) about their experiences of caring for these patients.

You will be asked to participate in an interview with Bonny lasting approximately one hour and a short follow up session lasting up to 30 minutes as well as an observation session while you are on shift. All the information that you give will be kept confidential.

Bonny has provided information packages that you may take with you today that provide more information on this study. If you are interested in participating or if you have any questions regarding the study, please contact Bonny at the numbers provided in the package.
Appendix C: Recruitment Pamphlets

Nurse Information Brochure for Nurses in Emergency

Title of Research Project: Nurses’ experience of caring for the older adult patient in the Emergency department

Principle Investigator and Supervisor: Dr. Kathy Rush, Associate Professor, Faculty of Nursing, University of British Columbia Okanagan.

Email: kathy.rush@ubc.ca

Co-Investigator: Bonny Taylor, RN, Staff nurse, XXX emergency, University of British Columbia- Okanagan, MsN Candidate, University of British Columbia Okanagan. Phone (250) 807-9973.

Email: bonny.taylor@ubc.ca

What Is This Study About?

Older adult patients are among the largest users of the emergency department (ED). Presentation by the older adult patient to the ED is considered a sentinel event predictive of increased mortality, increased morbidity, and functional decline. The older adult patient frequently presents to the ED with serious illness requiring admission. Given the problem of ongoing overcrowding in most ED’s, older adult patients who are admitted frequently have prolonged stays in the ED while awaiting inpatient beds. The purpose of this study is to explore nurses’ experience of providing care for the older adult patient in the ED setting. This study is part of Masters Studies in the Faculty of Nursing at the University of British Columbia Okanagan.

Who Can Participate?

To participate in this study:

- You must be either a Registered Nurse with a minimum of three years experience
- Work in the emergency department of XXX either as a full-time, part-time or casual nurse
- Have cared for an older adult patient (75 or older) in the last 6 months
What Will I Be Asked To Do?

Participate in a face-to-face in-depth interview with the researcher (Bonny Taylor). Answer questions about your experiences of caring for older adult patients in the emergency department. Commit about 30 minutes to 1 hour of your time. Agree to have the interview digitally recorded and later transcribed for analysis. Agree to being observed over a 2-4 hour period during a scheduled shift in the ED. Complete questions about you personally such as your age, level of education and years of experience in nursing. Sign a consent form. Please be assured that any information provided in this process will be kept confidential. Details about how this will be done are provided in the consent form.

What Do I Do If I Am Interested in Participating?

If you agree to take part in this study, please contact me, Bonny Taylor at 250-807-9973 or Bonny.Taylor@ubc.ca and I will arrange a time to take your consent.

For additional information or information any time during the study, please contact Bonny Taylor at 250-807-9973 or Kathy Rush at 250-807-9901.

If you have any concerns, you may contact the ethics board at the University of British Columbia and/or the ethics board at Interior Health Authority (IHA).
**Appendix D: Demographic Form**

**Demographic Form**

1. **Sex:** □ Male □ Female

2. **Age:** ____________

3. **Ethnic Background:**
   - Caucasian □ First Nations □ Indian □ Asian/Pacific Islander
   - □ Other (specify) _________________________

4. **Highest Level of Education in Nursing:**
   - □ Diploma in Nursing
   - □ Bachelor’s Degree in Nursing
   - □ Master’s Degree in Nursing
   - □ Other _________________________________

5. **Have you completed Specialty Education in the care of the older adult?**
   - □ Yes □ No If yes, explain: _________________________________

6. **Current status:** □ Full time □ Part time □ Casual

7. **Years of Experience in Nursing:** ____________ yrs.

8. **Years of Experience in Emergency Nursing:** ____________ yrs.

9. **Did you work in another area of nursing prior to the ED?**
   - □ Medicine □ Surgery □ Specialty Area ____________ (specify)

10. **On average, how many older adults would you care for on any given shift?** ____________
Table D:1 Demographic Findings

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<td>Master Science Nursing-0 (2 in progress)</td>
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<td></td>
<td>Neuro-geriatric course-1</td>
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<td>6. Years of Experience in Nursing</td>
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<td>33 years- 1</td>
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<td>38 years-1</td>
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<td>7. Other areas of nursing practice</td>
<td>Medicine- 3 ( one from intensive care)</td>
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<td></td>
<td>Telemetry, neurosurgery- 2</td>
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<td>8. Years of ED experience</td>
<td>3 years- 2</td>
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<td>Average number years of Ed experience-9.9</td>
<td>9.5 years-1</td>
<td>20 years-2</td>
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Appendix E: Interview Guide

I am particularly interested in care of the older adult in the Emergency department (ED). Think about an older adult that you cared for in your last few shifts.

1. Tell me how care for the older adult has changed over time?
2. Talk about a time when you felt that you gave the best possible care to an older adult?
   - What was going on in the ED at that time?
   - What allowed you to give the best possible care?
   - Tell me about how you felt?
3. Talk about a time when you felt you were unable to give the best possible care?
   - What was going on in the ED at that time?
   - What would have helped/ supported you in providing the best possible care to the older adult?
   - Tell me about how you felt?
4. What would improve your ability to give care to the older adult in the ED?
5. How do you manage competing priorities in the care of the older adult in the ED?
Appendix F: Observation Guide

Observation Guide

1. What activities are occurring in the environment?

2. What is the physical layout of the ED?
   - Where is nurses station in relation to rooms/beds where older adults are placed, noise levels, high/low activity areas
   - Movement through the environment

3. What is the nature of nurses’ interactions with older adults?
   - How many times do nurses interact with the older adults in their care?
   - How long does the nurse spend during her interaction with the older adult?
   - What activities does the nurse undertake with the older adults?

4. What other professionals does nurse consult about the older adult?
   - What information do nurses communicate with each other in relation to the older adult?
Appendix G: Consent form

Consent Form

Title: Nurses’ Experience of Caring for
Older adult patients in the Emergency Department

Principal Investigator:
Dr. Kathy Rush- Associate Professor, UBC Okanagan School of Nursing
Contact Phone: 250- 807-9561

Co-investigator:
Bonny Taylor- RN, BsN, Clinical Assistant, UBC Okanagan School of Nursing,
Casual Staff Nurse XXX Emergency Department, MsN candidate, UBC Okanagan
Contact Phone: 250-807-9973

Study Information and Purpose

Older adult patients are among the largest users of the emergency department (ED). Presentation by the older adult patient to the ED is considered a sentinel event predictive of increased mortality, increased morbidity, and functional decline. The older adult patient frequently presents to the ED with serious illness requiring admission. Given the problem of ongoing overcrowding in most ED’s older adult patients who are admitted frequently experience prolonged stays in the ED while awaiting inpatient beds. Emergency nurses caring for these patients not only need to provide care for the admitted patient in the department but must also be prepared to care for other patients continuing to present to the department. The purpose of this study is to explore nurses’ experience of providing care for the older adult patient in the ED setting. This study is part of a Masters Studies in the Faculty of Nursing at the University of British Columbia Okanagan.

Who Can Participate?

To participate in this research study you must be a Registered Nurse with three or more years of ED nursing experience, speak English, work in the emergency department of XXX, and have cared for an older adult patient within the last 6 months.

What Does the Study Involve?

I will ask you a few open-ended questions regarding your practice in the ED and in particular with older adult patients. I will take notes during and after the interviews.
Interviews will take place at a time and place that is convenient for you. There is no right or wrong answer. The discussion will take approximately an hour of your time. Our conversation will be digitally recorded and transcribed verbatim. After the preliminary findings are analyzed I will ask you to validate your responses. Additional sessions may be arranged if clarification of information given by the participant is required. You will also be asked to complete a form that asks you for information about you personally—such as your age, level of education, and years of experience in nursing.

In addition to the interviews I will also spend several sessions (approximately four) in the department observing departmental activities. During these sessions I would be looking at the number of interactions you have with the older adult patients and would validate with you the type of interventions you are undertaking with them, such as personal care or medication administration. These sessions would be at different times during the day and would be between two and four hours each. During these observational sessions I will not become involved in any patient care. I will ensure this by:

- not wearing a nurses’ uniform during the observational sessions
- not participating actively in nursing clinical discussions or problem solving during the observational periods
- not performing actual ‘hands on’ nursing care

Risks

There are no perceived risks to participating in this study except perhaps the time involved.

Benefits

One of the benefits of participating in the study is increasing your awareness of nurses’ practices with older adult patients in the ED. The information you provide may not contribute to any immediate changes for you but may help to promote greater understanding of nursing practice in the ED. Participating in this study may bring you satisfaction that you are helping to improve the lives of older adult patients.

Confidentiality

A number of measures will be used to keep your identity confidential. The recordings and printed discussions will be kept in a locked cabinet, made available only to members of the research committee, and will be destroyed in 5 years. To further ensure confidentiality each participant will be assigned a code number which will act as a pseudonym for the participant. All printed discussions will use these code numbers so no participant can be identified. All documents will be identified only by code number and kept in a locked filing cabinet. **All information collected is for the purposes of the study and is in no way an evaluation of your practice. Any**
information which you provide which may be sensitive in nature will not be shared with any persons in authority.

A synthesis of the findings will be shared with others who study and work with older adult patients, especially in the ED, and be communicated in written papers or oral presentations. The information placed in publications may be in the form of a direct quotation from the interview. If quotes are taken and used in publication, every care will be taken to ensure that your identity is not compromised. It is anticipated that results from this study will also be used to guide future research in this area. If you would like a report of the findings please include your mailing address in the space provided at the bottom of this form. You will also be provided with a copy of the signed consent form.

**Contact for information about the study:**

If you have any concerns, questions or would like further information about the study, you may contact Dr. Kathy Rush at the number given above. Signing this consent form in no way limits your legal rights against the investigators.

**Contact for concerns about the rights of research subjects:**

If you have any concerns about your treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Okanagan Office of Research Services at 250-807-8832 or if long distance email to RSIL@ors.ubc.ca or the Chair of the Interior Health REB through the Research office at 250-870-4602.

**Consent**

Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time during the course of this study. If you do decide to stop participating you will still receive the honorarium as described below.

Your signature indicates that you have read this document and consent to participate in this study. Indicate your choice in the box to the left.

- I agree to be interviewed and observed as I work in the emergency department.
- I agree to participate in the interview for this study but not to be observed as I work in the emergency department.

All participants will receive a beverage gift card as an honorarium (a value of $10.00) whether or not the study is completed.

Participant signature        Date
Printed Name of Participant

Witness Signature

Date

Address of Participant (For sending study results)

Thank you for your time!
Appendix H: University of British Columbia Research Ethics Approval Certificate

The University of British Columbia Okanagan Research Services
Behavioural Research Ethics Board
3333 University Way
Kelowna, BC V1V 1V7

Phone: 250-807-6832
Fax: 250-807-8438

CERTIFICATE OF APPROVAL - MINIMAL RISK

PRINCIPAL INVESTIGATOR: Kathy Ruah
INSTITUTION / DEPARTMENT: UBC/UBCO Health & Social Development/UBCO Nursing
UBC BREB NUMBER: H10-02253

INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT:

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<th>Site</th>
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<td>Okanagan</td>
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CO-INVESTIGATOR(S):
Janice Stanbury
Ronny Taylor

SPONSORING AGENCIES:
N/A

PROJECT TITLE:
Nurses experiences' of caring for the older adult in the emergency department.

CERTIFICATE EXPIRY DATE: October 8, 2011

DOCUMENTS INCLUDED IN THIS APPROVAL: DATE APPROVED:

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<td>August 31, 2010</td>
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The application for ethical review and the document(s) listed above have been reviewed and the procedures were found to be acceptable on ethical grounds for research involving human subjects.

Approval is issued on behalf of the Behavioural Research Ethics Board Okanagan and signed electronically by:

Dr. Daniel Salhani, Chair
Appendix I: Interior Health Research Ethics Approval Certificate

**Certificate of Research Ethics Board Delegated Approval**

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<th>Principal Investigator:</th>
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<th>IH Research File Identifier</th>
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<tr>
<td>Dr. Kathy Rush</td>
<td>UBC Okanagan</td>
<td>2010-036</td>
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**Research Study Title:**
Nurses’ Experience of Caring For the Older Adult In the Emergency Department

**IH Administrative Contact**
Cindy Crane

**Co-Investigators**
Bonny Taylor  
Janice Stanbury  
Mary Jane Cullen

**Sponsoring/Funding Agencies**
Unfunded

**IH Departments Involved in Research Study**
KGH Emergency Department

**Documents Covered by this Approval**
- Proposal V2 dated 27 Sept 2010  
- Nurse Information Brochure V2 dated 27 Sept 2010  
- Consent Form V3 dated 04 Oct 2010  
- Demographic Form V2 dated 27 Sept 2010  
- Interview Questions V2 dated 27 Sept 2010  
- Letter to Unit Manager V2 dated 27 Sept 2010  
- Statement for Staff Meeting V2 dated 27 Sept 2010  
- Observational Guide V2 dated 27 Sept 2010

**Certificate of Approval from Primary REB**
UBCO BREB Oct 8, 2010

**Certification**
It is the assessment of IH that this research study poses minimal risk to human subjects and therefore qualifies for delegated review.

The above named documents have been reviewed according to Interior Health Research Ethics Board policy and the procedures were found to be acceptable on ethical grounds for research involving human subjects.

This Certificate of Approval is valid for the term specified below provided there are no changes in the study procedures.

*The Interior Health Research Ethics Board is in compliance with the ethical principles presented in the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*

**Conditions for Approval**
It is the responsibility of the principal investigator to inform the IH Research Office if there are changes to consents or other materials used with human subjects – these must be submitted to the IH Research Office for review and approval prior to implementation.

It is the responsibility of the Principal Investigator to inform the IH Research Office if human subjects experience serious or unexpected events.

**Approval Date**
October 8, 2010

**Approval Term**
1 year

**IH Authorized Signature**

![Signature]

B. Ann Ferguson, Chair, Interior Health Research Ethics Board