

**THE IMPACT OF OVERCROWDING ON THE PRACTICE ENVIRONMENT  
FOR EMERGENCY DEPARTMENT NURSES**

By

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## Abstract

Overcrowding in the Emergency Department (ED) occurs when there is an imbalance between resource supply and demand. In other words, the ED is challenged to provide quality care within acceptable time frames. Overcrowding literature illustrates that ED overcrowding has become so common that it is now considered normal, which begs the question: are terms such as “overcrowded” still pertinent to the current context of the ED environment in which overcrowding is a normal state?

A recent and growing body of Canadian literature describes negative workplace environments in acute care facilities, but there is as yet no literature that examines overcrowding in relation to workplace environments in the ED. This interpretive descriptive study examines the relationship of overcrowding to the practice environment of emergency departments. Data were collected over six months and included in-depth interviews with ten experienced emergency department nurses. These data illustrate the negative impact of overcrowding on the emergency department environment. Emergency department overcrowding has occurred in parallel with fundamental restructuring of the health care system, creating a new era environment. This new environment is characterized by chronic overcrowding and an equally chronic shortage of resources. Within this environment nurses face several new challenges, such as understanding the discourse of overcrowding, reconciling conflicting values, and navigating the cycles of tension that arise from this new situation.

Many of the changes to the ED have resulted from changes imposed elsewhere in the system, such as the closure of acute care beds. EDs are consequently in a state of transition as health care providers attempt to put the pieces back together. Within this

new era environment many challenges have emerged and data analysis suggests that new era EDs support negative workplace environments.

It is crucial that policy makers be well informed when making decisions that impact EDs. In order to be able to influence policy makers it is essential that nurses be proactive and involved in charting the course for the future. It is also necessary for organizations to invest in leadership by creating appropriate positions at appropriate levels so that leaders can be visible and available to create vision and help nurses through the transition to the new era environment. This study argues for the need to create an increased body of research that will inform policy makers about how ED overcrowding negatively affects the practice environment.

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*For my wife Monica and my children Hannah and  
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*For my dad who never gives up and my mom who  
wont let him !*

## CHAPTER ONE

### INTRODUCTION

Overcrowded Emergency Departments (EDs) in British Columbia threaten the quality of practice environments for nurses working in this specialty. Creating and maintaining a positive work environment is pivotal in attracting and retaining qualified professionals to the specialty of emergency nursing. Quality practice environments create and nurture organizational cultures, which attract and retain professional nurses.

According to the Registered Nurses' Association of British Columbia (RNABC) (2002), there are five broad guidelines for creating a quality practice environment: 1) Workload management, i.e. ensuring there are enough nurses to provide safe, competent, ethical care; 2) Nursing leadership, i.e. placing competent and well-prepared nurse leaders at all levels in the organization; 3) Control over practice, i.e. giving nurses responsibility, authority, and accountability for nursing practice; 4) Professional development, i.e. ensuring that the organization supports and encourages a lifelong learning philosophy and promotes a learning environment; and 5) Organizational support: ensuring that the organization's mission, values, policies, and practices support and value nurses and the delivery of safe and appropriate nursing care.

A decade of restructuring has hampered the health care system's ability to attend to these guidelines. Health care restructuring has principally focused on fiscal responsibility and balanced budgets. While both of these goals are linked to the overall accountability of the health care system, some of the strategies enacted to achieve them have had deleterious effects in acute care settings. According to Greenglass & Burke

(2001), hospital restructuring in general is associated with stressful changes such as deterioration of facilities, bed closures, layoffs, bumping (where one nurse replaces another due to greater seniority), and use of unlicensed health care personnel in place of trained nurses. Moreover, specific restructuring strategies have had a negative impact on practice environments. In acute care hospitals, staff reductions and fewer acute care beds have resulted in congested and gridlocked EDs across British Columbia and Canada. Ieraci (2002) states that overcrowding is predominantly due to inpatient bed access block. Consequently, the pressure of emergency department overcrowding has become the single most influential factor preventing EDs from developing and maintaining quality practice environments.

Overcrowding is a situation “in which the demand for emergency services exceeds the ability of a department to provide quality care within acceptable time frames” (CAEP & NENA, 2003). ED overcrowding has a significant impact on the practice environment for nurses working in the emergency specialty. Stephens (2000) describes full rooms, occupied gurneys in every hallway, interminable waits at every step of a patient’s visit, extensive lengths of stay, a high rate of patients leaving without being seen, and staff members stretched to their limits. This kind of overcrowding is a workplace reality for ED nurses across British Columbia, making it difficult for them to provide the quality of care that meets the standards of emergency nursing in Canada..

#### Background to the Problem

In January of 2003 I worked a day shift and was in charge of a large emergency department in a busy urban hospital. On one decidedly chaotic day, the department became completely grid locked. Twenty-two admitted patients were waiting for inpatient

beds, the resuscitation room housed an intubated patient waiting for the Intensive Care Unit, and two patients were experiencing myocardial infarctions (MIs). Eleven patients packed the waiting room and were growing increasingly impatient with long waiting times; 4 of the 11 were experiencing cardiac-type chest pain, potentially having heart attacks, in the waiting room!

I became acutely aware that this scenario was adversely affecting the ED environment. In particular, the discord experienced by the ED nurses as a result of these circumstances became very obvious, as emergency nurses were faced with balancing the care of admitted patients with that of new patients arriving in the ED. Suddenly the department felt like an island, with the staff isolated and with no resources except ourselves. Although everyone rose to the challenge and did what was necessary, feelings of anger, frustration, and disappointment were clearly evident. The once relaxed and friendly atmosphere of the department became instead cold and unfriendly. I observed nurses engaged in emotional debates with other nurses, physicians, patients, and families. The activity level within the department rose and the normally controlled chaos changed into something that felt out of control. Under the extreme pressure of overcrowding, the highly effective emergency team broke apart and individual agendas replaced common goals.

Reflecting on this experience forced me to think about how overcrowding affects nurses and their ability to care for patients. Overcrowding creates a vicious cycle of negative energy within the emergency department. Nurses are forced to balance caring for admitted patients with caring for new patients arriving in the ED and this balancing act inevitably creates conflict.

Several of the staff working on this day commented: "If I wanted to work on a ward, I would." Emergency nurses work in this specialty for an array of reasons, including the wide variety of patients, quick turnover, and rapid pace. Overcrowding causes frustration because as throughput is blocked, the ED becomes just another inpatient unit, however unlike other inpatient units patients keep arriving. New patients keep arriving, experiencing waiting times far beyond those recognized as acceptable by national guidelines. The nurses working on this January day were profoundly frustrated by their inability to get to the potential MI's in the waiting room, as routine care for admitted medical and surgical patients impeded their ability to deliver care to arriving emergency patients.

Further reflection pushed me to consider this phenomenon in relation to the organizational culture of EDs and the recent restructuring of health care in Canada. Over the past ten years it has become increasingly difficult to transfer patients to inpatient units once they are admitted via the ED. There has been an unprecedented closure of inpatient beds, which results in patients waiting for days to be transferred to inpatient units. Increasingly, patients are being discharged directly from the ED following an entire hospitalization in this environment.

I realized that this complex and dangerous situation can only worsen if issues are not addressed, and strategies are not implemented to improve practice environments in EDs. Nurses with specialized knowledge and skills who are not satisfied with their work environments may leave in search of happier workplaces, and, of course, losing specialist ED nurses will only make the problem even worse.

This research project has evolved directly from my involvement with providing

emergency nursing care in British Columbia, as staff nurse, ED manager, and educator. I have also been involved with The Emergency Nurses Group of British Columbia as their president, and have heard repeatedly how overcrowding has profoundly and consistently affected practice environments across the spectrum of EDs in BC and across Canada. Through this research I hope to expand our knowledge about how overcrowding impacts the practice environment. I also hope to be able to use this knowledge to influence hospital administrators, planners, and policy makers to make decisions and implement strategies to address the issue of overcrowding in emergency departments.

#### Research Problem

Health care restructuring over the past decade has resulted in increased overcrowding in emergency departments, creating environments in which it is increasingly difficult for registered ED nurses to practice their particular skills. While there is an abundance of literature on ED overcrowding, workplace environments, and quality practice environments, there is little information on how these three phenomena are viewed by ED nurses. Within the current context of health care it is crucial to inform the efforts of administrators and policy makers.

In this research project I will explore ED nurses' perceptions about how overcrowding impacts the ED practice environment and nursing care. My intent is to discover and describe ED nurses' experiences by listening to their stories. By contextualising and analyzing these stories I hope to illustrate and articulate the significant impact of overcrowding on the ED practice environment.

#### Purpose of the Study

The purpose of this interpretive descriptive narrative study is: (1) to explore how

nurses describe experiences of overcrowding and their impact on the practice environment, (2) to examine how nurses' ability to provide patient care is affected by overcrowding, and (3) to understand nurses' experiences of working in overcrowded EDs.

### Research Questions

In this project I will explore three questions from the perspective of nurses working in emergency departments:

1. How is the emergency environment affected by overcrowding?
2. How does overcrowding influence emergency nursing practice?
3. What are the experiences of emergency department nurses when overcrowding occurs?

## CHAPTER TWO

### LITERATURE REVIEW

In this chapter I explore relevant literature in order to position this project within existing knowledge. In the tradition of an interpretive descriptive analytic framework, this project will be located within existing knowledge so that “findings can be constructed on the basis of thoughtful linkages to the work of others in the field” (Thorne, Reimer Kirkham, & Macdonald-Emes, 1997).

Emergency department overcrowding, nurses’ workplace environments, and quality practice environments are topics which are well-described in the literature. However, there are significant differences in how these concepts are presented. Overcrowding is generally described anecdotally or in discussion papers and position statements, and literature exists which describes overcrowding from a hospital utilization perspective. There are only a few scientific studies which address focused aspects of overcrowding such as cause and effects of overcrowding. Work environments and quality practice environments are examined in both opinion articles and numerous research projects. However, to date I have not identified any research examining these three phenomena from the specific perspective of ED nurses.

In this literature review I will argue that emergency department overcrowding impacts the practice environment of registered nurses working in this specialty. Furthermore, I will demonstrate that, to date, the specific impact of overcrowding on the ED practice environment has not been properly examined.

Using the EBSCO host search engine, the following databases were searched:

CINHL, Medline, Health Consumer (professional), and ERIC. Searches were completed systematically using combinations of search terms such as “Emergency Department,” “Emergency Environment,” “Emergency Nursing,” “Emergency Department Overcrowding,” “Canadian Health Care and Restructuring,” “Practice Environment,” “Positive Practice Environment,” “Work Environment,” “Interpretive Description,” “Narrative Inquiry,” and “Qualitative” and “Quantitative” “Nursing Research.” Searches were completed using the names of leading Canadian authors who have studied nurses’ workplace issues, including Heather Laschinger, Judith Shamian, Colleen Varcoe, Paddy Rodney, and Sonia Acorn. Additional searches were completed using the names of authors considered expert in qualitative methods, including Margaret Sandelowski and Sally Thorne.

In the first part of this literature review I will explore the typical emergency department environment commonly described in the literature. The characteristics of the emergency environment that attract nurses to work in this specialty are particularly relevant to my discussion. While the emergency environment is described in a few sources, these descriptions are opinion-based; there is no research-based literature in which the emergency nurse’s experience is described in the context of the contemporary system. In order to describe the contemporary acute care setting, I will discuss the recent literature that examines acute care workplace environments. Secondly, I will examine the recent restructuring of the Canadian health care system that provides the context for this study, and discuss the social and political influences on this process. Thirdly, I will illustrate how health care restructuring has impacted emergency department overcrowding. In the fourth section I include a discussion about literature describing

positive practice environments in order to establish an understanding of what constitutes a healthy workplace environment. Finally, I summarise the current state of knowledge and identify existing gaps.

### The Emergency Environment

The emergency department is frequently a fast-paced environment with a lot of noise and activity. This environment is sometimes referred to as one of “controlled chaos.” Traditionally emergency departments have functioned as rapid assessment units. Patients were assessed; initial treatment was begun, and patients were quickly transferred to appropriate inpatient units. Nurses working in EDs are attracted to this area for several reasons. As described by Fitzpatrick (2000), in the ED the pace is fast, there is a constant throughput of patients, and patient care is acute, episodic, physical, and/or psychological in nature. The variety of patients is endless, and emergency nurses have the opportunity to work with a wide spectrum of patients. Harlow (2001) states: “Part of the attraction, in what many consider to be a high stress area of nursing, is the challenge of knowing that no two days are going to be the same” (21). In the descriptive literature there is a lack of systematic, research-based evidence describing this environment, and no analysis of what draws individuals to work in this environment. The existing literature is editorial and anecdotal in nature. To gain insights into nurses’ experiences of working in acute care environments I turned to the growing body of research that describes hospital nurses’ experiences of working in the context of the current Canadian health care system. Although it is not specific to the ED, this work highlights many of the variables which impact ED specialty practice.

### Health Care Restructuring

The evolution of overcrowding has occurred within the context of the turbulent health care environment over the past fifteen years. According to Schull, Szalai, Schwartz, and Redelmeier (2001), reports of overcrowding have coincided with the restructuring of hospitals and health services due to financial cutbacks and efforts to modernize health care delivery. The results of Schull et al.'s study clearly illustrate that ED overcrowding was infrequent and stable prior to hospital restructuring, and that the phenomenon began to increase substantially during restructuring.

Health care in Canada has changed dramatically over the past 30 years. In the 1960s the Canadian health care system was established, combining American and British principles and "putting in place the major social and security programs necessary for a modern industrial nation" (Hibbard, Slovic, & Jewett, 1997, p.11). With the commitment of governments to social programming came commitment to the financial cost. In 1984 the Canada Health Act was passed by the Federal Government in an attempt to protect the five principles of the system: accessibility, universality, comprehensiveness, portability, and non – profit administration. Throughout the 1980s and 1990s health care costs rose at unprecedented rates. According to Health Canada (2000), health expenditures rose from \$911 per person in 1980 to \$2200 per person in 1990. This rapid rise in cost resulted in simultaneous efforts to control spending leading too dramatic health care reforms during the 1990s. According to Shamian, Kerr, Laschinger, and Thomson (2002), during the 1990s the Canadian Health care system underwent major reform. The main elements of the reform were downsizing of inpatient capacity in the hospital sector, reduced funding of the health care system, and regionalization of 9 of the

10 provinces; at the level of acute care health services, many hospitals underwent significant budget reductions.

The reduction of budgets forced policy makers to implement strategies that addressed financial shortcomings. According to Tourangeau, Giovanetti, Tu, and Wood (2002), health care leaders searched for strategies to decrease total hospital spending. Nursing services, as the single largest hospital operating expense, became a vulnerable target. In order to reduce deficits and balance budgets governments employed strategies that directly affected nursing delivery.

The single greatest factor associated with restructuring has been the closure of acute care beds. Hospital bed shortages have been a direct result of restructuring and regionalization, which peaked in the late 1990s. Fiscal restraint and balanced budgets have led to bed closures across Canada: "In Ontario alone there was a 22% decrease in acute care beds and a jump in occupancy from 85.6% in 1994/95 to 93% in 1999/2000" (OHA, 2000, p. 5). This reduction in the number of acute care beds has had a direct and lasting impact on ED overcrowding. Patients wait for long periods of time for inpatient beds, occupying emergency stretchers and blocking access to those stretchers for new patients arriving in the ED. According to Espinosa, Miro, Sanchez, Coll-Vincent, and Milla (2002), overcrowding of emergency departments is a major problem in hospitals.

#### Corporatization of Health Care

The restructuring of Canadian health care and consequent ED overcrowding have occurred in the context of globalization. According to Axworthy (2002), globalization is the worldwide trend towards greater interconnectedness in economic, technological, demographic, and cultural domains. Navarro (1999) states that there is nothing

intrinsically good or bad in the flow of capital, labor, and knowledge around the world. However, interconnectedness has put a new pressure on governments to be competitive within a global market, and in order to achieve a competitive edge, government policies have become underpinned by neo-liberal, market-oriented philosophies resulting in the corporatization of health care. These philosophies underpin policies established to create profit and success in the global market and thereby address the challenges of immense expenditures of the 1990s. Health care has experienced the emergence of stronger and stronger efficiency discourses as government and health authorities react to the increased pressure to balance budgets. Government and health authorities in British Columbia have responded to these pressures by implementing strategies directly related to these philosophies, such as the recent move to privatize many hospital services in the public system. Thus, emergency departments now exist in a context of market-driven ideals: "Neo-liberals generally view anything in the public sphere as something which would benefit from privatization" (Coburn, 2000, p. 141). The question remains, however: are decisions based on a market ideology really in the best interest of patient care?

Market -driven political ideology has profoundly influenced health care in British Columbia. According to Varcoe and Rodney (2002) although the espoused intent of the health care reforms occurring in Canada and other Western countries is to improve the quality and accessibility of health care, the implementation of these reforms is fueled by a powerful and covert corporate ideology. In other words, health care restructuring is driven by the underlying pressure to balance budgets, thus serving the interests of governments and political leaders. Ultimately, in BC and throughout Canada, this has been illustrated by restructuring of health regions, closure of hospital beds, consolidation

of services, and, as previously stated, privatization of services. Varcoe and Rodney suggest that the implementation of this approach to save money has resulted in a mechanistic, reductionist approach to health services that threaten the Canadian commitment to universal and equitable health care. For emergency departments this reductionist approach has resulted in overcrowding.

#### Overcrowding

The impact of overcrowding subsequent to restructuring has been immense. According to the joint position statement released by the Canadian Association of Emergency Physicians (CAEP) and the National Emergency Nurses' Affiliation (NENA) (2003), overcrowding has far-reaching effects. Inadequate patient care inevitably results from a mismatch between patient needs and the availability of ED resources to meet these needs. Emergency departments are staffed to provide emergency care, not comprehensive inpatient care. When overcrowding occurs, not only are there prolonged delays in the treatment of pain and suffering as patients wait in crowded public waiting rooms for an appropriate space in which to be assessed and treated, but as patients experience long and uncomfortable waiting times, their level of satisfaction naturally declines. This decline sets the stage for strained relations between patients and health care providers and ultimately results in both losing confidence in the system as a whole. The effects of overcrowding extend beyond the ED: emergency paramedics and ambulance personnel are also adversely affected by long waiting times offloading patients and by the process of being diverted from one hospital to another.

The effects of overcrowding are consistently observed throughout the literature. Fatovich (2002, p.5) identifies effects similar to those noted above, and goes on to

describe decreased clinical productivity and effectiveness, violence, and medico-legal consequences related to overcrowding. McCabe (2001) states that emergency department overcrowding has a negative impact on the emergency department's nurses and physicians, such as increased stress and frustration. Espinosa et al. (2002) describe the consequences of overcrowding in terms of decreased patient satisfaction, and increased risk of medical mistakes. According to Kollek (2002), overcrowding is one of the causes of inadequate patient care, prolonged delays in the treatment of pain, and ambulance diversions. In essence, the literature outlines increased stress and pressure on the environment in the ED. In an environment where controlled chaos is the norm, overcrowding has a particularly negative impact. Emergency nurses are faced with an increased workload and the daunting task of balancing a huge demand with limited supply.

The concept of overcrowding is complex. Overcrowding has been evident in literature since the early 1980s. McCabe (2001) notes that overcrowding of our nation's emergency departments, an intermittent, geographically isolated phenomenon in the 1980s, has re-emerged as a widespread, chronic, and debilitating situation today. Numerous criteria have been used to establish definitions of overcrowding, including initiating ambulance diversion, patient waiting times, exit block, access block (gridlock), and inadequate resource allocation. According to CAEP and NENA (2003), emergency department overcrowding is best defined as a situation in which the demand for emergency services exceeds the ability of a department to provide care within acceptable timeframes. Emergency department overcrowding therefore interferes with patients receiving timely and appropriate care. Schneider (2001) describes the effects of overcrowding as follows:

“patients in the hallways, full occupancy of ED beds, and long patient waits occurring several times a week or even daily”(p.1045). As noted, this phenomenon has become increasingly prevalent since the 1980s, and several principal causative factors for this increase appear consistently in the descriptive literature on overcrowding. According to Drummond (2002), ED overcrowding occurs primarily because patients are increasingly aged, complex, and acute; in other words, an aging population is now presenting with more chronic (and worsening) conditions, which require more frequent ED visits. There is also an increased demand for diagnostics such as lab tests and medical imaging such as CTs, which increase length of stay in EDs as patients wait for these tests. Over all there has been an increase in the number of patients seen by emergency departments; emergency departments are frequently major access points to the health care system, serving as safety nets. In Canada there has been a rise in the rate of infectious diseases, and patients experience complications from these diseases that require ED visits. Patients often wait for specific inpatient placement, as many infectious diseases such as MRSA and VRE require special inpatient placements to avoid spread. Increased substance use in Canada has created increased complications such as overdose and infection, which in turn result in increased ED visits. As a result of health care restructuring, many psychiatric facilities have been closed, leaving increased numbers of patients in the community with inadequate supports. Ultimately, these patients arrive at the ED for varying reasons related to exacerbations and associated issues related to their illness. According to CAEP and NENA (2003) another significant cause of overcrowding is alternative level-of-care patients. These are patients who require chronic complex care, respite, and palliative care. While these patients do not require specialized, high-level acute care services, they do

require services that prohibit their discharge home or into the community. Therefore, there is no choice but to keep them in hospital, thus blocking the flow of new patients into the emergency department. Another factor that contributes to ED overcrowding is lower socioeconomic status, which generally results in lower levels of health and decreased access to primary health care services.

The factors influencing the increase in ED overcrowding are complex and inter related. ED overcrowding occurs as the symptom of an over-taxed system: "When the health care system sneezes, the emergency department gets pneumonia" (Wilson, 2001). ED overcrowding has increased as a result of health care systems undergoing constant changes and repeated unrest. According to Fatovich (2002), health care in Western societies has been through a period of severe economic rationalization, resulting in the closure of thousands of beds in the acute care system. When access to acute care beds is reduced by such closures, EDs become congested with patients who are admitted with nowhere else to go.

### Nursing Workplace Environments

#### Impact of Restructuring on Nursing

Over the past decade, health care restructuring and subsequent overcrowding have dramatically changed the nursing workplace environment. As Baker, Beglinger, King, Salyards, and Thompson (2000) attest, today's health care delivery environment is turbulent and marked by an unprecedented pace of evolution in both the expectations of, and demands on, the health care system. Dramatic changes to the system have created significant changes in practice environments. Aiken, Clarke, and Sloane (2000) reported serious erosion in the nursing practice environment over time. In the period from 1986 to

1998, results illustrate a decline in resource adequacy, nurse manager support, and status of nursing, resulting in the erosion of acute care practice environments. Shamian et al. (2002) state that nurses have recently experienced lay-offs in unprecedented numbers. Many nursing departments have been dismantled and their nursing leaders absorbed into general health service administration, as organizations attempt to control the rapid rise in the cost of delivering health care. These strategies, while intended to improve efficiency and responsibility, have actually resulted in difficult working conditions in acute care settings (Acorn, Baxter, & Walker, 1999; Baumann et al., 2001; Laschinger, Almost, & Tuer-Hodes, 2003; Rodney & Varcoe, 2001; Shamian et al., 2002).

#### Nursing Leadership

Restructuring of the health care system has significantly impacted nursing leadership in Canada. According to Meilicke (1999), many variables contributed to the targeting of nursing during restructuring: nursing's lack of objective policy or data to support priorities, nursing's lack of sufficient political power, and a split occurring between nursing management and unions. According to Meilicke, in this context senior management frequently took direct control of nursing and persons who were not nurses controlled nursing at a senior level. A major decentralization of responsibility to the level of staff nurses ensued. Many middle-management and support-staff positions were abandoned and nurses were not only left unrepresented at a senior level but also unsupported at the level of patient care. Subsequent to restructuring, decentralization has left nurses without adequate leadership, especially at the level of direct patient care.

#### Impact of Restructuring on Workplace Environment

While I found no literature that specifically discusses emergency workplace

environments, there is a growing body of Canadian literature describing current workplace environments in acute care settings. Given that EDs are generally located in acute care hospitals, I have drawn on this literature to provide a context for this study. Nurses in acute care environments are now caring for ever greater numbers of ever sicker patients, working extended shifts and increased overtime hours, often working short-staffed, and being held accountable for the work of unlicensed personnel and nurses working outside of their practice scope. Shamian et al. (2002) found that full-time work was associated with burnout, poor general health, and loss of control over practice. Nurses across Canada report working conditions that are not conducive to job retention, job satisfaction, or good health. Currently, the Canadian literature illustrates that practice environments in many acute care facilities in Canada are undesirable work settings. According to Rodney and Varcoe (2001), this new but growing body of research warns that the past decade of health care reform has been one of profound deterioration in the conditions of nurses' work, with increasingly deleterious effects on health care delivery.

Health care reform resulting in reduction of staff and closure of nursing units in acute care hospitals has directly impacted emergency departments (Derlet & Richards, 2002; McCabe, 2001; Schneider et al., 2001; Eastaugh, 2002; CAEP & NENA, 2003). Emergency patients who *are* admitted inevitably spend long periods of time waiting to be transferred to inpatient units because there are no beds available and/or no staff available to care for them. Subsequently patients arriving to the ED face increased waiting times as all emergency stretchers are filled with admitted patients. Emergency nurses are faced with balancing the needs of large numbers of very ill patients with sparse resources, resulting in stressful and potentially unhappy work environments.

## Creating Positive Practice Environments

The importance of positive and supportive environments for nurses to practice in is well known. In the 1980s, during a major nursing shortage in the UNITED STATES, the American Academy of Nurses commissioned a study to investigate the characteristics of systems that impeded or facilitated professional nursing practice in organizations. The authors of the study, published by McClure et al. (1983), identified “magnet” hospitals as those that could consistently attract and retain qualified staff. The characteristics of magnet hospitals were grouped into 3 main categories: Administration, Professional Practice, and Professional Development. Moreover, it was noted that excellence in these categories fostered positive practice environments for nurses. Since then, the same concepts have consistently reappeared in the literature. Aiken (1994), Buchan (1999), Kramer (1991), and Upenieks (2003) have all built on the original magnet hospital research. Intense focus on “magnet” concepts is simple logic. These concepts illustrate the importance of a positive practice environment, and have remained consistent over time. They continue to be key principles guiding organizational policies related to recruitment and retention: “Organizations that do not create quality environments to attract new recruits and retain experienced nurses risk staff shortages that may endanger patients” (Baumann, 2001). What, then, are the specific characteristics of positive practice environments for registered nurses?

According to the 2002 Report of the Canadian Nurses Advisory Committee (CNAC), the factors influencing job satisfaction and retention have been studied intensely and repeatedly over the past 20 years. Villeneuve, Semogas, Perreboom, Irvine, McGillis, Walsh, O’Brien Pallas, and Baumann (1995) state that the leading workplace

concerns in their study of 300 Registered Nurses in Ontario were: job security, workload, inadequate staffing, personal safety, and concerns about quality care. In a 1994 study, O'Brien- Pallas, Baumann, and Villeneuve listed the factors related to nursing job satisfaction as follows: Nurses are generally happier when their personality and skills match their job and clinical area; nurses need feedback, praise, and learning opportunities at all stages of their career; many workplace concerns disappear when nurses are provided with the proper supplies and equipment to complete their work; and nurses place high value on direct nursing care and are frustrated with the pervasiveness of non-nursing tasks.

In Canada several initiatives have evolved to examine practice environments for registered nurses. In 2002 The CNAC report was published to support the implementation of a national nursing strategy, whose focus has been the improvement of nurses' working lives. In 2001 the Canadian Nurses Association published a position statement entitled "Quality Professional Practice Environments for Registered Nurses." In 2002 The Registered Nurses Association of British Columbia published guidelines for a quality practice environment. While there is clearly information available on healthy and positive work environments, at the time of this project, I have been unable to find any specific literature that describes the specific attributes of a positive work environment for emergency nurses. The current literature is vague in describing how and by whom such environments should be created. Furthermore, while guidelines and position statements are excellent resources, no mechanism exists to ensure that organizations implement and abide by their principles. Although guidelines that describe the characteristics of quality/positive practice environments exist, there is no clear direction about who is

responsible for creating and maintaining these environments.

### Summary of the State of Knowledge

There are anecdotal and opinion pieces in the literature that describe the emergency department environment from the perspective of nurses who work in this specialty. However, to date I have been unable to find any research-based literature that examines the ED environment itself, specifically illustrates the work environment of the ED, or notes the characteristics that attract nurses to work in this environment. There is a current body of research-based literature that examines acute care workplace environments (Aiken et al., 2000; Baker et al., 2000; Kreitzer et al., 1997; Laschinger, Finegan, Shamian, & Caster, 2000; Shamian et al., 2002; Tourangeau et al., 2002). This body of literature is scientific and describes the variables and characteristics of current workplace environments in acute care settings. Although it is not specific to EDs, it illustrates the challenges of acute care settings within the contemporary health care system. Thus the review of the literature points to a gap in research-based knowledge about emergency department environments. With no research available to illustrate the impact of health care restructuring on this specialty area of nursing practice, there is no information to inform individuals currently involved in influencing policies that could impact the ED practice environment. It is clearly important that this situation be remedied.

Overcrowding is well documented in the literature, and several research studies have described the causes and effects of this phenomenon. However, although the literature is consistent and clearly defines this concept, there is no research - based literature that specifically examines the impact of overcrowding on professional nursing

practice. It is crucial to produce information illustrating how overcrowding specifically impacts this practice in either positive or negative ways. It is only after these impacts have been identified that policy makers will be able to develop strategies to address them.

Health care environments are extensively studied and described in the literature; there is clear documentation of the system's evolution and subsequent effects. There is a clear body of research literature that describes and outlines the effects of fiscal restraint and restructuring on emergency department overcrowding. Current Canadian research conceptually locates ED overcrowding within the context of acute care work environments. This current body of literature illustrates the position of ED overcrowding within the current health care context.

The concept of the practice environment is well described in the literature. However, information is general and drawn from research performed in locations outside of emergency departments. I have been unable to find any literature specific to emergency department practice environments.

Several gaps have emerged subsequent to my literature review. First, there is no research-based literature to describe the characteristics of a positive practice environment in the ED. Second, there is no research exploring how health care restructuring has specifically impacted ED nursing practice. Third, at the time of this project I am unable to find any literature that specifically describes the impact of ED overcrowding on the practice environment in EDs.

I believe that this project provides a starting point for addressing these gaps. Furthermore, I hope that this project will provide data that will inform the efforts of health care administrators and policy makers in developing and implementing strategies

related to maintaining an efficient and sustainable ED. The problem addressed in this study is therefore significant to the health care system: "At such a time, the maintenance of a healthy work environment assumes paramount importance in the life of an organization" (Baker et al., 2000, p.357).

## CHAPTER THREE

### METHODOLOGY AND METHODS

My goal in this research is to develop knowledge based on emergency nurses' stories about working in overcrowded environments. My intentions in seeking the perspectives of these nurses are threefold. First, my goal is to understand how emergency nurses experience overcrowding as it occurs when they are working in the ED. Secondly, I aim to explore how ED nurses describe the influence of overcrowding on their practice environment. Finally, I aim to extend my understanding of how emergency nurses experience their work in overcrowded environments. These objectives have influenced the selection of the methods that will guide this project.

#### Theoretical Perspective Informing the Study

#### Interpretive Description and Narrative Inquiry

Morse and Field (1995) describe qualitative inquiry as research that provides the reader with understanding and enables others to make sense of reality. Interpretive description is one type of qualitative inquiry and the approach I used for this study. This method allowed me to locate my study within existing knowledge. According to Thorne et al. (1997), interpretive description should be located within the existing knowledge so that findings can be constructed on the basis of thoughtful linkages to the work of others in the field. Using this approach I was able to position this study within what is already known about overcrowding and workplace environments, making it possible to link both of these concepts specifically to the ED. This approach was a good fit for this study as the goals of the study were to identify nurses' subjective experiences of overcrowding.

According to Thorne, Reimer Kirkham, and O'Flynn-Magee (2004), the foundation of interpretive description is the smaller-scale qualitative investigation of a clinical phenomenon of interest to the discipline for the purpose of capturing themes and patterns within subjective perceptions and generating an interpretive description capable of informing clinical understanding. In addition to interpretive description I also drew on the tradition of narrative inquiry.

Storytelling is a mechanism that allows individuals to communicate their reality to others. Narrative inquiry is a qualitative method in which the researcher listens to an individual's story and identifies predominant themes. According to Sandelowski (1991), by using narrative models researchers can gain insights into the way human beings understand and enact their lives through stories. In this study I elicited an in-depth understanding of the impact of ED overcrowding on the practice environment for registered nurses working in this specialty. Using interpretive description and drawing one narrative inquiry, I was able to elicit responses from participants by asking informed questions. I was then able to reflect upon and critically analyze nurses' stories to generate an interpretive account of the data I collected, as reflected in the study findings.

#### Sample Selection

The data from this study was gathered using purposeful sampling. Purposeful sampling is a strategy that targets a specific group. The researcher selects a sample with an underlying purpose. Moreover, subjects are selected based on the variables the researcher is studying. A total of ten participants were enrolled in this study and engaged in open-ended, in-depth interviews. Participants were all emergency department nurses with a minimum of two years' full time experience. Two years seemed an appropriate

minimum to ensure that participants were competent practitioners, well informed about ED culture. Furthermore, this timeline is congruent with the work of Benner (1982) on the transition from being a novice nurse to an expert nurse, which suggests that, after two years, a nurse is considered competent in her practice according to her work.

Additionally, in keeping with interpretive descriptive principles, using this criterion helped to create a sample from a population with predictable variation. Recruitment of participants was performed through a call for volunteers from the Emergency Nurses Professional Practice Group via the Registered Nurses Association of British Columbia (RNABC). The RNABC consented to letters of invitation being sent out by the researcher to the Emergency Nurses' Group of British Columbia (ENGBC) members residing in the Lower Mainland area of British Columbia (see Appendix A & B). Individuals join this group on a voluntary basis and are generally nurses interested in professional practice issues associated with emergency nursing. In addition, the ENGBC executive consented to the procedure with written approval.

In small-scale qualitative studies like this one, sampling usually consists of 10 to 15 individuals from the population (Thorne et al, 2004, p.5). Using an interpretive descriptive approach, data collection and analysis proceeded simultaneously until saturation was reached. Data saturation occurred when themes began to repeat and no further new information was being collected. Sandelowski (1995) states that sample size in qualitative study is relative, often dependent on the quality of the interviews.

#### Recruitment of Participants

A purposive sample was used for this research project. Due to the highly specific population of informants required, I purposefully sampled participants who (a) resided in

the Lower Mainland area of British Columbia, and (b) were experienced emergency nurses with at least two years of full time emergency nursing experience. I relied on volunteers responding to a mailout through the ENGBC. Sixteen nurses responded and I interviewed ten. Selection of participants was based on order of response and availability for an interview. I communicated by telephone with all the nurses who contacted me. Those who responded but were not interviewed were informed that I had completed my data collection and thanked for their time and interest in my project.

#### Procedure for Approaching Participants

Recruitment for this project started by sending a message out to members of the Emergency Nurses Group of British Columbia who live in the lower mainland (see Appendices A and B). The letter was sent through a third party, the communications officer for ENGBC. Interested individuals were asked to contact me directly at which time I set up an interview at a mutually agreeable location and time. Upon meeting for the interview, I obtained informed consent prior to the start of the session.

#### Procedure for Informing Participants

At the initial interview, the research project was discussed, participants were given the opportunity to ask questions or raise concerns, which were then discussed. Once the participant and I were comfortable proceeding, written consent was obtained (Appendix C). Consent emphasized the voluntary nature of participation, the participant's right to withdraw at any time, and my commitment to maintain confidentiality.

Table 1

*Characteristics of the Interview Sample*

<i>PARTICIPANT</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>	<i>6</i>	<i>7</i>	<i>8</i>	<i>9</i>	<i>10</i>	<i>MEAN</i>
<i>SEX</i>	<i>F</i>	<i>F</i>									
<i>AGE IN YEARS</i>	<i>39</i>	<i>39</i>	<i>52</i>	<i>43</i>	<i>38</i>	<i>40</i>	<i>43</i>	<i>31</i>	<i>41</i>	<i>30</i>	<i>39.6</i> <i>YEARS</i>
<i>TOTAL YEARS IN NURSING</i>	<i>19</i>	<i>12</i>	<i>31</i>	<i>16</i>	<i>14</i>	<i>20</i>	<i>22</i>	<i>10</i>	<i>18</i>	<i>9</i>	<i>17.1</i> <i>YEARS</i>
<i>YEARS IN ED NURSING</i>	<i>15</i>	<i>7</i>	<i>17</i>	<i>14</i>	<i>10</i>	<i>15</i>	<i>18</i>	<i>6</i>	<i>15</i>	<i>4.5</i>	<i>12</i> <i>YEARS</i>
<i>YEARS IN CURRENT POSITION</i>	<i>12</i>	<i>7</i>	<i>17</i>	<i>14</i>	<i>10</i>	<i>14</i>	<i>6</i>	<i>6</i>	<i>5</i>	<i>4.5</i>	<i>9.5</i> <i>YEARS</i>

I interviewed ten nurses for this project, all of whom were members of the Emergency Nurses' Group of British Columbia (ENGBC) professional practice group. Participants were all female, ranging in age from 30 to 52 years old, with an average age of 39.6 years. Nurses in this sample had between 9 and 31 years of total nursing experience, with an average of 17.1 years. The total years of emergency experience varied from 4.5 to 18 years, with an average of 12 years. At the time of interview all of the nurses were employed in Emergency departments in the lower mainland of British Columbia. The average length of time these nurses had been in their positions was 9.5 years. Based on this demographic information, for the purpose of this manuscript I will

refer to nurses from this cohort as experienced nurses. I am defining an experienced emergency nurse as an individual with a minimum of 4.5 years of current ED nursing experience.

### Ethical Considerations

Prior to beginning this research project, approval for research with human subjects was obtained from the University of British Columbia's Behavioral Research Ethics Board.

### Confidentiality

In order to maintain confidentiality, this thesis will adhere to the following guidelines:

1. Participants are not referred to by name: Participants chose a code name prior to beginning the interview, which was used to track them.
2. Interviews were transcribed omitting references to specific people or places. Where a participant mentioned either, the transcriptionist removed the specific from the manuscript.
3. Tapes were not shared with anyone except the transcriber.
4. Tapes and transcripts are stored in separate, locked locations. They will be kept for a period of 5 years, after which transcripts will be shredded.
5. Tapes will be erased and destroyed at the end of this project's 5-year storage period.
6. Interviews or any other data will not be shared with hospital administrators or employers.

## Data Collection

### Data Sources

The primary sources of data for this study are the interviews with research participants and field notes.

### The Interview Process

The interviews for this research project were initiated and guided by open-ended trigger questions. The following questions were used:

1. Tell me about the emergency department when there is no overcrowding.
2. What attracted you to work in the emergency department?
3. Can you tell me how the emergency environment is affected by overcrowding?
4. Tell me about working in an overcrowded environment. What is your experience?
5. Would you like a summary of my thesis findings?

Open-ended questions acted as prompts to stimulate responses; the open-ended nature of questions gave informants the freedom to adequately respond. Trigger questions ensured that all of the topics being explored were covered. Additionally, I used probing questions to explore concepts and themes, and to clarify what respondents were saying. In the tradition of interpretive description I frequently asked questions based on hunches from previous interviews. In this way I was able to explore specific concepts and ideas. Furthermore, I frequently asked for examples of concepts to allow respondents to tell their stories about how they experienced specific phenomena. At the end of each interview I completed a field note which included the following: (a) observational notes on what happened during the interview, and on the interview environment; (b) methodological notes that discussed reflexivity and the ways in which I might have

affected the interview; and (c) theoretical notes that linked what I heard in the interview to the existing literature, when possible.

### Data Analysis

I approached the data from a critical, analytical perspective. Consistent with interpretive description, data collection and analysis occurred simultaneously. I approached the data from a critical perspective to ensure that my biases were accounted for in my findings. For example, there may be inherent biases related to the discipline of nursing. As a registered nurse practicing in the ED I had to ensure that a consistent reflexive process was in place in order to support critical analysis. Through this critical analysis I was able to account for and challenge the biases I brought to this project. I attempted to be very conscious of identifying pre-conceived or pre-determined ideas of my own when immersing myself in the data. I constantly asked myself if my reflections illustrated what the data was saying or what I was saying. Maintaining an awareness of my own assumptions and beliefs, making reflexive notes on the transcripts, and discussing the research with my committee were the primary methods I employed to attempt to support a reflexive analysis of the data. This process allowed me to account for and challenge my interpretations of the data.

The stories that the participants provided lent themselves well to interpretive descriptive work. According to Sandelowski (1995), data analysis can be triggered by data preparation and can be said to formally begin after transcripts are accepted as the raw data that will be analyzed. Therefore, I began my data analysis by proofing the transcripts and developing an understanding of each transcript as a whole. I attempted to read the manuscripts several times to avoid applying premature codes or limiting my

analysis. As Sandelowski suggests, I read each transcript several times in order to “apprehend its essential features, without feeling pressured to move forward analytically” (p.373). My goal at this early stage of analysis was to understand the interview as a whole and to separate key storylines. Additionally, particular characteristics of each transcript were noted, including unfinished thoughts, contradictions, and any unusual features. At the end of each transcript I identified the foci of the contents, the concepts reflected in the data, and/or major themes.

According to Sandelowski (1995), after getting a sense of the whole, a more disciplined approach is warranted, one that is systematically and consistently applied. Sandelowski suggests that one such method is to designate with the simplest wording possible the topical area being discussed. I used this method to analyze my data: after identifying key themes I assigned each a simple title and completed a title list that formed a preliminary list of codes. Once I identified my title list I went back to the interviews and collected data to illustrate or dimensionalize each topic area. I attempted to keep each topic area distinctly separate and included notes on who generated the topic, and on the order in which it came up in the interview. In order to apply this process I wrote directly on the manuscripts, using brackets, parentheses, and underlining. Key supporting text was identified for each topic area. Subsequent transcripts were reviewed applying the same process. Existing topics were recorded and new topics were identified. I generated lists of concepts and themes for each interview and included supporting text from the interviews. At the same time I experimented with combining identified concepts and themes and excluding others. At this stage of analysis I included notes that I generated for myself, such as reflections, observations, and questions. An initial set of codes emerged

from this process, with which I began to organize my findings. This illustrates an inductive approach that is consistent with the interpretive descriptive paradigm.

The next phase in my analysis involved meeting with my faculty supervisor for working sessions. We discussed each of the labels I had identified through early coding and established preliminary titles for 3 major themes that had emerged. Using the data I then dimensionalized each theme using an interpretive descriptive framework, and provided supporting text from the data. In addition, I engaged in reflexive discussion with my committee chair to identify potential “blind spots.” Identification of these “blind spots” was pivotal in helping me to account for my biases, ensuring I remained critical in my analysis, and assisting me in intensifying and broadening my thinking.

The next phase in my analysis included meeting with all the members of my research committee to review the progress of my analysis. Scholarly discussion encouraged me to use a more critical approach to interpret my data. For example, the initial coding from my preliminary analysis appeared narrowed and heavily influenced by my own personal experiences. Discussion with my committee centred on stepping back and focusing through the lens of critical analysis to ensure all of my biases were brought to the surface, identified, and acknowledged.. Using this approach I then read all of the interviews again and began to deconstruct the initial 3 preliminary themes that had previously been identified. From this critical perspective I defined the underlying issues and concepts embedded in the data and attempted to explain them from the participant’s perspective. This reflexive process helped to support the truth value and confidence of this study. Consistent with interpretive description, this dialogue challenged my initial conceptualizations, and provided me with additional insights into these

conceptualizations.

The final stage of data analysis involved further discussion with my research committee, and completion of the findings section of this project, including reflection on memos and on the data used to dimensionalize topic areas. The process included simultaneous critical analysis of current data, collection of new data, and testing of emergent themes. The process included writing, reflection, and re writing. The final result was the identification of 3 main themes that represented a refinement of the original 3 themes: the discourse of overcrowding, conflicting values, and cycles of tension.

#### Rigor in Interpretive Description

Qualitative research requires attention to trustworthiness. Lincoln and Guba (1985) describe trustworthiness in terms of credibility, applicability, consistency, and confirmability. In simple terms trustworthiness establishes if a study is a good one or not.

#### Credibility

This aspect of trustworthiness is concerned with ensuring that the truth value of the study is participant-oriented. This means that the researcher has not defined in advance what the findings will be. I addressed this issue in the current project by acknowledging my own values and feelings and constantly reflecting on my findings to ensure I was not ordering them according to my preconceived beliefs. I also used feedback from my research committee as a means to maintain a critical perspective on my analysis.

#### Applicability

Applicability is concerned with the ability to transfer findings to other contexts or settings. I believe the sample chosen for this study to be representative of experienced

emergency nurses in the Lower Mainland of British Columbia.

#### Consistency

Consistency focuses on the study's ability to generate similar findings if replicated with the same subjects under similar circumstances. In order to address this, I used the same guiding questions and approach throughout my interviews. I independently interviewed all of the participants and tried to create similar environments for all of the interviews.

#### Confirmability

Confirmability refers to keeping research procedures and results free from bias. In order to address confirmability I attempted to follow guiding principles from the interpretive descriptive paradigm, and attempted to account for the biases of my study explicitly. According to Thorne et al. (1997), in interpretive description, attempts to eliminate all biases are naïve; therefore, the researcher must explicitly account for the influence of bias upon the research findings as much as possible.

#### Auditability

Morse and Field (1995) describe the importance of an audit trail in tracing and documenting decisions made by a qualitative researcher. To address this issue I ensured the completion of memos in the form of field notes. These notes include observational information such as the specifics of date, time, and atmosphere during interview, methodological annotations such as how I affected the interview, and theoretical remarks that create links to the existing literature. In addition, emotions and impressions, ideas and hunches evoked during the interviews were recorded in my field notes. These notes and records clearly illustrate the process I used to systematically code the data and refine

the labels. Interviews were conducted using a standard approach in which I provided explanations, and used standard forms (Appendix A, B, C, D). I also kept notes from meetings with my supervisory committee. Using all of these strategies I created an audit trail that ensures that another researcher could follow my decision-making process.

### Reflexivity

Reflexivity refers to the concept of the researcher s both influencing and being influenced by the process of engaging in research. A reflexive approach to qualitative research recognizes this reciprocal relationship and seeks to make it explicit. Reflexivity is the process of cultivating a critical awareness of the relationships between the researcher's perspectives, the informant's ideas, the researcher's ideological perspective, and the emerging data categories. (Marcus 1994). I addressed this issue through conversations with my supervisory committee and via a reflexive journal included in my field notes. I believe that my knowledge and experience as an emergency nurse added to the richness of the data I collected. I was able to access the informants as an insider, and seemingly this approach helped me to engage participants in a process of telling their stories.

### Reciprocity

I have incorporated a philosophy of mutuality into this project, and considered ways to "give back" to informants. According to Frank (1998), the act of telling one's story is a powerful positive intervention. I hoped that the informants would find telling their stories to be a cathartic and positive experience. I discussed this with some of the respondents at the end of the interview, once the tape recorder was turned off. During these discussions many of the respondents informed me that they had indeed found it

cathartic to be able to talk about their experiences with someone who understands the issues. In addition, many felt positive about the fact that attention was being paid to this issue, and felt validated by the experience of sharing their stories. I offered all of the respondents a copy of my findings when complete. I also informed them that I hope to publish my research in a journal article and/or present at a conference when I complete this project. In this way I hope I have dealt with reciprocity.

#### Limitations of the Study

The first limitation of this project is my lack of expertise as a researcher. This project is my initial attempt at qualitative research, and I am a novice in all aspects of the research process. The challenges of being a new researcher became apparent from the beginning as I navigated my way through the process of conducting an interview. The most significant challenge for me was analysis. It was very challenging to acknowledge all of my biases and try to make them explicit in the analysis process. Guidance and support from my supervisory committee helped me to find a balance in this challenge, and ensure I was analyzing the data from a critical perspective.

Secondly, this study is limited by the sample of nurses interviewed. The findings are very specific to this group of respondents, as the perspectives they provide are exclusively those of experienced emergency nurses. In order to gain additional insights and validate or challenge presented ideas it would be necessary to theoretically sample and interview a population of less experienced emergency nurses. However, completing further interviews with this group was beyond the scope of this project.

## Summary

In this chapter I have described the design of this project. Drawing on the traditions of narrative inquiry, I selected interpretive description as the method for this study. I have outlined the processes involved in data analysis and discussed how I addressed the issue of rigor, and the limitations of this project. In the following chapter the findings of the research will be presented.

## CHAPTER FOUR

### FINDINGS

My intent in this project was to explore and describe the impact of overcrowding on the ED practice environment, and to understand how overcrowding impacts nursing practice for ED nurses. Over all, the ED nurses in this study described overcrowding as having a significant negative effect on their ability to care for patients. Nurses described overcrowding as a negative influence on the ED practice environment, with far-reaching negative consequences for everyone within that environment including patients, families, and health care providers. The reality in the current context of health care is that the problem of overcrowding has worsened significantly since the late 1990s, and there does not appear to be any respite from this situation. Overcrowding is an extremely complex concept with equally complex effects. The perspectives of experienced nurses in this project illustrate this complexity and demonstrate the prolific negative effects of overcrowding on the ED environment. In this chapter, I will discuss the 3 major themes that emerged from the data: 1) the discourse of overcrowding in EDs, 2) conflicting values in new era environments, and 3) cycles of tension present in ED environments.

#### The Discourse of Overcrowding

In the interviews, nurses described overcrowding as a well-established phenomenon. The nurses in this study had an average of 12 years' experience in the ED, and I therefore refer to them as experienced nurses. Each participant talked about overcrowding as an issue that has historically challenged emergency departments. Descriptions of overcrowding consistently depicted admitted patients as the primary

cause of overcrowding, creating access block for new patients arriving in the ED. As one nurse stated, "Overcrowding is when you have a large proportion of admitted patients with no where to go and you've also got a significant number of people in the waiting room, waiting way longer than they should."

This quotation illustrates the imbalance that occurs between supply and demand with overcrowding. The available resources do not match the immediate need, and this translates into patients not receiving timely care. One nurse commented: "[I]t's like you're holding back the tide, you have between 1 and 25 patients in the waiting room, waiting to go to a bed. With a question in their eyes."

Participants consistently attributed overcrowding to admitted patients awaiting transfer to inpatient units. According to the Canadian Association of Emergency physicians (CAEP) and the National Emergency Nurses Affiliation (NENA), (2003), ED overcrowding can be defined as a situation in which the demand for emergency services exceeds the ability of a department to provide quality care within acceptable time frames. The nurses in this study consistently articulated that admitted patients block the flow of new patients into the ED, thereby blocking access to timely, appropriate emergency care. One nurse defined overcrowding as follows: "Overcrowding to me means that we're not able to receive patients into the emergency department because our stretchers are occupied by admitted patients."

#### Overcrowding: The New Norm

These findings clearly illustrate that from the perspective of experienced emergency nurses, what is new about overcrowding is the frequency of its occurrence. Overcrowding used to be an occasional phenomenon, whereas now it is a daily state of

affairs. The following quotation describes one of the participants' observations about the frequency of overcrowding:

When I came to BC there wasn't that problem. Patients moved quickly and we had lots of empty beds all the time and it would seem that in the last, I don't know, 8 years, certainly in the last 5, it's just a chronic problem.

Nurses in this project clearly and repeatedly described this phenomenon as worsening over the past five to ten years, and ultimately described overcrowding as a chronic state of affairs. This finding correlates with the patterns of restructuring in health care in British Columbia and Canada over the past decade and a half, which have been characterized by the influences of neo-liberal philosophy and corporate ideology. Participants described overcrowding as worsening over the past 5 years; during the same time period in BC, health policy has been heavily influenced by ideals of market driven efficiency, with a focus on eliminating deficits and balancing budgets. This time period saw the coining of phrases such as "efficient and sustainable" and "a new era in health care" in government policy statements. Such phrases illustrate a financial focus for health care and beg the question of whether "a good bottom line" can equal good health care.

According to Anderson (2000), controlling health care costs has been a top priority. Driven by the discourse of scarcity and efficiency in the 1980s and 1990s, cost containment in countries such as Canada has resulted in massive restructuring of health care services, which has created dramatic reductions in the number of acute care hospital beds: "Over the past decade there has been a 40% decrease in hospital bed capacity in

Canada” (Eggertson, 2004, 1653). It follows that, as beds are closed and services cut, emergency departments become busier, overcrowding occurs more frequently, and, ultimately, as a result of restructuring, emergency departments become chronically overcrowded. While closing beds may make good sense financially and have a positive influence on budget sheets, the impact on the environment of emergency departments has been felt directly on the front line as chronic overcrowding. In fact, overcrowding has become such a normal occurrence that it begs the question: is the language of “overcrowded” and “overcrowding” even pertinent to the current context of the ED environment, since overcrowding has become a normal state? From the perspective of the nurses in this study, overcrowding has become “the new normal.”

What used to be considered a bad day in the emergency department has become just another day in the emergency department. However, although overcrowding is now described as normal, it was apparent during interviews with participants that this issue continues to elicit strong emotional responses. Nurses struggled with the acceptance of overcrowding by the system. One nurse said: “[B]ecause it has become a forced normal. And, it’s not...it’s not right.” While nurses in this project acknowledged that overcrowding was happening, they also resisted the acceptance of the phenomenon. Entries made in my field notes illustrate that nurses frequently increased their hand gestures and/or became red in the face, and even started to cry when discussing overcrowding and its effects on the ED practice environment. One nurse described the effects of overcrowding as follows: “[Y]ou know this whole thing is wrong and nobody does anything to help you and then everyone is stressed and everyone’s upset and you can’t see a solution so people just shut down and become like statues.”

For the nurses involved in this project, “overcrowding” is a term that helps to construct and describe the reality of their workplace environment; in effect it gives them a political voice, a way to express their concerns to others. It is even a rallying point for negotiating resources: as one ED nurse explained, “If I’m in charge I am saying, Look you know I’ve got 15 admits here, I need to get rid of 7 of them.”

My findings reveal that for this sample of nurses overcrowding has shared meaning, and helps to create an understanding of their history. Reflections on my field notes and interview transcripts illustrate overcrowding as a distinct part of ED culture for this sample. As a result the question arises: What does the term overcrowding add to the discourse of the new era emergency department?

#### Weight

Overcrowding is a term used to communicate. This term has acquired a surprising level of weight in the language of EDs. The weight of this term gives ED nurses power in their arguments for resources. The nurses in this study spoke about using overcrowding as a leverage tool: overcrowding is discussed in terms of severity, and based on the severity of the overcrowding, nurses are able at times to negotiate additional resources, such as inpatient beds and extra staff. Nurses also spoke about overcrowding in reference to communicating with perceived policy makers within organizations to describe the current negative practice environment in EDs.

#### Boundary

Overcrowding as an idiom creates a boundary between the ED and “everyone else.” The concept of boundary emerged from the data as participants discussed EDs being left to deal with the overcrowding phenomenon independently. The findings

illustrate that ED nurses in this sample saw a clear distinction between themselves and the rest of the health care system including management, administration, health regions, and government. This distinction became clear when nurses described their perception of the unwillingness of those outside their boundary to address the issue of overcrowding. The creation of this boundary around the ED led to nurses experiencing and describing a sense of isolation in connection with overcrowding.

### Isolation

Overcrowding contributes to the isolation of ED nurses. The experienced nurses in this study frequently alluded to a lack of awareness in other people, units, hospitals etc.: “They don’t understand.” Overcrowding keeps the ED within an established boundary and causes isolation.

Weight, boundary, and isolation stem from overcrowding, and as a result a discourse of victimization emerges in the discussion of overcrowding. Nurses in this sample spoke about “us and them,” complaining that “that’s just the way things are” and “they don’t care.” This sample of nurses had a perception of themselves as victims of the phenomenon of overcrowding. The following quotations illustrate how the nurses in this study create this perception in their discussion.

I just feel like I’m being thrown to the wolves because I have to make the decision, what happens is there is no beds, you have to deal with it...just cope...just deal, so that’s not fair.

You're on an island, no one else cares. We have to cope, everyone else closes their doors and we can't, overcrowding has affected our department more than any other place in the hospital.

I think that we have suffered the most from bed closures. We have to look after their patients and ours, it's just not right that they can shut their door and we can't.

These comments illustrate how nurses in this project feel they are victims of overcrowding. Their discussions often describe the direct effect of overcrowding on the ED and the practice environment. However, in order to engage in creating positive workplace environments, nurses must abandon the victim mentality and be willing to actively engage in the process of change. The implications of this finding are discussed in Chapter 5.

#### Normalization of Overcrowding

Historically, overcrowding is a term that has been used to describe times when the demand for emergency resources temporarily outweighs their availability. The findings of this study indicate that the imbalance between supply of and demand for resources in emergency departments has become a chronic situation resulting in chronic overcrowding. In fact, this imbalance has become so consistent that overcrowding is now considered normal, and what was once considered normal has become unusual. One nurse described this process of normalization: "On a normal day...well it's not so normal anymore because overcrowding is actually the norm and a *regular* day is unusual."

As this quotation clearly illustrates, ED overcrowding has become a normal state of affairs. However, when the nurses in this study commented on the new era ED environment and overcrowding, they contrasted this situation with their experience of what the emergency department used to be. I contend that within this new era, using the term “overcrowding” does not accurately describe the complexities of current emergency departments. Furthermore, the term does not have a consistent meaning for all ED nurses. The findings of this study illustrate the connection of the term overcrowding to the EDs of the past. It is a reasonable assumption then that in order to use this term, an ED nurse must in fact have an understanding of the EDs of the past. In fact, many nurses in this study talked about the lack of understanding among less experienced ED nurses about how emergency departments used to function, and how this same group of less experienced nurses perceive the ED in a very different way. Indeed, what experienced nurses (those with at least four years of experience) call overcrowding, less experienced practitioners may consider an ordinary day in the ED. This argument has been crafted from the perspective of nurses sampled for this study, a population of experienced emergency nurses. In order to authenticate this argument, it would be necessary to use theoretical sampling to purposefully interview those nurses who would be considered less experienced; this is beyond the scope of the current study.

The following quotations illustrate how the experienced nurses in this study experience less experienced nurses’ disconnection from their past and the way things used to be:

The new ones are seeing a world that is very different and I think that's one reason why I find Med Surg nurses that go to Emerg', they're quite comfortable in many ways because its full of admitted Med Surg patients.

Like the new nurses; they don't know because this is all they've been used to so they don't realize why we're fighting. But it used to be better; this is not the way it should be. But for them it's like this is the way it's always been.

These comments exemplify the sample's perception that less experienced nurses cannot understand what it was like to work in the ED before overcrowding became the norm. Participants clearly felt that less experienced nurses are missing a link to the past. Without this connection, less experienced nurses may not undergo the same emotional reactions and distress caused by the current overcrowded conditions of EDs.

The experienced nurses in this study clearly describe a new era for emergency nursing, resulting from the sequelae of chronic overcrowding. The characteristics of current ED environments are significantly different from those of the past. The question then arises: What is different about this new era? Strikingly, from the perspective of the nurses in this study, the most dramatic, defining difference for the new era is change in throughput and flow in the ED. As a result of this change the ED environment has been significantly altered, and from the perspective of nurses who remember the way it used to be, this change has not been positive. The following quotations show how two of the participants feel about some of the changes that have taken place:

...because it's not OK that people are waiting six to eight hours when they come in with abdominal pain. It's not okay that we're doing ECG's any old place we can and then make decisions after that while they're back out...the patients are back out in the chair somewhere. It's not okay that they're two or three nights in emergency with the lights on.

So we have adapted because we've now become a cross between medical nurses and Emerg' nurses which is not a comfortable fit...at all. Because people are lying on very hard stretchers with no physio, no air mattresses, infrequent turns because we just cant' get back to them, spotty AM care if at all, no basic hygiene...I mean people have no time...just human dignity are going by the wayside.

Clearly, as these statements show, the emergency nurses in this study are troubled by the effects of overcrowding, specifically in relation to how this impacts patient care in the ED. The findings illustrate that what is different in the new era is the inability of ED nurses to provide the type of care they want to. My findings reveal that according to the study sample of experienced ED nurses, EDs have historically been viewed as prestigious places to work. The characteristics of this prestigious environment which originally attracted participants to this specialty included acquiring advanced knowledge and skills, working in a busy environment with a lot of variety, working as a team to provide emergency care to patients, more autonomous practice, and the opportunity to help and make a difference to patients and families. One of the respondents summed up her

attraction to the ED in a simple sentence: "The ability to give good, safe, excellent care." The new era for EDs has evolved in such a way that from the perspective of this sample, many of these attractive characteristics have been lost, and providing "good, safe, excellent care" has become increasingly difficult. My findings reveal that the current environment supports a culture of conflicting values, which in turn leads to an atmosphere of tension and mistrust.

### Conflicting Values

In my interviews, experienced ED nurses' discussions describe the ED atmosphere as full of conflicting values. According to Tabers (1997) *conflict* is the state created when a stimulus produces two opposing reactions. It is useful to consider this definition in terms of the number of stimuli occurring in the ED at any given moment, and the number of possible reactions to that stimulus. Nurses describe overcrowded ED environments as more chaotic, tense, and stressful, and it follows that this creates more conflict.

Conflicting values in the emergency department result from various forces, including how individuals view the world, what their assumptions and expectations are, and how they manifest emotions such as distress. Emergency nurses in this new era of overcrowding are struggling to make sense of this new reality, and their stories often make reference to "then and now," "before and after," and "how it used to be." As nurses struggle to sort through all these issues, they must also wrestle with the conflicting values that have emerged as a result of the normalization of overcrowding as one of the realities of the new era. The question then arises: What is contributing to these conflicting values in the emergency department?

### Generation Gap

The findings of this study reveal that when experienced nurses talk about their work environment, there is a noticeable split between different groups of nurses. The nurses in this study crafted their stories from the perspective according to which they belonged to a group of senior, experienced nurses, and in opposition to another group of younger, newer, and junior nurses. It is difficult to extract from the data how participants defined these terms; indeed, they appeared to be used interchangeably to refer to nurses with less practice experience and/or who were perhaps younger in age. Participants commented: "It impacts them...just the general stress level around them and I think in the feeling of non-support as well because the senior nurses are stressed out," and "If you're a very old nurse....and if you're a really new nurse," and "(T)here is a real difference between the way we treat new and seasoned practitioners."

The nurses in this study were homogenous in terms of being experienced, and would all be considered senior staff members in their respective departments. I will refer to these groups now as experienced and less experienced to avoid the implication of any negative terms or labels. Passages such as these are found throughout the transcripts of this project and create a distinct separation of this population of nurses. The findings illustrate that from the perspective of experienced nurses in this project, significant differences exist between the two groups. These perceived differences emerged as participants talked about how the less experienced nurses spend their time, how they prioritize their actions, and how they perceive the current emergency environment:

[T]he younger you are at this point, the less likely you are to work.

All they see is the critical and when it comes down to care, there's no care, and I don't...I don't know...I mean there's a lot of strong personalities in Emergency any yet you often see them,[strong personalities, experienced ED nurses] cuddling old people...or brushing somebody's teeth...they haven't lost the ability although you'd probably frighten us on a break with them. I don't understand this, just like...it's like there's a ten year gap in between 25 and 35, somewhere in there; the ones 25 and under just don't...they don't get that or they don't.

Remarks such as these suggest that from senior nurses' perspectives, there is a difference in how professional nursing is enacted by younger nurses. There is also an implication that younger nurses lack some of the caring characteristics which the more senior nurses possess. What might account for these differences? Many of the newer and younger nurses can be categorized as "Generation X" employees, individuals born between 1961 and 1981, children of the baby boomers. According to Kupperschmidt (1998), Generation X is a workforce whose work ethic and values are vastly different from those of previous generations. Different values and beliefs result from tremendous social, political, and economic changes. While the specifics of these differences are debatable in the literature, from a nursing perspective the key is to recognize that in fact there are very real deviations in how individuals see the world and enact their lives, and that different values and beliefs are played out at the level of direct patient care. For example, a senior nurse from this study may spend the occasional spare moment holding a patient's hand, as in the quotation above, whereas a younger nurse may spend the same

moment on the Internet. Clearly such divergence serves as a catalyst for the formation of tension, which I will discuss in greater depth in the next section.

The generation gap also signifies how new ED nurses generally perceive the workplace. Having been brought up in the current environment, they cannot know what it used to be like to work in the ED. At the same time, the experienced nurses in this study are in the midst of a transition from the previous ED environment to the current state of constant overcrowding. The following passage illustrates how the emotional reactions of experienced nurses are potentially exacerbated by the less experienced nurses' disconnection from the past:

[T]he newer nurses who come into Emerg' don't seem as fired up or angry or have the same motivation to... this is bad! This overcrowding and these waits at triage! Why don't these young people get it?... but this is the environment that they were brought up in, this is their expectation of what emergencies are.

Busy, congested emergency departments are the only environment known to the less experienced emergency nurses, and they do not have to deal with the transition process that the experienced nurses are clearly going through. It is crucial that policy makers acknowledge the significance of this transition in order to ensure that nursing leaders have adequate knowledge and skills to facilitate more experienced nurses' adaptation to new era ED environments. This state of transition is discussed in greater depth in Chapter 5.

### Conflicting Roles

Nurses working in new era emergency departments experience role confusion and conflict in various forms. The nurses in this study talked about struggling to let go of old roles while simultaneously attempting to define new ones. Chronic overcrowding has forced emergency departments to reengineer how they support patient care. As a result the responsibilities attached to specific roles have changed. For example, with increased numbers of acutely ill patients in the waiting room, the role of the triage nurse has changed dramatically. Nurses talked about this role expanding to include more detailed assessments, initiation of diagnostics, and implementation of interventions. For experienced triage nurses this evolution has been difficult, as they find themselves changing their practice and redefining what the role of the ED triage nurse is in the new era ED. One nurse expressed frustration:

Many of us initiate treatment because under the premise that you're doing the patient a service by facilitating quicker care we can initiate ECGs, start blood work in an attempt to get diagnostics going -- but at the end of that time you still have nowhere to put your patient.

It is inevitable that emergency nursing roles change, and nurses find themselves working in a new environment with new roles and responsibilities. However, according to the nurses in this study, changes are taking place in an uncoordinated and unplanned manner. As the quotation above illustrates, nurses are instinctively changing their practice, but there are underlying issues that are not being addressed. Moreover, it appears that some

of the practice changes are reactive, and only deal with immediate situations. Although it is necessary and acceptable to adapt to overcrowding by initiating treatment in the waiting room, and, as a result of this adaptation, patients receive care, albeit in an undesirable, inappropriate location, ultimately, this can only be seen as a “band-aid strategy.” The fact remains that once patients are diagnosed in the waiting room there is still nowhere to put them. This clearly supports the argument that underlying issues have not been attended to. Furthermore, while ED nurses attempt to adapt and deal with challenges in new era Eds, there is a perception that other parts of the system are doing little or nothing to address the issues. Why then has change been so difficult for experienced ED nurses?

It is essential to consider the concept of organizational change in this discussion. There are many different theories about change in organizations. Theorists such as Ferguson (1980), Kanter (1983), and Rogers and Shoemaker (1971) consistently describe the need for a structured, well-planned approach to change to ensure effective implementation. In this way, management of effective change is similar to the nursing process and should include assessment, planning, intervention, and evaluation. Health care restructuring has caused profound change, leaving nurses to restructure their work and roles in a reactionary manner. The nurses in this study described their lack of input into health care decisions, and talked about decisions being made far away from their everyday reality in the ED. Their experience reflects a haphazard imposition of change. Without consultation, one nurse explained,

[T]he quasi essential “they” and the quasi essential “them” whom I do not know who “they” and “them” are, they make the decisions, and if I’m in charge and I’m saying, look I’ve got 15 admits here and I need to get rid of 7, and they say well, you know, so and so had 17 the other day and she did just fine, Yeah! They make the decisions about what you can have and what is acceptable it seems.

It is apparent from this comment that the nurses in this study feel left out of decisions that directly impact their practice. The new era ED is thus characterized by a state of transition, which, according to Bridges (1991), is a three-part psychosocial process that extends over a long period of time. The experienced ED nurses in this study seem to be moving through this three part psychological process. According to Bridges, this process includes letting go of the old state, experiencing neutrality that includes disengagement, disidentification, and disenchantment, and finally experiencing new beginnings. The nurses in this study frequently described situations that illustrate the neutral phase. Findings reveal feelings of separation from the old ED environment, confusion with the current ED environment, and a sense that things seem to be “falling apart.” One nurse describes this as follows:

[It] is falling to pot in that department and it’s taking patient care and patient safety with it. And our government is turning a blind eye and the thing is, as you devalue the people that are working for you, in turn they begin to devalue the that people that are working under them or the patients in their care. It’s starting to

crumble and it's not a happy place. It's not a safe place. So, yes, I think they should be paying more attention to the people that actually do the job.

Role conflict and role ambiguity are clearly linked to the state of transition in new era EDs. According to Wylie and Smith (1999), role conflict can be defined as the differences between perceptions of the ideal role and the actual role. The experienced nurses in this project articulated their perception of their ideal role in terms of the role they used to have, which conflicts with what their actual roles are in the new era ED. Emergency nurses seem to experience role deprivation as a result of how they want to practice and how they are constrained by their workplace. Varcoe and Rodney (2002) indicate that nurses must adjust their work to this evolving corporate context and attempt to make sense of changing work conditions. Nurses adjust their work using a variety of strategies focused on processing more patients, more quickly. Unfortunately, these strategies often result in nurses focusing on practical nursing tasks to the exclusion of less tangible aspects such as simply listening to patients. And it is these less tangible aspects of nursing that seem to generate the greatest satisfaction for both nurse and patient. Corporatization negatively affects the ED practice environment. According to the nurses interviewed for this study, the corporate environment of the new era ED effectively prevents them from providing the type of care they want to.

Furthermore, consistent with Bridges (1991)'s theory, many of the respondents talked about leaving their organizations, resulting in a further negative influence on the ED. Two participants commented: "I'm going to stretch my wings, try something different," and "So certainly with overcrowding being routine as well, I can imagine

myself going elsewhere and looking for perhaps new challenges.” Such comments suggest the nurses’ intentions to follow through on leaving their organizations.

### Conflicting Goals

There are many different nursing roles within the emergency department. Roles include but are not limited to medical /surgical corridor, monitor nurse, trauma nurse, triage nurse, and in-charge nurse. Nurses are assigned to these roles according to their individual knowledge and skill-level. The nurses in this study suggested that antagonism often develops as a result of nurses in different roles having focused agendas and objectives that stem from their specific roles. Initially, it was my belief that, embedded within the participants’ talk about always needing to move patients, there was a general shift in focus from caring about patients to caring about beds. Further exploration of this theme illustrated that this particular shift is in fact related to the specific roles in which nurses function. This discussion is limited to the observations made by the nurses in my study; however, I am fully aware that other variables, such as personality, can influence how individuals respond to enacting any given role. How then do nurses’ goals change with their assignments? The following excerpts illustrate participants’ perspectives on different roles in the ED:

[T]he triage nurse leans on the bedside nurse, the bedside nurse gets angry at the triage nurse, the triage nurse is getting angry at the charge nurse because they’re not creating beds...it’s a really bad cycle.

So they are on the case of the triage nurse to ask them to bring people in and the triage nurse is responding with, I can't bring them in because there are no stretchers. So, it creates tension between the nurse and physician. Then there's the tension between the charge and triage because triage is saying to charge I really need stretchers and charge is saying, I'm trying but I can't get anything.

When the charge nurse came around to see, Okay who have I got here, what do I have to do, she was interested that her heart rate wasn't so bad and she was... when I began to tell her about the urine she just cut me off and took off... I thought, "This is important; I'm concerned about this for this lady," but she wasn't interested in that.

These comments illuminate how individual nurses can have individual agendas, driven by the objectives of their ED role. In the new era of emergency nursing, different nurses may have very different ideas about what the plan is for any given patient. When there is a chronic shortage of resources -- for example, a lack of stretchers, and a waiting room full of patients in need of a stretcher -- nurses report extreme pressure to "move patients." Antagonism arises when nurses disagree about what may or may not be in the patient's best interest. While the charge nurse may be completely focused on clearing a stretcher, the bedside nurse may have concerns about a patient and advocate for a patient to stay. One nurse described the following scenario:

A few weeks ago I had a patient in bed 5 who was 70 years old, lived with her husband who was also frail, and had come in with, I think, with a recent history of falls. The CT scan was negative and the patient could mobilize with a walker but was quite shaky and needed a one-person standby. Now I can well remember that 10 years ago she would have never been discharged. She would have gone up to the floor, have a couple of days of physio, we would have mobilized discharge planning and she would have gone home then. I remember, because this woman was quite scared about going home, that we had quite a debate between the physician, charge nurse, and I whether this woman should be discharged. And, the three of us were clear that under better circumstances she would not be discharged but we were going to push her out the door because we had 12 patients in the waiting room, all who needed this bed...you're forced to take really strong stands and it almost gets to the point of antagonism in the course of your acting as an advocate for your patient.

Emergency department work naturally includes some conflict. In fact, I believe that professionals expect to engage in dialogue and debate about all aspects of their work, including patient care decisions. However, the participants' experiences and comments suggest that this debate can become unpleasant and destructive, particularly when nurses feel forced to make decisions that they do not consider to be in the best interest of the patient. Furthermore, according to Storch, Rodney, Pauly, Brown, and Starzomski (2002), their inability to do what they know should be done and pursue the right course of action results in moral distress.

### Atmosphere of Antagonism

My findings suggest that new era emergency departments are environments teeming with antagonistic forces. Emergency nurses find themselves in an environment where there is a continuous struggle to mitigate the disparity between supply and demand.

### Competition for Resources

The nurses in this study frequently described attempting to sort out their roles and responsibilities in addition to balancing competing interests. For example, one issue that was mentioned repeatedly was the allocation of resources between admitted patients and new patients requiring emergency care:

I might be attempting to care for four admitted cardiac patients who ideally I would be reassessing on an hourly basis or a quarter hourly basis, depending on the presenting complaint and spending the time that I would like to be on teaching, assessing, intervening, but it's at the same time I'm trying to accommodate caring for a new patient who's arriving into my emergency department who needs primary assessment and aggressive intervention, I'm really not able to concentrate my care on the second population which is the admitted patients very well and I think they are done a disservice.

You're looking after someone who is having a heart attack and in the mean time you've got the little old lady beside you, banging her bedpan, "Nurse! Nurse!"

And you're trying to deal with this fellow but if you don't go and do something she's going to crumple in bed and break her hip.

I feel that the ability to meet standards of care for patients is compromised because of the overcrowding. For example, if I am part of a nursing care team that's been assigned 10 beds, 9 of them are total care patients who would benefit from mobilization, getting out of bed, activities of daily living, but at the same time we're trying to treat and triage and provide interventions for other patients – two other patients that are perhaps turning over, I'm not able to provide adequate level of care for those admitted patients. It just doesn't work ... there's not enough nursing care for that.

Emergency nurses are forced to make multiple and layered decisions.

Unfortunately, decisions about the care they provide are often driven by the availability of resources, including available stretchers and time, rather than the best interest of the patient. A major theme that emerged from the data was the significant lack of resources in emergency departments. According to the nurses in this study, the new era emergency departments are chronically, dangerously under-resourced. Emergency departments have failed to acquire adequate new resources to deal with the increased workload demands of chronic overcrowding, resulting in antagonism between individuals and populations competing for the resources.

Ultimately, the emergency nurse is left to reconcile the imbalance. From the nurses' perspective, a crucial resource that is not available in the new era is time itself.

Participants noted that they no longer have the time for the “caring” part of nursing practice, as they are forced to shift their focus to immediate physiological needs:

You can't... you can't do the things that you want to do. There are too many people and you're spread so thin that you can't be that nurse that you were supposed to be... that's why you went into nursing so that you could have these conversations with your patients and care... be caring.

How can you provide safe, competent care? I mean, sometimes the critical care... the critical component is care... when you ain't giving any! Because you've either got all these extra bodies that you're required to care for or you are providing quick and dirty service in the Triage area, you people getting things done while they're sitting in a plastic chair. Still got that burning chest pain. I don't think that's fair and I don't think that a 90-year old with a broken hip that's lying there for 11 hours in a soiled bed because there's no one to change it, that's not care, that's not why I went into nursing, let alone emergency.

The above clearly illustrates that despite increased workload caused by overcrowding there has been no addition of resources to address this issue. As a result, the experienced nurses in this study described many situations in which patients are not receiving adequate basic nursing care.

## Wrestling with Ethics

When nurses work in environments where they are constantly faced with antagonistic forces, they experience moral and ethical chaos. The comments of participant in this study illustrate their daily encounters with moral and ethical issues, and the resulting distress they experience. According to Varcoe and Rodney (2002) and Storch et al. (2002), health care environments today constrain nurses in their ability to practice ethically, which in turn often leads to ethical or moral distress. Moral and ethical distress results from nurses not being able to provide the care that they want to. The nurses in this study described situations in which they were not able to enact the caring part of nursing because of resource-scarcity. According to Varcoe and Rodney, this reflects the disposable aspects of nurses' work for the efficiency of the system and is manifested by the sacrifice of nurses' intellectual and emotional labour, personal time, and well-being.

Nurses in this study experienced moral and ethical distress as a result of antagonism that develops when there are competing interests for limited resources. This begs the question: what or who is competing for emergency department resources? According to the nurses in this study, the major competition for resources is between emergency patients and admitted patients.

Emergency nurses sometimes find it difficult to balance the needs of these two patient populations. Both groups require nursing care, and emergency nurses are continuously prioritizing and organizing care of these groups. At times admitted patients may require care less urgently than emergency patients, and therefore have to wait to have their needs met while ED nurses deal with patients who have more urgent needs. To

health care professionals, this decision-making scheme is based on simple logic. However, for patients waiting for assistance to use the washroom, or waiting to receive routine medications, such logic provides little consolation. Furthermore, the emergency nurses who have to make such decisions often experience considerable anguish at the realization that they are not meeting a patient's needs. The following passages illustrate how two the participants in this study describe this phenomenon.

Emergency patients keep coming and they are like really needing care so you shift your priorities to them knowing that other patients are waiting for things, things that don't seem important to you at the time, but imagine if you really had to go to the bathroom and you couldn't

Sometimes I feel so bad because I know that some one needs something, but, its like I just can't get to it right away because something else needs my attention sooner, I feel like I'm always struggling to keep up, and always just short!

Senior emergency nurses in this study reported great frustration over not being able to fully meet the needs of all patients arriving in the emergency department. Despite using national triage guidelines and following established procedures, nurses ultimately have to allocate sparse resources in the form of ED stretchers to this group of patients.

One nurse said:

Emergency patients are the ones that are kind of squished through the cracks of leftover, so of the patients that are left not yet diagnosed, we get a glimpse of what their problem is at the Triage desk, and out of the 15 charts that I have waiting for the acute care side I have to determine which one of them brings forward the most compelling reason to let them be the next in, and the other ones we just hope for the best, and that we've been able to gather enough information that they can hold off for a few more hours before we intervene.

This constant competition for limited resources contributes to tension and mistrust in the workplace, which is discussed further in the next section. In addition to reconciling resource issues, the emergency nurses in this study talked about reconciling role confusion in new era EDs. Findings also demonstrate the antagonism that develops as a result of contrary patient care objectives, which may vary according to the different role an individual may be working in within the ED.

### Cycles of Tension

The normalization of overcrowding has created an environment of conflicting values, which emergency nurses are continuously resolving. In turn this environment creates an atmosphere of tension and mistrust. Microsoft Encarta dictionary (2004) defines *tension* as the act of stretching, or inner striving, unrest, or imbalance, often with physiological indication of emotion. The nature of emergency nursing ultimately results in tension; however, as a result of overcrowding becoming normalized this tension has reached unprecedented levels in the new era. Nurses in this study talked about many

scenarios where there is a correlation between the extent of overcrowding and tension.

One nurse stated:

At first it seems OK, you think people get a bit of a rush out of it because it's sort of...you know it is working toward that common goal but I think once you've started on your shift and you actually can't meet that goal, it gets frustrating and I find that because there's no one to blame so the triage nurse leans on the bedside nurse, the bedside nurse gets angry at the triage nurse...I think working 12 hour shifts in this type of environment; lots of things are said that probably wouldn't be said in a different environment. The burnout is very high.

As this nurse was speaking, she became more animated, her voice elevated, and it was apparent from her body language that even recounting and describing tension elicited a strong emotional response. When overcrowding is present the level of tension rises, and nurses find themselves in a tense, confrontational environment. Questions remain about the levels at which tension is experienced, and the effects of this tension. The nurses in this study described cycles of tension at three specific levels: personal, interpersonal, and organizational.

#### Personal Level

Experienced nurses in this project describe tension having significant effects at a personal level. Working in the new era ED environment had physical and psychological impacts. Physically, nurses are frequently exhausted. One nurse stated:

And after 12 hours, with insufficient breaks and blab, blab, blab, you're beat. I go home and I fall asleep, drooling in a chair. I can go all day and climb Grouse Mountain and do all kinds of things and I don't drool in a chair. I go home and there is nothing left. Every cell is exhausted.

All of the nurses in this study described working in the new era ED environment as onerous and difficult. Clearly, when nurses feel such dramatic effects, they are at increased risk for stress and burnout. This is a key finding for policy makers, as these employees can significantly impact organizations: "A stressful environment can contribute to employee problems which, if not addressed, can exert a toll on the organization" (Acorn, 1999, p. 249).

These findings also illustrate that, at a personal level, experienced nurses also experienced tension at home as a result of practicing in a negative work environment. One nurse explained:

And that is all I can do. And then I have to suck it up and go home. And that's when you go home and explode cause there's no milk! I don't care that there's no milk in the fridge, I'm angry for other reasons but that's where it comes out.

This excerpt clearly illustrates how working in a negative environment can affect the personal lives of registered nurses. Nurses in this study frequently described similar scenarios, in which frustration from work was manifested at home. The effects of tension in the workplace extend deep into the personal lives of nurses working in such

environments. While it is beyond the scope of this study to explore these effects, it is important to acknowledge how they could exacerbate many of the issues identified in this study. For example, if experienced emergency nurses leave the specialty, staff shortages will be exacerbated, ED workload will be further increased, and the ED work environment will become even worse. The cycle will then be repeated.

#### Professional Level

The nurses in this project described the ways in which the environment in the new era ED has impacted their professional life. They articulated that this new environment restricts their ability to practice nursing in the way they want to, and reported being consistently unable to meet the physical and psychological needs of patients. Ultimately, for the majority of this study sample, these experiences have resulted in disempowerment and decreased work satisfaction:

[Y]ou don't feel like you can make a change or big difference where you are, you don't feel very satisfied is what's happening. My job satisfaction would come from knowing that I made a difference...burnout is way high for me, there's times when I have burned out and had to go part time, I had to leave for a while and then come back. I don't think I get really angry, but I think I just get kind of frustrated and saddened by the whole thing.

The comments of the nurses in this study illustrate the negative effects of overcrowding on their professional satisfaction. Findings show that when ED nurses are dissatisfied, they leave or seek extended periods away, and this creates a further cycle of

tension for the ED. When experienced nurses leave the ED they are frequently replaced by less experienced nurses. The burden of orientation, mentoring, and workload for these nurses falls to the remaining experienced nurses, and this may subsequently contribute to increased stress for the experienced nurses. In this way a vicious circle or cycle of tension is created and nurtured by the new era ED.

#### Interpersonal Level

Senior nurses in this project described how cycles of tension form and influence interpersonal relationships in the new era ED environment. Emergency care providers have historically had a reputation of being “close-knit” and “team-oriented,” working together for the patient. The nurses in this study spoke about close relationships both at work and outside of work, and described these relationships as a system of support in the old ED. New era EDs do not support these concepts. Instead, the atmosphere is described as much more “business-like”: “I really see that it becomes a more business-like relationship instead of a more friendly relationship.” Participants noted that, as a result of this change, everyone was now looking out for themselves, and the sense of “team-work” had been lost.

Tension in the workplace causes individuals to behave in unusual and unfamiliar ways, and when this happens, further tension is created and cycles are produced. ED nurses may inadvertently be supporting a negative workplace culture as they adapt to the new environment’s tensions:

I had an incident with a colleague of mine where he would come in to work every single day and he was bitter, bitter, bitter and nobody wanted to work with him

because he was so angry and frustrated with the way the system was and he would complain about it constantly.

[T]hat influences people's attitudes, behaviours, and that to me is the biggest cost from a health care professional...this overcrowding...is the cost to people's human kindness because without you realizing it, sometimes you become the worse person that you didn't think was possible to be and when you other people looking at you thinking...GOD! She was always such a nice person.

As these excerpts illustrate, nurses in this environment react and respond in unique ways, which at times are seemingly inappropriate. Reactions like those described above suggest that overcrowding has contributed to some of the negative behaviours that nurses may be exhibiting. Clearly, when such behaviours occur, interpersonal tension can arise. This tension may be further worsened as colleagues attempt to address or have the individual acknowledge such behaviours.

#### Organizational Level

These findings illustrate vicious cycles of tension throughout organizations as a result of the normalization of overcrowding. The nurses in this study described tensions arising from the antagonistic relationships between the ED and the rest of the organization. The perception of this sample is that the ED is viewed by the rest of the organization as almost "pestilent" in its constant attempts to off load patients and clear gridlock. Conversely, ED nurses in this sample felt there was a lack of acknowledgement for overcrowding as a systemic problem, and a lack of commitment to systems strategies

to address the issue. The nurses in this study spoke about feeling as if they were “on an island,” and “left to deal with this alone.” Findings illustrate that nurses in this sample have lost trust in their organizations. As one nurse explained:

No one else is willing to help in this process and no one else really cares because it's confined in Emerg'...countless staff meetings, countless planning sessions about how we can have gridlock called in Emerg' and then all the floors have to go over census. And it just isn't enough...to solve the problem.

According to Laschinger et al. (2000), without trust, people cannot or will not work together except under conditions of stringent control. As organizations restructure and re-engineer in the name of efficiency and effectiveness, organizational trust is an increasingly important element in determining organizational climate. Overcrowding is a systems problem and it seems the nurses in this study have lost trust in the system's willingness to address the problem. Loss of trust appears to be a catalyst for nurses to give up advocating for their work environment. Loss of trust appears to function as permission to give up, to succumb to the problems, and to stop caring. In effect, losing trust functions as a coping mechanism, albeit a negative one, a mechanism for nurses to accept loss of control and force responsibility away from “us” and on to “them.”

Ultimately, as nurses subscribe to this coping strategy, there are big implications for organizations. Lack of motivation to work as part of the team has the potential to increase sick time, overtime, recruitment, and retention, all of which will increase organizational expenditures. In the corporate climate of health care organizations need to

attend to any issues which threaten to increase expenditures needlessly. The next chapter will address how organizations might recapture the trust of nurses.

### Summary

In this chapter I have presented the major study findings of this project. Three major themes emerged from critical analysis of the study data. Massive restructuring of the health care system has resulted in chronic ED overcrowding, which is the new normal state of contemporary EDs. As a result of this normalization of overcrowding, environments have become established with conflicting values and cycles of tension. In order for ED nurses to navigate the future and create positive workplace environments it is essential that they actively engage in the process.

## CHAPTER FIVE

### IMPLICATIONS AND RECOMMENDATIONS

Throughout this project, nurses used analogies to describe their frustrations, anger, and feelings of hopelessness about current ED environments. One nurse compared working in new era EDs to being a “hamster on a wheel,” while another likened dealing with chronic resource disparities to “boiling a frog.” What I found fascinating and extraordinary about these desperate analogies is that despite the frustration of current environments, emergency nurses keep going back! The tenacity of this study sample was striking. These nurses keep going back to work, continue to brainstorm strategies, and genuinely want to be part of the solution. It is my assumption that ED nurses want to be involved in solutions to help create positive practice environments in which they can provide high quality, comprehensive, and timely nursing care to ED patients. In this spirit I have attempted to outline implications and craft meaningful recommendations.

#### Summary of Findings

The three primary objectives of this study were 1) to explore how overcrowding impacts the practice environment of emergency departments, 2) to explore how emergency nursing practice is impacted by overcrowding, and 3) to explore nurses’ experience of working in overcrowded environments. In relation to these objectives the major findings of this study are threefold.

First, chronic overcrowding has resulted in normalization of this phenomenon and the emergence of a new era ED. Overcrowding is not a new concept: it has existed for two decades in the literature. However, according to this sample of experienced nurses,

since the late 1990s, this phenomenon has grown in severity and frequency, and ultimately become normalized, contributing to a new era emergency environment.

Emergency nurses in this study continue to discern and redefine their roles in this new environment as they work through the transition process and struggle to understand this new era.

Secondly, new era emergency departments are environments with significantly conflicting values. The findings of this study illustrate that from the perspective of the ED nurses interviewed, there are significant differences between the ways in which experienced ED nurses and less experienced, younger nurses enact their roles as Registered Nurses in the emergency department. Several factors contribute to the conflicting values that have emerged among these two populations of ED nurses. These factors include generational issues and confusion about the roles and responsibilities of ED nurses in new era EDs. According to what is known about the majority of the current generation of graduating nurses (Generation X), it seems that values and beliefs in all areas of their lives are dramatically different from those of the more experienced nurses (baby boomers) in this study. The findings illustrate that different values can sometimes lead to conflict, when the behaviours of one group are contrary to the expectations of another. For example, generation X nurses may find value in spending time on the Internet rather than engaging in therapeutic communication with patients during a spare moment. Generation X nurses have values and beliefs that are characteristic of the socio-political culture in which they have matured. Currently society values technology and communication and thus Generation X nurses are likely to demonstrate this through their attitudes and behaviours. For the sample of nurses in this project the dichotomy in how

time is utilized was a catalyst for conflict. In addition to generational differences, the nurses in this study also described role conflict that is due to new, evolving practice patterns in new era EDs. They discussed changes in practice patterns between past and present that put ED nurses in new and challenging situations. For example, ED nurses are sometimes being asked to carry out actions which may not be in the best interest of an individual patient, such as discharging a patient to clear a bed when it may be in the patient's best interest to be kept for observation. Situations like this cause moral distress for nurses as they navigate the ethical implications of the decisions they are making.

Third, cycles of tension are rampant in new era emergency environments. The findings of this project illustrate that emergency department overcrowding has a negative effect on the workplace environment. In negative workplace environments nurses experience cycles of tension in personal, interpersonal, and organizational relationships. Exposure to these cycles of tension results in decreasing personal and professional health for registered nurses in the emergency specialty, causing nurses to consider leaving the specialty to practice in more positive environments. Almost all of the nurses in this study outlined plans to reduce their practice time or leave the emergency specialty entirely, due to the challenges of tension in the workplace.

The overriding conclusion from this project is that from the perspective of experienced ED nurses, overcrowding negatively affects the practice environment of the ED. While this conclusion is not surprising, it is important that this relationship has been demonstrated using a scientific approach. It is my hope that this will inform and influence policy makers as they continue to develop and implement strategies to address the issue of ED overcrowding. New era ED environments have emerged as a result of imposed

change, and this in turn has resulted in environments where transition has been ineffective and/or incomplete. These environments are teeming with issues that need to be addressed. As I have noted, overcrowding has been normalized as the new reality of ED nursing. From this perspective I have proposed three areas of discussion that I consider as areas where tangible strategies could be implemented to facilitate transition to the new era ED and resulting practices.

### Setting a Path for the Future

Florence Nightingale influenced the British Army in the 1800s by collecting and interpreting statistics in a scientific way. Since Nightingale's time nurses have been integral agents for change in the health care system. For example, recently nurses across Canada have been instrumental in the development of Nurse Practitioner programs to ensure that nurses have the opportunity to practice at levels that represent their fullest potential. Such initiatives demonstrate the enthusiasm and tenacity of registered nurses to drive change. It is crucial for emergency nurses to carry on this tradition and actively participate in how emergency care is provided in new era EDs. Emergency nurses in new era EDs have two choices: they can either become actively involved in setting a path for emergency nursing practice in the future, or they can passively allow change to happen, and be told what the path for emergency nursing is. The latter appears dangerous and undesirable, particularly in an era where decision-makers are typically business experts, rather than health care experts. Emergency nurses are the experts, and as such must be actively involved in the process of planning and implementing change. The reality of contemporary health care is that fiscal accountability and responsibility are absolutely necessary. ED nurses must work collaboratively within this reality to ensure policy-

makers are aware of how their decisions impact the ED practice environment. Nurses must engage in this process realizing that collaboration and partnership are necessary. Nurses must be involved in practical terms, they must also be committed to allowing change to happen. How then do emergency nurses engage in this process of setting a path for the future? Political awareness is the key. Political action is the process of influencing others in practical terms for ED nurses political action means influencing for the purpose of allocating scarce resources wisely.

Emergency nurses must continue to work hard to establish themselves as a power base. Despite increased workloads and current lack of motivation, it is imperative that nurses mobilize and function as political activists. ED nurses must recognize the value of this strategy and consciously choose to engage despite the current challenges and issues. According to Kerr & MacPhail (1996), there is strength in numbers. This is an important factor where nursing is concerned, since nurses are the largest group of health care professionals. As the largest group of professionals working in the ED it is logical that nurses have the potential to appreciably influence organizational policy. It is crucial that ED nurses maintain close networks by involving themselves in professional groups, committees, and task groups, and taking any other opportunity to make links and connections. In order to achieve influence ED nurses must be willing and committed to being involved.

Willingness to become involved means nurses must feel confident that their contributions are valuable and meaningful. It is crucial that ED nurses let go of feeling burdened and helpless, so that they can accept responsibility for their future. It is essential that ED nurses be willing to remove both the boundaries that separate unique cohorts of

nurses within the ED and the boundaries that isolate the ED from other areas within the hospital. In order to address many of the current issues, it will be necessary for ED nurses to work collaboratively with each other and with other areas within the hospital. ED nurses must be willing to accept the fact that the current practice environment of the ED is unique in many ways, and that it is therefore necessary to respond to this environment with unique strategies that are thoughtful and specific to ensuring the best care for emergency patients and the best work environment for nurses. Finally, ED nurses must be willing to commit to making these things happen.

Setting a path for the future requires commitment. ED nurses must be committed to engage in the process, despite time limitations and the structured nature of working in an organization. Specifically, engaging in the process requires committing time and energy to affect positive change. Time and energy are precious commodities, particularly given the exhaustion nurses experience working in the current practice environment. However, in order to accept responsibility for setting a future path, ED nurses must be present at every single table where decision makers and policy makers discuss and debate plans which may directly or indirectly influence the emergency department. While I acknowledge the difficulties inherent in enacting this ideal, I strongly believe that commitment and involvement are absolutely necessary to improve the practice environment of EDs. I also believe that organizations should support nurses' involvement. Organizations can implement many basic strategies such as paid leaves to attend meetings, scheduling extra staff to cover nurses attending meetings, and booking meetings at appropriate times and locations to facilitate nurse participation. While it may be difficult for ED nurses to commit to such activities given their work schedules and

level of exhaustion, there are some simple ways to influence the path for the future. For example, participation in professional practice groups advocating for the emergency nursing specialty is one way to exert influence. Membership in such groups provides group leaders with the power of numbers when they lobby nursing leaders and other individuals with the ability to influence policy. Additionally, membership connects ED nurses, and fosters communication and information-sharing.

### Leadership Renaissance

Existing literature has long described leadership as a key factor in positive work environments. As previously discussed, the massive restructuring that occurred in the 1990s had deleterious effects on nursing leadership. So significant were these effects that at the National Conference on Nursing Administration in Ottawa in 1996, Dr. Ginette Lemire Rogers issued a call for nursing leadership in her address to the audience. In this address Dr. Rogers outlined the need for leadership during an unprecedented period of change. She described the need for leaders who could guide nurses through transitions. Sadly, according to my study findings, there has been little change at the front-line level since this address. Emergency departments are still awaiting a renaissance in nursing leadership.

New era emergency departments need strong, visible leaders who advocate for emergency nurses and patients. The characteristics of these leaders were first documented in the early 1980s in the magnet hospital literature. This body of knowledge described the characteristics of hospitals that were able to attract and retain nurses during a national nursing shortage in the United States. Research identified several key characteristics of nursing administration in these "magnet" hospitals, and many of these findings are still

pertinent more than 30 years later (Upenieks, 2003). Nurses continue to need adequate numbers of leaders who are politically adept, visible, and supportive of professional nursing practice. How then could organizations support a leadership renaissance?

The first priority of health care organizations should be to ensure that there are an adequate numbers of nurse leaders. Corporatization of health care has resulted in many nurse leaders becoming generic program managers responsible for large multidisciplinary portfolios. A positive aspect to corporatization and large generic portfolios is that nurses with impressive educational backgrounds and experience now occupy many higher-level positions within organizations. However, busy, high-level, generic managers have little time to provide leadership to those front-line staff who desperately need support and guidance. The emergency nurses in this study described a visible absence of leadership in new era EDs. As nurses continue to work through the process of transition to the current environment, is it crucial that policy makers address the issue of lack of front-line leadership. Emergency nurses need nursing leaders who are present at the department level, who can help them identify issues, develop and implement strategies, and who can provide a vision to empower nurses for success in the reality of the new era ED. Organizations need to recognize the value of front-line leadership and support the implementation of nursing positions and structures to accomplish this goal. For example, emergency departments would benefit from the implementation of clinician roles to complement often overstressed educators.

Organizations must also be accountable and responsible for ensuring that nurses in leadership roles are given appropriate support. I contend that organizations need to ensure that nurses in leadership roles have access to education and mentorship programs

to learn how to be excellent leaders. As the findings of this study clearly indicate, when change is not thoughtful and planned, the results are disastrous. Nurse leaders must understand how to effect change in a positive way, including facilitating the transition process, and empowering nurses to be successful as a result of planned change. By attending to these strategies organizations will ultimately re-establish the trust of emergency department nurses.

#### Concluding Comment: Generate Evidence

In order to inform policy makers at all levels of health care it is necessary to have current, applicable, research based literature. Competition for health care funding is fierce and decisions are made based on arguments supported by science. For example, nursing has suffered in the past from a lack of research to support how nurses carried out their work. According to Van DeVelde-Coke (1999) this absence of compelling evidence for the design of nurses' work has left nurses poorly situated at a time of fiscal constraint. As a result nurses have been subjected to changes that reflect good financial decisions, not good health care decisions. In completing the literature review for this study it became clear that there is scant Canadian research examining the influence of restructuring in this country. According to Varcoe and Rodney (2002), there is alarmingly little systematic Canadian research to evaluate the impact of these changes.

In order to address negative outcomes it is necessary to first be able to create a viable cause and effect relationship. It is therefore important to ensure that evidence is generated in a systematic and scientific manner so that these relationships can be identified and clarified. Nursing leaders can then use this information to support arguments for addressing issues. If nurses are truly committed to advancing the

emergency nursing specialty, their willingness to engage in and generate evidence will hopefully inform policy makers at all levels of health care.

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**APPENDIX A****Letter from Emergency Nurses Group of British Columbia communication officer**

Dear ENGBC Member:

I am sending you the attached letter on behalf of an ENGBC member who is commencing their Master's Thesis and is looking for research participants.

This correspondence is in no way connected to RNABC or ENGBC business, but is solely for the purpose of this individual's research project.

The decision to participate is entirely your own. Confidentiality has been, and will continue to be, maintained. The researcher is not aware of the individuals who have been contacted and as the third party mailing this request I will not be aware of who responds.

You would be under no obligation to continue if you decided to participate, and if you decided to withdraw there would be no consequences.

The project is outlined in the attached letter, and has been approved by The University of British Columbia Behavioural Research Ethics Board.

Thank you for taking the time to consider the attached request.

ENGBC Communications officer

I understand that my participation in this study is voluntary. I may refuse to participate in or withdraw from the study at any time without any consequences whatsoever. If I have any questions about this study, I may contact one of the investigators listed above. In addition, if I have any questions about my rights or treatment as a research subject I may contact the Office of Research Services at The University of British Columbia, at 604-822-8598.

I have read and understand the information given above and my questions have been answered. By signing this consent, I hereby consent to participate in this study. I have received a copy of this consent form.

Please print your name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature \_\_\_\_\_

Witness's printed name \_\_\_\_\_ Date: \_\_\_\_\_

Signature \_\_\_\_\_

## APPENDIX D

### Interview Guide

#### The Impact of Overcrowding on the Practice Environment for Registered Nurses

##### Interview Questions

Code Name: \_\_\_\_\_

Date of Interview: \_\_\_\_\_

Interview # \_\_\_\_\_

##### Background information:

Sex: \_\_\_\_\_ Age: \_\_\_\_\_

# years nursing \_\_\_\_\_ in ED \_\_\_\_\_

Education \_\_\_\_\_

Current position/type of hospital \_\_\_\_\_ length \_\_\_\_\_

- You know I am interested in overcrowding and how it impacts nursing practice. Can you tell me, in your own words, how the emergency environment is affected by overcrowding?
  - Describe the typical environment.
  - Describe the environment during overcrowding.
  - Can you describe what overcrowding is? When does it happen?
- You have talked a lot about overcrowding and the environment. Can you tell me in your own words how overcrowding impacts nursing practice?
  - Tell me about how your ability to care for patients is affected.
  - Can you talk about being able meet standards of care?
- What is your experience of working when overcrowding occurs?
  - Tell me about the challenges - what's the hardest part?
  - How does this experience impact your future in the emergency specialty?
- Would you like a summary of my thesis findings?