New Emergency Nurses Descriptions of Making the Transition to a More Experienced
Emergency Nurse: An Interpretive Descriptive Study

by

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Abstract

How do new emergency nurses describe their experiences as they make the transition from being a new to becoming a more experienced emergency nurse? What are the needs of new emergency nurses as they make this transition?

In this qualitative study, new emergency nurses were interviewed for the purpose of identifying what it was like to be a new nurse in the emergency department; what were their needs; what health care personnel, educators and administrators could do to help them; and their intent to leave.

Interpretive description was the research approach utilized in this study. Ethical approval was obtained from the University of British Columbia Behavioural Research Ethics Board and the Fraser Health Clinical Investigation Committee. Using theoretical sampling, eight new emergency nurses, from the lower mainland and Vancouver Island of British Columbia, participated in semistructured, audiotaped interviews. They had three years or less of emergency nursing practice and had completed the core courses of an emergency specialty program.

The new emergency nurses felt overwhelmed and unprepared as they started their emergency practice. They encountered inconsistencies and deficiencies in their orientation programs. They encountered factors in the workplace environment that created challenges for them to practice safely and ethically. Workplace challenges included: the nursing shortage; the lack of resources; frustrations with management; the high patient acuity and volume; the challenges of attempting to meet organizational and technical changes; and the expectations of patients and patient's families. Hospital overcrowding created an
environment where the nurses experienced occupational stress; mental and physical fatigue plus abuse from patients, patient families and emergency personnel. The participants did not utilized professional services to debrief stressful incidents. They described favourable relationships with emergency physicians and experienced horizontal violence from nursing colleagues. Six of the eight participants anticipated leaving the emergency department or changing their status in a year. They expressed feelings of being frustrated, stressed, overwhelmed and exhausted. The study’s findings suggest implications for policy makers, nursing practice and nursing education. Further research is needed to explore the experiences of emergency nurses, the work place environment, the abuse they encounter and strategies to retain them.
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Dedication

This thesis is dedicated to my family: My mother, Daphne; my late father, Arnold; my sisters Annette and Stacey; my brother, Paul; my nephew, Alexander; and my niece Sarah whose love, support, and encouragement keeps me strong.
Chapter 1

Introduction

Becoming an EN is a challenging and complicated process. It calls for adaptations in the philosophy of how nursing care is conducted, readjustment of priorities in nursing care and the development of knowledge, skills and patterns of knowing regarding emergency patient care. In the current health care environment, nurses are experiencing burnout and dissatisfaction with their jobs. Currently, a nursing shortage exists and it will expand if new nurses are not retained in the system. There is a void in the nursing literature concerning the experiences and the needs of new ENs. The purpose of this study is to describe the experiences and the needs of new ENs as they progress from being a new to becoming a more experienced nurse in the ED. Interpretive description was chosen as the method of research for this study because it is a qualitative nursing approach that is designed to facilitate the understanding of clinical phenomena; and hence, yield implications that can be applied to the clinical environment (Thorne, Kirkham, & O'Flynn-Magee, 2004). It is hoped that the descriptions obtained from this study will inform nursing practice and contribute to nursing knowledge which may then help promote the transition, the nursing satisfaction, reduce the nursing turnover and the improve retention of new nurses in the emergency setting. In this chapter the background to the problem; the statement of significance; the purpose; the research questions; a definition of terms and the assumptions of this study are presented.
Background to the Problem

The emergency department (ED) serves as an intermediary among the doctor’s office, the hospital and the community (Marsden, 2003; Morrison, 1999; Varcoe, 1997). Physicians may refer patients to the ED for investigations and treatments that are more accessible through the ED (Marsden). In addition, the ED provides an access to emergency care for those patients with acute conditions and it also acts as a safety net for those people who may not have access to health care from other sources. The homeless, the mentally ill, those with substance abuse concerns and victims of violence are some examples of the marginalized populations the ED serves (Holleran, 2002; Marsden; Varcoe). Its doors are often open 24 hours a day. This fact plus long emergency waits, high stress illnesses, it’s noisy environment, the volume of patient’s, patient’s and family’s expectations and the ability of emergency personnel to meet these needs makes the ED a volatile and challenging place to work (Levin, Beauchamp Hewit, & Misner, 1998; Morrison; Presley & Robinson, 2002). It is an environment that is in constant transition.

The ED is a busy place. It is not uncommon for larger urban EDs in the Greater Vancouver area to see 50,000 to 65,000 patients in a year (University of British Columbia [UBC], Department of Family Practice, n.d.; Innes, 2003). Of those, 80% to 85% are discharged back into the community (Marsden, 2003; Innes; Varcoe, 1997). The number of patients and the complexity of their conditions is unpredictable (Sbaih, 2001; Varcoe). An emergency nurse (EN) may initially have a patient assignment with empty beds that then fill quickly. The ED environment may change from subdued to mayhem rapidly and without warning. Patients lined up in the hallways waiting to be transferred to the ward, children screaming, personnel yelling for stat tests, patients becoming unstable, ambulances bringing
in a violent patient and frustrated patients waiting in the ED waiting room to be seen are not uncommon in a typical EN's day (Varcoe). Because the volume, acuity and complexity of patients fluctuate, a sense of chaos and vigilance is always present among the emergency staff. When patients come to the ED, they are often treated quickly and efficiently in order to have them discharged or referred to another service; thus, emptying the stretchers for the next wave of patients (Varcoe). Emergency nurses must have the ability to provide care for a wide spectrum of patient problems and conditions; in addition, they must be familiar with a multitude of policies, equipment, supplies, and processes (Gilbert, 2003; Proehl, 2002a, 2002b). ENs must also have the skills, knowledge and the ability to move a patient through their emergency visit safely, efficiently and expeditiously. A condition that has significantly influenced emergency practice is the nursing shortage (Robinson, 2003; Zimmerman, 2000).

At the current time, there is a shortage of Registered Nurses (RNs) in British Columbia (BC), Canada, the United States of America (USA), and worldwide (Duffield & O'Brien-Pallas, 2002; Duffield & O'Brien-Pallas, 2003). There are multiple factors that contribute to the shortage. An increase in career opportunities for women has contributed to a decrease in the number of young people entering nursing programs (Duffield & O'Brien-Pallas, 2003; Canadian Institute for Health Information [CIHI], 2001). In addition, those students entering and graduating from nursing are older (Duffield & O'Brien-Pallas, 2003). The average age of RNs graduating in the 1970's was 22 years, in the 1990's, the average age was 26.7 years (CIHI). Consequently, these nurses potentially have fewer years of practice before retirement. Another factor contributing to the nursing shortage is the fact that the average age of RNs practicing in Canada is increasing. In 1994, the average age of the practicing nurse was 41 years, while in 2000 it was 43 years (CIHI). Over this time span, the numbers
of employed RNs in the 50 to 54 year age range rose by 34% (CIHI). British Columbia has one of the oldest nursing workforces in Canada, in 2001 the average age of a BC RN was 44.8 years. In BC 50% of the RN workforce who are 55 years or older, will be eligible to retire within the next ten years (CIHI).

An additional factor that has contributed to the nursing shortage is the fact that the population is aging (Duffield & O'Brien-Pallas, 2003). Between 2000 and 2020, it is estimated that the aging population will require a 40% increase in healthcare resources (U.S. Department of Health and Human Services, 2002). In addition, nurse dissatisfaction over increasing workload demands, inflexible work schedules, plus the challenges of working with acute and complex patients in an unfavourable work environment has contributed to the nursing shortage (Aiken, 2001; Duffield & O'Brien-Pallas). Aiken, Clarke, Sloane, Sochalski, and Silber (2002) conducted a survey of 10,184 staff nurses working in hospital surgical areas of care in the USA. They found that 43% of nurses who reported burnout and were dissatisfied with their jobs intended to leave within the year. Only 11% of the staff nurses who were satisfied with their jobs intended to leave. Midwifery, critical care, intensive care, operating room, emergency, cardiothoracic surgery and mental health nurses have suffered from the inability to retain its nurses (Duffield & O'Brien-Pallas, 2002). In the USA, it is estimated that it costs $81,681 to replace a speciality nurse (Contino, 2002). In addition, it is estimated that if a 500 bed hospital reduces its nursing turnover from 13% to 10%, it would save 800,000 USA dollars annually (Advisory Board as cited in Aiken, 2001).

In the Greater Vancouver area, the British Columbia Institute of Technology (BCIT) provides emergency speciality education. The speciality program consists of core courses and two practicums. Eight weeks of the program is completed as part time home study and
the remaining 13 weeks is completed fulltime on campus or in the hospital setting (S. Smith, Program Head, Emergency Specialty Nursing, BCIT, Burnaby, BC, personal communication, December 3, 2003). In attempts to attract and educate new ENs, Health Authorities in the Greater Vancouver area have sponsored RNs through the program. The Health Authority paid the entire costs of tuition and books during 2003 and 2004 (T. Wharton, Employee Services Advisor, Human Resources, Providence Health Care, Vancouver, BC, personal communication, February 25, 2004). In addition, 55% of the RN's wages were provided while the nurses completed the full time component (T. Wharton, personal communication, February 25, 2004). A one year commitment to the Health Authority was requested in return (T. Wharton, personal communication, February 25, 2004; Sue Smith, personal communication, December 3, 2003). The approximate cost to educate a new emergency nurse is $27,000 (J. Westman, Nurse Educator, Emergency Department, Providence Health Care, St. Paul's site, personal communication, March 24, 2004). These figures do not take into consideration the time and costs to orient the new emergency nurse or the 30% reduction of efficiency in a new employee during their first month of employment in a new area (Duffield & O'Brien-Pallas, 2002). Little is written in the nursing literature regarding the experiences of new ENs as they make the transition to becoming a more experienced nurse or what their needs are. A better understanding of both their experiences and needs may yield information useful in promoting nursing satisfaction and potentially assist in promoting retention.

I have been a practicing Registered Nurse for 17 years and an EN for 9 years. I have vivid recollections of my experiences as a new EN. I clearly remember how anxious and fearful I was at that time. Several senior ENs respectfully addressed my questions and concerns;
demonstrated appropriate nursing interventions; provided gentle support and utilized humour, which assisted my development into a more experienced EN. Later in my career, I remembered my past experiences and wanted to assist new ENs in adjusting to their role as an EN. I attempted to be helpful by assisting the new EN’s with their patient assessments; monitoring both overtly and covertly, their more acutely ill or complex patients; and assisted in the preparation, the implementation and monitoring of complex drugs and interventions. I attempted to be supportive and have a sense of humour. Unfortunately, over time I developed the impression that my actions were not helpful or appreciated by a number of the new EN’s. I was perplexed because I didn’t know what their needs were or how to assist them. I was also concerned because this lack of understanding regarding the needs of these nurses could potentially have an impact on staff morale and patient care. Lastly, I observed that these new ENs were leaving the ED after a year of employment and the process of supporting additional new EN’s would start again. This cycle was disappointing and tiring for myself and the other ENs who continued to work in the ED.

Statement of Significance

In the current health care environment, nurses are experiencing burnout and dissatisfaction with their jobs (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002). Nurses who report burnout and dissatisfaction are more likely to leave their jobs within a year (Aiken et al.). If hospitals can reduce the turnover rate of nurses by even three percent, substantial savings in replacement costs and loss in efficiency can be made (Aiken, 2001). These savings can be allocated to other areas in need of health care dollars. The younger generation have a large variety of career options to choose from and less of them are choosing nursing as a career (CIHI, 2001; 2002a; 2002b). In addition, the nursing workforce is aging (CIHI, 2001;
2002a; 2002b). As a result, a current nursing shortage exists and it will expand if new nurses are not retained in the system. Becoming an EN is a challenging and complicated process. It calls for adaptations in the philosophy of how nursing care is conducted, readjustment of priorities in nursing care and the development of knowledge, skills, and patterns of knowing regarding emergency patient care (Sbaih; Varcoe). It is hoped that the descriptions obtained from this study will inform nursing practice and contribute to nursing knowledge which may then help promote the transition, the nursing satisfaction, reduce the nursing turnover and the improve retention of new nurses in the emergency setting.

**Purpose**

At this time there is a void in the nursing literature concerning the experiences and the needs of new ENs. There is little research that explores the needs of new ENs as they see it, how they make the transition from new to a more experienced EN, what helps and what hinders this transition and their intent to stay with the department. The purpose of this study is to describe the experiences and the needs of new ENs as they progress from being a new to becoming a more experienced nurse in the ED.

**Research Questions**

The research questions providing direction for this study are: How do new ENs describe their experiences as they make the transition from being a new to becoming a more experienced EN? What are the needs of new ENs as they make this transition?

**Definition of Terms**

For the purpose of this study, an emergency nurse refers to a Registered Nurse who has completed the core courses of a speciality nursing education program in emergency nursing. A new emergency nurse (NEN) will be defined as an EN who has less than three full years of
A senior emergency nurse (SEN) will be defined as an emergency nurse who has greater than three full years of full time nursing practice in an ED.

The term patient will be used to refer to the persons receiving care by health care personnel. The term patient has been used in this thesis, as it was the term that was predominantly utilized by the participants and the majority of the literature. In order to maintain the participants’ anonymity, all of the NENs will be referred to as being female.

**Assumptions**

Four assumptions underlie this study. The first assumption is that NENs undergo a transition process in their progression in becoming an emergency nurse. The second assumption is that NENs have needs as they make the transition to a more experienced emergency nurse. Third, NENs want and would benefit from measures to assist them in meeting their transitional needs and in their adaptation to their new role. Lastly, assisting NENs to meet their needs will promote their transition, effective functioning and retention in the ED.

This thesis is presented in six chapters. In the first chapter, an overview and background to the problem, a statement of significance, the purpose of this study, the research questions, a definition of terms and the assumptions made while conducting this research are presented.

In Chapter 2, a review of both research and nonresearch literature regarding: the team relationships and the priorities of emergency care; the hazards of emergency work; the socialization of new nurses; and the emotional context of nursing work is presented. Chapter 3 provides an overview of the research method used in this study. Chapter 4 provides a demographic overview of the interviewed participants. Chapter 5 includes a discussion of the findings from the interviews and a further exploration of the literature. Finally, in Chapter 6,
a summary of the findings of the study, the implications for nursing practice, the implications for nursing education and recommendations for future research are presented and discussed.

Summary

In this chapter a background to the problem was presented. The statement of significance, the definition of terms and the assumptions underlying the study were discussed. Finally, the purpose for the study and its the research questions were provided.
Chapter 2

Literature Review

A literature review of formal research and clinical interpretations assists in bringing to light theoretical assumptions, biases and perceptions that have driven previous research and practice (Thorne, Kirkham, & MacDonald-Emes, 1997). A review of the literature can also assist in setting the foundational fore structure of a new inquiry (Thorne et al.). In order to set the foundation of this study, the previous research and the clinical interpretations regarding emergency practice and new nurses in the emergency setting were explored. A review of the team relationships, the hazards of emergency work, the priorities of emergency care, the socialization of new nurses and the emotional context of nursing work were explored and is presented.

*Team Relationships and the Priorities of Emergency Care*

When patients are admitted to the Emergency Department (ED), they are assessed and treated by a team of practitioners that include the EN and the Emergency Physician (EP). Nurses and physicians work closely together to deliver client care, however the relationship is not always congenial (Stein, Watts, & Howell, 1990). The "doctor-nurse" game has been identified as a mechanism by which nurses and doctors have interrelated and communicated over the last century. Steeped in a history of gender relations and dominant group dynamics, the game is played by the avoidance of open disagreement (Pilliteri & Ackerman, 1993; Roberts, 1983; Stein et al.). Nurses communicate by making suggestions to physicians without appearing to do so and physicians give orders in the guise of a request (Stein et al.). When played correctly, nurses appeared as valuable consultants to the team while physicians earned the admiration of nurses. The purpose of the game was the avoidance of open conflict.
and the efficient operation of the team. Intelligent nurses who refused to follow the rules were disliked and physicians who refused to play met with resistance (Stein et al.). Stein et al. reexamined the “doctor-nurse” game and concluded that while the game was not dead, it had changed as a result of endeavours made by the nursing profession and society’s changing views of the medical profession. Porter (1991) reported on a study of nurse-physician communication and found that nursing communication and decision making were more open and deliberate than the communication patterns originally described by Stein et al. in their earlier discussions of the “doctor-nurse game”.

Nurses have sought a collaborative relationship with physicians as nursing autonomy has grown over the years (Stein et al., 1990). Collaboration consists of a collegial nonhierarchical relationship in which mutual respect, competence, confidence and comfort is experience by those involved (Holt, 1998; Stein et al.). However, physicians are often unaware of the skills and knowledge that nurses possess (Pavlovich Danis, Forman, & Simek, 1998). In a study by Greenfield (1999), physicians were found to be unfamiliar with what constituted nursing, disagreed with nursing acting as patient advocates and visualized nurses as being an extension of themselves. Nurses, on the other hand, saw themselves as patient advocates and expected to use their own knowledge to direct their nursing care (Baggs et al., 1999; Greenfield). In addition, while nurse-physician collaboration has been associated with better patient outcomes in a critical care setting and greater job satisfaction for nurses; nurses have been found to communicate a more positive attitude towards physician-nurse collaboration than their physician colleagues (Hojat et al., 2001). While some physicians are more open to collaboration than others, Greenfield found that physicians
are less supportive of collaboration than their nursing colleagues due to fears of the erosion of their position and power of authority.

In the emergency setting, elements of the "doctor-nurse game" and interdisciplinary collaboration exist. When a patient comes to the ED for treatment, they report to the triage desk. The specially trained triage nurse assigns the patient to an area in the ED where they will be treated according to the severity of their presenting condition. In that area, the EN assigned to the stretcher where the patient will be treated conducts an assessment of why the patient has come to the ED and a physical assessment (Varcoe, 1997). These elements are considered a priority in the assessment performed by ENs (Varcoe). The psychosocial aspects of health plus the screening for substance abuse and domestic violence are also conducted in a less thorough manner.

The level of collaboration and recognition of nursing care is physician and nurse dependant. While some EPs interrupt nursing assessments and disregard the information that nurses obtain, others recognize its value (Varcoe, 1997). Once the initial patient assessment is completed by the EP, the EP provides physicians orders often in the form of a request. While some EPs offer explanations for their assessments findings and course of treatment, others do not. The EN reassesses the patient intermittently and communicates significant findings to the EP during the course of the patient's stay. The EN needs to be collaborative and assertive when working with EPs (Gurney, 2002). They need to ask the EPs their impression of the patient's condition and the plan of care. ENs and EPs negotiate for each other's time and attention. Senior ENs are often more successful in influencing EPs due to their experience as an EN while the ability of an EP to influence the EN occurs on an individual basis (Varcoe).
The overriding atmosphere in the ED is one of being prepared for whatever comes through the doors. Patients are assessed, treated and discharged back to the community or referred to other services quickly (Varcoe). What also contributes to the practice of efficient, succinct, emergency care and expedient flow through the department is the way in which EPs earn their income (Varcoe). Most EPs are paid on a fee for service basis earning anywhere from $53.25 to $106.04 per patient depending on the time of day and the acuity of the patient (Government of British Columbia, 2003; CIHI, 2002). As a result the more patients the EP sees, the greater the EP income; therefore, expedient flow through the ED is encouraged (Varcoe). At times the interests of the EP and the EN collide resulting in friction. Competing areas of confrontation are the use of nursing time and the nonphysiologic needs of the patient (Varcoe). For example, the EP may decide that the patient is ready for discharge from their point of view; however, the EN may feel that the patient needs to stay for psychosocial or health reasons (Varcoe). Negotiating to hold the discharge of the patient for further treatment or services becomes the role of the EN and can result in an uneasy truce (Lyttle, 2001).

In general, while ENs practice a greater level of open decision making and communication in the emergency setting, the EP still has the advantage of a formal education and a greater legal status than the EN; thus, the final say (Porter, 1991; Varcoe, 1997). What the experiences of new ENs are as they adapt to a physiological focus of care, negotiate in the collaborative relationships with physicians and practice in an environment were expedient patient flow in and out of the ED is valued, has not been established.
Hazards of Emergency Work

A review of the nursing literature reveals that violence is a major concern for nurses in general and especially for emergency nurses (Duncan et al., 2001; Fernandes, Bouthillette, Raboud, & Bullock, 1999; Hesketh et al., 2003; Levin et al., 1998). Verbal and physical violence is a frequent occurrence in the emergency setting (Fernandes et al.). Emergency's 24 hour open door structure, the nature of the client's condition and the lack of ability to control who comes through the emergency doors has significant impact on the level of violence and the level of stress experienced by emergency staff (Fernandes et al.; Levin et al.). Although there isn't a consensus on the definition of violence, witnessing of physical and verbal abuse (Fernandes et al.); verbal abuse and threats of assault (Duncan et al.; Fernandes et al.; Hesketh et al.; Levin et al.); emotional abuse (Duncan et al.; Fernandes et al.; Hesketh et al.) and physical violence (Duncan et al.; Fernandes et al.; Hesketh et al.; Levin et al.) have emerged as constituents of the definition. There is evidence that violence is underreported (Fernandes et al.; Hesketh et al.; Levin et al.). Emergency personnel experience one of the highest levels of violence (Duncan et al.; Hesketh et al.). While patients are the main perpetuators of violence, family members and visitors also abuse health care personnel (Duncan et al.; Fernandes et al.; Hesketh et al.; Levin et al.; Presley & Robinson, 2002). Therapeutic relationships are often disrupted by the transient nature of emergency care and the brevity of emergency encounters which limits the capacity to perform complete discharge planning and address family concerns (Morrison, 1999). When a patient or family's concerns are not met, violence can erupt (Morrison). Emotional abuse is also a major concern in the workplace. Emotional abuse is often not reported (Duncan et al.; Hesketh et al.). In addition, coworkers were found to contribute to emotional abuse (Duncan
et al.; Hesketh et al.; Lapsoa, Alden, & Fullerton, 2003). Physicians were found to be
collectors of emotional abuse and negative consequences for reporting the abuse to
administration was experienced by some nurses (Duncan et al.; Hesketh et al.; Laposa et al.;
Levine et al.). Nurses also contribute to emotional abuse; furthermore, intranurse abuse is
not the same as that enacted by physicians (Hesketh et al.). Intrapersonal conflict has also
been associate with symptoms of post traumatic stress disorder (PTSD) among emergency
personal (Laposa et al.). The age of the nurse, employment status of the nurse, the quality of
care, staffing levels, the support for reporting and prevention measures have also been found
to have an influence on violence in the workplace (Duncan et al.; Fernandes et al.; Hesketh et
al.; Levin et al.).

Violence has an impact on the people involved. Nurses who witnessed or experienced
violence experienced decrease job satisfaction (Hesketh et al., 2003), were afraid of patients
(Fernandes et al., 1999), felt victimized (Fernandes et al.), experienced short and long term
physical and emotional effects (Levin et al., 1998) and some left emergency nursing
(Fernandes et al.; Levin et al.). Emergency personnel who experienced violent episodes in
the emergency or witnessed traumatic events sought support from colleagues rather than the
help of professional services in place (Fernandes et al.; Laposa et al., 2003). Younger nurses
report higher levels of violence than other age groups (Duncan et al., 2001). Whether these
younger nurses experience higher levels of violence due to their age and lack of experience
or whether younger nurses are more willing to acknowledge the violence is still
undetermined. Whether this is the same for younger ENs has not been established.
Furthermore, what experiences new ENs have with violence in the Emergency setting and the
extent of its impact are still unclear.
Socialization of New Nurses

The EN practices in an environment where there is a constant preoccupation in regards to what may be coming through the door, where efficiency is valued and where priorities have to be set (Varcoe, 1997). The continuous flow of patients in and out of the department creates an environment in which the subtleties in communication and expertise are not easily recognized among new ENs or those unfamiliar with the emergency environment (Varcoe). The need to be efficient and to focus on the physiological problems of patients creates a culture and standard of acceptable practice among ENs. More experienced ENs communicate this culture to new ENs who must then reform their practice of more holistic nursing care to meet the emergency nursing expectations (Varcoe).

With experience, ENs develop expectations regarding their work. These expectations include the types of patient who will be seen in the ED; the type of care patients will receive; the type of work their colleagues will provide and the flow of patients in and out of the department (Sbaih, 2001; Varcoe, 1997). More experienced ENs develop patterns of knowledge and expectations of care based on their previous experiences which then becomes the basis by which they practice their nursing (Sbaih). Based on previous experience, ENs develop ideas about the normal case scenarios; for example, the "normal" ankle injury, the "normal" chest pain and so on, which then directs how they conduct their nursing care (Sbaih). Establishing these patterns of knowing enables the EN to allocate the amount of time, care and space allocated to the ED patient, which then ultimately facilitates safe care and patient flow out of the department. This efficiency also creates a sense of having done a good job and working as a team. New ENs need to learn the patterns of knowing, the normal case scenarios and how to facilitate the patient flow through the department (Sbaih;
Varcoe). They need to learn how to prioritize, become efficient and recognize when patients do not meet the normal case scenario (Gurney, 2002).

The benefits of mentoring or mentor-like programs in emergency nursing has been expressed by several authors (Betts, 2003; Gurney, 2002; Marett, 2000). In general, "the cultural system of nursing or nursing culture has its own distinctive characteristics: a common language, common rules and rituals, a common dress" (Suominen, Kovasin, & Ketola, 1997, p. 187). Nursing culture is expressed through its shared values, beliefs, norms and practices which in turn guides how nursing decisions are conceived and nursing actions employed (Suominen et al.). Students and new nurses are socialized to nursing culture through their education and clinical experiences. One method to guide new nurses into the culture, the environment, their new role and the recognition and utilization of their clinical resources is through a process called mentoring (Green & Puetzer, 2002).

Traditionally, mentorship has consisted of a long term relationship, with a mentor who is more mature and experienced than the mentee (Andrews & Wallis, 1999). The mentor is concerned with the mentee's wellbeing and career advancement. The mentor serves as a counsellor, an advocate, a teacher and a confident (Klein & Dickenson-Hazard, 2000; Watson, 1999). The mentor contributes a large personal and time investment in the relationship in order to guide the mentee in their adaptation to the reality of the workplace environment and the profession (Andrews & Wallis; Green & Puetzer). The mentee is usually young, a student, or a novice (Andrews & Wallis). Student's benefit from the support and role modeling demonstrated by mentors. Women benefit from peer mentoring that has a friendship component (Byrne & Keele, 2002). The personal support has a positive impact on the mentee's mental health and self-esteem. Mentee's appreciate frequent and
appropriate contact with their mentors (Andrews & Wallis). Mentees value interpersonal skills over the mentor’s knowledge. Mentors who are supportive and approachable created a comfortable learning environment; consequently, students believe that they learn more (Andrews & Wallis). Recently, there has been a shift in thinking from the traditional older mentor, younger mentee model of mentoring (Klein & Dickenson-Hazard). Mentors who had recently graduated themselves were found to be preferred by younger mentees because these mentors had a greater understanding of the mentee’s experience (Andrews & Wallis). Other authors contend that as long as the mentor relationship consists of a mentor that the mentee can confide in; provide help and support; and move them to the next level, the relationship can be cross generational (Klein & Dickenson-Hazard). Byrne and Keefe contend that nurses may have multiple mentors; in addition to, multiple peer relationships that function as a mentoring experience throughout their career.

The concept of mentoring and the role of the mentor are not well defined in the nursing literature (Andrews & Wallis, 1999; Watson, 1999). Synonymous terms are often used in the literature creating confusion, conflict and a lack of clarity for those involved (Andrews & Wallis; Green & Puetzer, 2002; Watson). Several authors have expressed the benefits of mentoring in emergency nursing (Betts, 2003; Gurney, 2002; Marett, 2000). However, there is little consensus on its definition (Andrews & Wallis; Green & Puetzer; Watson). Preceptorship and orientation programs have been described in the emergency nursing literature (Gurney; Proehl, 2002a, 2002b). Only one description of a temporary mentoring program in emergency nursing was found in the nursing literature (Betts). The mentoring program was adapted to meet the needs of the emergency personnel of a large urban ED as they coped with a large influx of new ENs. The program consisted of having one senior EN
act as a mentor providing guidance, support, on the spot education and problem solving for all new ENs, eight hours a day, six days a week for nine months. At the end of the pilot program, mentors voiced that the program was beneficial in assisting the new ENs in their transition to a more experienced EN. The author stated that the program was beneficial for the new ENs because it enabled them to address their learning needs quickly and receive immediate feedback. In addition, staff morale and nurse retention were improved. However, no formal assessments of the new EN perceptions or progress were made.

The benefits of mentoring or mentor like programs in emergency nursing has been expressed by several authors (Betts, 2003; Gurney, 2002; Marett, 2000). Betts contends that new ENs benefit by the improvement in the care they deliver and also in their transition as an EN. The department benefits from greater EN retention and greater staff morale (Betts; Gurney). While mentorship has been praised in the nursing literature, little research has been conducted in the area (Watson, 1999). In the Greater Vancouver area, when a new EN starts in the ED, they receive a few days of classroom departmental orientation and then four to eight shifts (48 to 96 hours) of on the unit buddied shifts with an EN already working in the ED (S. Fuller Balmey, Health Services Manager, Emergency, Royal Columbian Hospital, personal communication, December 3, 2003; J. Westman, Nurse Educator, Emergency Department, Providence Health Care, St. Paul’s site, personal communication, March 24, 2004). No further formal mentorship programs are in place after this time.

*Emotional Context of Nursing Work*

An examination of the nursing literature has revealed that practicing in the current workplace environment can result in burnout, decreased job satisfaction and a lack in the intent to stay with the organization (Aiken, 2001; Boyle, Bott, Hansen, Woods, & Taunton,
High physical and cognitive demands, working under time pressures and the hardship of shiftwork has been associated with burnout (Demerouti, Bakker, Nachreiner, & Schaufeli, 2000; Dunleavy, Shamian, & Thomson, 2003; Janssen et al.; Thomas et al.). Unpredictable work environments results in staff experiencing a sense of depersonalization and a lack of personal accomplishments (Garrett & McDaniel, 2003). Furthermore, staff experience burnout when there is little social support in the nursing environment (Aiken et al., 2002; Janssen et al.; Thomas et al.). Nursing staff who experience burnout and dissatisfaction intend to leave their jobs within a year (Aiken et al.). Staff develop negative attitudes and distance themselves from their work when they feel they have little input into decision making, little control over their jobs, little variety in the performance of their tasks and little support from their supervisors (Demerouti et al.). Staff who had disengaged from their work environment were also found to be unsatisfied with their life experiences (Demerouti et al.). Staff were not committed to stay with the organization when their expectations of appropriate salary, responsibility and opportunity to learn were not met (Janssen et al.). Furthermore, when nurses felt that the content of their job lacked quality; for example, gave them little autonomy, little variety in the skills they performed and minimal social support, they had a higher intent to leave (Janssen et al.). Nurses considered changing jobs if a manager lacked power or control over staff or if they had experienced a traumatic event at work (Boyle et al.; Laposa et al., 2003). Organizations that offered nurses the potential for upward mobility, control over their practice, and successful conflict resolution were found to have staff that had a higher intent to stay (Boyle et al.).
The ED is an environment in constant turmoil. The constant flow of patients in and out of the department means that ENs and EPs must be efficient and attentive to the priorities of the patients presenting condition (Varcoe, 1997). Focus on the physiological condition and a lesser emphasis on the psychosocial aspects of a patient’s health enables health care practitioners to refocus the patient’s condition into a manageable case for treatment (Varcoe). However, this focus on the physiological condition creates conflict for nurses because they focus less on the patient as an individual (Dunleavy et al., 2003; Varcoe). The gradual wearing away of the ability to be able to focus on the whole person results in nurses becoming uncomfortable with their nursing role and ultimately burning out (Varcoe).

Recent trends in health care have resulted in the blockage of hospital beds and the inaccessibility of services in the community (Four Reasons You’re Stuck In Emergency, 2000). As a result, the ED becomes the safety net for those who cannot receive the health services they need (Holleran, 2002; Marsden, 2003). Practicing in this environment has become increasingly complex and stressful as the ED becomes backed up with admitted patients and there are no available beds in the hospital for transfer to the ward (Etherington, 2000). Emergency personnel end up spending valuable time shuffling patients from more acute to less acute areas of the department and encouraging attending physicians to see their patients as quickly as possible (Etherington). Although it is the goal of the ED to transfer patients to the ward within 10 hours of their admission, it is not unusual for patients to remain in the ED longer than this and it is not unusual for psychiatric patients to receive the full course of their treatment while in the ED (Etherington). Admitted patients add additional strain to the already formidable pressure the EN works under. Admitted patients create distress for ENs because they divert the ENs attention from other emergency patients, in
addition, the EN recognizes that admitted patients require a different type of care that they cannot provide (Varcoe, 1997). Furthermore, when nursing admitted patients, ENs may end up working with patient conditions they are not familiar with, personnel they do not know, and treatment regimes unfamiliar to them (Duffield & O'Brien-Pallas, 2003). Finally, ENs need to be assertive when trying to get patients transferred to the ward when a bed does become available (Lyttle, 2001). As a result, friction may result between the ED and the ward nurses with ENs developing a reputation of being assertive, aggressive, demanding, tenacious, and bossy; also known as “that ED attitude” (Lyttle, p. 49).

Keough, Schlomer, and Bollenberg (2003) published the results of an educational survey that was conducted with emergency nurses in Illinois, USA. They found that the nursing shortage, unpredictability of the emergency environment, increasing responsibilities, lack of administration support, lack of incentives to stay, low staff morale and increasing levels of violence have all contributed to a feeling of crisis for ENs. The nursing shortage and the increasing volumes of acutely patients have contributed to ENs feeling overburdened, overstressed, overwhelmed, unsafe, dissatisfied, and unappreciated in their jobs (Keough, Schlomer, & Bollenberg). ENs felt that they could not attend to the basics of nursing care. Short staffing also resulted in nurse’s performing nonnursing duties such as janitorial work or the work of unit clerks. Nurses were asked to take on extra departmental projects while still being expected to provide a high level of care. ENs felt that education opportunities were being cut due to financial constraints. They also believed that their skills, experiences, knowledge and loyalty were not valued or rewarded. Low salaries, the lack of educational benefits, undesirable shift rotation schedules, plus the lack of respect from physicians and administrators resulted in ENs feeling that they lacked institutional rewards for staying in
their jobs. The nurses also experienced low staff morale. Many ENs felt that new ENs lacked work ethic, lacked concern for ED cohesiveness and had negative attitudes. New staff members were treated with derogatory behaviour. ENs also found that working in the high stress environment of the ED resulted in them having difficulties in their home life. Shift work kept them away from their families and family responsibilities. ENs also expressed concerns about the rising violence in the ED and the little resources for protection they observed. Finally, ENs expressed that they experienced little joy in their jobs. EN's faced time constraints and pressures in the ED; consequently, they found it hard to view patients as people, became emotionally hardened, disconnected and disengaged. As nurses became overburdened, overstressed and burned out, they considered another career.

Keough, Schlomen and Bollenberg's (2003) survey of emergency nurses has yielded results that are alarming and calls for concern in emergency nursing. The lack of experienced staff; feelings of being overwhelmed; overstressed and burned out; large workload demands, responsibilities and time pressures; the lack of rewards or incentives to stay; low staff morale; plus, the lack of support from administration and physicians paints a picture of a crisis in emergency nursing. What is missing in the nursing literature is how these factors impact new ENs.

Summary

A review of the current literature regarding new nurses, new nurses in the emergency setting, in addition to, emergency practice has yielded research and clinical interpretations in the areas of team relationships and the priorities of emergency care; the hazards of emergency work; the socialization of new nurses and the emotional context of nursing work. There are still many questions left unanswered regarding new emergency nurses; hence, this
study will endeavour to provide more knowledge concerning the experiences and the needs of new ENs as they progress from a new to a more experienced nurse in the ED. My research questions are: How do new ENs describe their experiences as they make the transition from being a new to becoming a more experienced EN? What are the needs of new ENs as they make this transition?
Chapter 3

Method

This research study is designed to describe the experiences and the needs of NENs as they progress from being a new to becoming a more experienced nurse in the ED. In this chapter, details regarding the recruitment procedure, the sampling, the data collection, the data analysis and the principles of rigor utilized while conducting this study are discussed.

Research Design

Qualitative research is a method of inquiry utilized when little is known about a phenomenon of interest (Morse & Field, 1995; Sandelowski, Davis, & Harris, 1989).

"...[Q]ualitative researchers study things in their natural setting attempting to make sense of, or interpret, the phenomena in terms of the meaning people bring to them" (Denzin & Lincoln, 1994, p. 2). Consequently, the phenomenon is described from the emic or the participant’s point of view and the context in which it occurs becomes an aspect of the phenomenon itself (Morse & Field; Sandelowski, 2000). Sandelowski (2004) reports that at this time, there is urgency about the utility of qualitative research findings. This urgency is due to the fact that practical knowledge is now becoming increasingly valued because of its focus on use. Interpretive description was chosen as the method of research for this study because it is a qualitative nursing approach that is designed to study the human experience with the purpose of developing nursing knowledge (Thorne, Kirkham, & MacDonald-Emes, 1997). It is an inductive analytic approach that is designed to facilitate the understanding of clinical phenomena, and hence yield implications that can be applied to the clinical environment (Thorne, Kirkham, & O'Flynn-Magee, 2004). Researchers who use this approach strive to “answer questions of relevance to a clinical discipline in which
understanding something of the nature of the focus of that discipline’s action is considered important” (Thorne et al., 2004, p. 8). I chose interpretive description as the research approach for this study with the intent of creating sound interpretive descriptions of the experiences and the needs of new emergency nurses in the emergency setting. I believe the descriptions that were obtained can contribute to our understanding of the NENs experiences, needs and what nurses can do to make a difference. The descriptions of NENs regarding their experiences and their needs were comprised of complex interactions. Through the use of the interpretive description approach, I identified common patterns, regarding the experiences of NENs; as a result, these common patterns can then guide practical applications, which can be individualized to the NEN in the emergency context.

Recruitment Procedure

Participants for this study were initially recruited from three hospital EDs in the Fraser Health Authority Region of British Columbia. The Fraser Health Authority Region is located east of Vancouver. These three hospitals were chosen because they provided a representation of urban and community emergency care. In order to begin establishing trust, Morse and Field (1995) recommends informally meeting with members in the research setting prior to beginning the study. Furthermore, Holloway and Wheeler (2002) suggest that meeting persons in power early may assist in facilitating access to the research setting and enhance their co-operation. Lastly, in addition to those in management positions, Holloway and Wheeler recommend meeting persons in nonmanagement positions so that potential participants do not misinterpret the study as being management driven. While waiting for formal ethical approval from the Fraser Health Clinical Investigation Committee and the University of British Columbia Behavioural Research Ethics Board to be granted, I
informally met with the nurse manager from one of the urban hospital EDs in the Fraser Health Authority Region. I provided a brief description of the study and participant sampling strategy. I was unable to meet with the other nurse managers and nurse educators due to their time constraints and vacation time. Once ethical approval was obtained from both boards, I met with the nurse managers of all three hospitals in person. The previously mentioned urban hospital ED had obtained a new nurse manager since gaining ethical approval for the study. I was able to meet with one nurse educator in person and, due to their busy schedules, spoke to the other two by phone. In all instances, a brief description of the study and the participant sampling strategy was discussed. A hard copy of the information letter for initial agency contact was given to those I met in person, as well as hard copies of the letter of introduction form for participants (See Appendices A and B). A copy of the information for initial agency contact and multiple copies of the letter of introduction for participants were also left with the nurse managers and for the nurse educators I did not meet in person. Of the participants interviewed, two were recruited from these channels.

**Sampling**

For the purposes of developing nursing knowledge, Thorne et al. (1997) recommends utilizing theoretical sampling with interpretive description. In theoretical sampling, participants are chosen according to the needs of the study (Morse, 1991; Sandelowski, 1995b; Sandelowski, 2000). “Samples are purposively and often theoretically generated, reflecting an awareness of expected and emerging variations within the phenomenon under study” (Thorne et al., 2004, p. 6). New emergency nurses were chosen to be the sample for this study because they were viewed as having the expertise on the experiences and the needs of NENs. The sampling criteria used to select participants were NENs who: (1) had
completed the core courses of a critical care speciality program and (2) had 3 years or less of 
emergency nursing experience. The selection of an adequate and appropriate sample is 
necessary to ensure the quality of qualitative research. Morse describes appropriateness as 
being the identification and use of participants who will be good informants for the study. 
For this study I interviewed emergency nurses who were knowledgeable about the topic of 
being a NEN; reflective; willing and able to articulate about their experiences; tolerant and 
patient of the research questions; and able to devote uninterrupted time for the interview 
(Morse; Thorne et al.). The data obtained from these participants interviews facilitated the 
understanding of what is was like to be a new nurse in the emergency setting. Striving for 
maximal variation also guided the sampling of participants (Sandelowski, 1995b; Thorne et 
al.). New ENs from five community and two urban EDs were interviewed. Of the eight 
participants interviewed, seven were from the lower mainland, and one was from Vancouver 
Island. An adequate sample size is necessary to ensure representation of the phenomenon 
under study (Morse). Adequacy can be described as the gathering of sufficient and quality 
data that will provide full, rich descriptions of the phenomenon or a new and richly textured 
understanding of an experience (Morse; Sandelowski). The sample size utilized in this study 
was adequate in that the data obtained consisted of rich descriptions and revealed new 
understandings regarding the experience of being a NEN. Data saturation was used as a test 
of data adequacy (Morse). Data saturation occurs when no new themes or information 
emerge from the data (Morse; Sandelowski et al., 1989). In this study, data saturation was 
met for the major patterns identified. Snowball sampling was also utilized in this research. 
Through the use of snowball sampling, the assistance of participants already in the study was 
sought to assist in the selection of other participants (Holloway & Wheeler, 2002; Morse).
For example, once an EN had been interviewed, the EN was then asked to suggest another EN who might be informative for the study. The interviewed nurse, as well as other Registered Nurses who knew of additional NENs who may be interested in participating in the study, were given information letters to give to the NENs. The EN was asked to contact the new EN on my behalf and provide my contact information. If interested, the suggested NEN then contacted me. Unexpectedly, this method of sampling facilitated the recruitment of the majority of participants in this study. Six participants were obtained through the use of snowball sampling.

The final sample size and composition was determined when rich descriptions of the experiences and the needs of NENs were obtained. Credible and clinically significant findings can be produced when single researchers, theoretical sampling and a homogenous sample, such as ENs, is employed (Sandelowski, 1995b). Some qualitative authors suggest that a sample size of six to eight data collection units is needed when using a homogenous group (Holloway & Wheeler, 2002). In this study eight participants were interviewed, six participants were interviewed once and two participants were interviewed twice for a total of 10 interviews. The richness of the data obtained determined that the final number of 10 interviews was adequate for this study. The data obtained in this study was rich in its descriptions and contributed to answering the study’s research questions concerning how NENs describe their experiences as they make the transition from being a new to becoming a more experienced EN and what the needs of new ENs are as they make this transition.

**Ethical Considerations**

Ethical approval from the University of British Columbia Behavioural Research Ethics Board and the Fraser Health Clinical Investigation Committee were obtained prior to the
recruitment of participants (See Appendices F and G for copies of the Ethical Approval Documents). When participants made contact about participating in the study, they were asked if they had received an information letter, screened to ensure they met the criteria for the study and any questions they may have had prior to setting up a time for the interview were fielded. Prior to the interview, they were again asked if they had received an information letter and questions they may have had were fielded. The consent was explained, questions they may have had were answered, they then signed two copies of the consent form (See Appendix C). The participants received a signed consent form. Prior to the interview, participants were informed that their consent was voluntary, that they could withdraw from the study at any time and that they could have information removed from their transcript at a later date at their will.

Anonymity of the participant’s identity was protected. All audiotapes and interview transcripts had names and identifying features removed. Every participant was given a code and only I have the key to the code. The key and the audiotapes were locked in a filing cabinet and only I have access. Five years after the completion of the study, the key and the tapes will be destroyed. Transcripts will be retained for future educational and research use with written consent from the participant (Morse & Field, 1995).

Data Collection

Interviews of participants whose accounts reveal the elements that inform the experience of what it is like to be a newly specialized nurse in the emergency setting was conducted as is consistent with an interpretive description approach (Thorne et al., 1997). After written informed consent was obtained, demographic data was gathered to obtain a generalized overview of the characteristics of the participants (Appendix D). Included in the
demographic form was a job satisfaction scale. The participants were asked to rate their level of job satisfaction when they first started emergency nursing and at the time of the interview. They were asked to rate their satisfaction on a scale of 0 to 10 with 0 being no satisfaction and 10 being the most satisfied. I conducted 10 in depth, semistructured, audiotaped interviews lasting approximately 45 minutes to 90 minutes in length. The face-to-face interviews were conducted at a mutually convenient time and place as selected by the participant. They were conducted on the days the participant was not scheduled to work. The participant determined the general content and the pace of the interview. Trigger questions were utilized to stimulate the discussion (Rubin & Rubin, 1995). The trigger questions were developed through the use of the literature and based on personal experience (Appendix E). As the data collection progressed, the interviews were adapted to investigate emerging themes in the data; two participants were interviewed twice, the second interview was to clarify, supplement or verify the data (Morse & Field, 1995). These subsequent interviews were also used to discuss emerging themes that arouse from the data analyses and whether these interpretations fit with the participant’s interpretation of their experiences.

Fieldnotes were completed to support the audiotaped interviews. While audiotapes record the dialogue of the interviews, fieldnotes were used to objectively describe the physical setting, impressions of the interviewer and nonverbal communication (Morse & Field, 1995). To facilitate the retention of data, I recorded or wrote fieldnotes in a quiet place, as soon as possible following the interview, before discussing the interview with others and in the sequence of events as they occurred (Morse & Field). A journal was kept to record my subjective thoughts, hunches and reflections following the interviews. Finally, the progress of the research and any significant changes in methodology was documented in an audit trail.
The unexpected reliance on snowball sampling was documented in the audit trail journal.

**Data Analysis**

As with all interpretive research processes, data collection and analysis inform one another iteratively, and thus the shape and direction of the inquiry evolve as new possibilities arise and are considered (Sandelowski, 2004; Thorne et al., 2004). Comprehending, synthesizing, theorizing, and recontextualizing are the analytical procedures used in interpretive description (Thorne et al., 1997; Thorne et al., 2004). I engaged in data analysis, sampling, data collection and data verification simultaneously (Morse & Field, 1995; Sandelowski, 1995a). During comprehension, the literature was held “in abeyance” (Morse & Field, p. 126). A transcriptionist was employed to transcribe audiotaped interviews and fieldnotes verbatim, the transcripts were checked for accuracy, corrected as necessary and supplemented with content from the fieldnotes (Sandelowski, 1995a). I immersed myself in the data, reading and rereading the transcripts while attempting to apprehend the overall picture (Sandelowski, 1995a). I asked myself “What is happening here?” (Thorne et al., 1997, p. 174) and “What am I learning about this?” (Thorne et al., 1997, p. 174). Line by line coding was performed with the initial six interviews in order to assist with sorting the data and uncovering the underlying meaning in the text (Morse & Field). The codings were compared; recurring patterns and relationships that emerge from the data were identified. Data comprehension was reached when patterns, themes and stories were identified and data saturation achieved (Morse, 1994; Morse & Field). Data synthesis then began. The transcripts of the ten interviews were continually analyzed in terms of commonalities and categories (Morse & Field; Sandelowski). When the norms; range and variation of
behaviours; aggregate stories and a composite description of the experiences of NENs were obtained, data synthesis was then completed (Morse; Morse & Field). Data theorizing consists of searching for alternative explanations of the data, lateral thinking by searching for links of similar concepts and asking questions that will connect the data to established theory (Morse; Morse & Field). Theoretical sampling was utilized to check and verify the patterns found. In latter interviews, further exploration of the emerging themes was conducted. Two participants were interviewed a second time to verify and check the emerging themes. The final stage of data analysis is recontextualizing. Recontextualizing of the data took place. The patterns that emerged from the findings of the research study were compared to the existing literature as well as the original setting to determine whether they either supported the current literature or contributed to it (Morse; Morse & Field). Through the use of this inductive data analysis, the interpretive description approach used in this research enabled me to know individual cases of NENs intimately, abstract relevant themes plus produce sound and usable knowledge that can be applied back to the nursing practice context in regards to the experiences and the needs of new ENs as they progress from being a new to becoming a more experienced nurse in the ED.

Rigor

The attention to rigor and how the research approach is reported is critical in the interpretive description approach (Thorne et al., 1997). Several measures were undertaken to ensure rigor in this study. The measures described by Thorne et al. (1997), Thorne et al. (2004); Morse and Field (1995) and Sandelowski et al. (1989) were used as guidelines to ensure rigor, as these authors and researchers are considered experts in the field of qualitative research. Data appropriateness was used to ensure that participants were selected who could
best inform the research and the developing needs of the study (Morse & Field). Sufficient and quality data that provided full and rich descriptions of the phenomenon, of being a NEN, were obtained. Fieldnotes were used to link the contextual aspects of the interview with the phenomena of the perceptions of new ENs (Thorne et al., 1997). In interpretive description, a reflective journal is recommended to guide and document the reactive process experienced when engaged and interpreting the data, as well as, to counter biases that may occur during the research process (Thorne et al., 1997). I journaled about my reactions and thoughts of interviews, accounted for my perspectives and discussed how they may influence my findings. I discussed my perspectives with my committee members. A clear documentation of the decision making process used by myself in the selection of participants, data collection and data analysis were undertaken in an audit trail journal (Morse & Field). This journal was also employed to record preliminary findings and the rationale for any methodological changes that occurred during the study. The audit trail was also discussed with my committee members. Continuous checking with the committee members and the participants, for the representativeness of the data, the emerging patterns and the emerging themes, was performed throughout the project (Morse & Field; Sandelowski et al.; Thorne et al., 1997). Committee members were utilized in regards to the data analysis and its interpretation.

Summary

In this chapter, a description regarding the design of this study and of the interpretive description approach was discussed. In addition, details regarding the recruitment procedure, the sampling, the data collection, the data analysis and the principles of rigor utilized while conducting this study were provided.
Chapter 4

Demographic Overview

Eight participants were interviewed for this study. All eight came from varied backgrounds and emergency departments in the Lower Mainland and Vancouver Island of BC. Each provided valuable insights and perspectives that have contributed greatly to this study. A brief description of each participant is provided to give a picture of the participant and give depth to his or her contributions. Both male and female participants were interviewed in this study. In order to maintain their anonymity, all of the participants will be referred to as female. In addition, when describing the participants, minor details have been altered that have no influence on the findings of this study. The demographic information collected at the time of the interviews is also presented in this chapter.

The Participants

Participant 1A was in the 40 to 49 years of age range and had been a RN for over 10 years prior to entering emergency nursing. The participant had extensive experience in several areas of nursing. At the time of the first interview, Participant 1A had been nursing in the ED, of a community hospital, for one year. She had a general nursing diploma and had completed the core courses of an emergency speciality program. This participant spoke easily about her experiences and perceptions of being a NEN. The participant provided valuable insights regarding: the relationships with physicians; generational differences, the overcrowding in the ED, the disruptive behaviour from coworkers (for example, being pushed out of the way so that the SEN could admit a new emergency client; being tested to see if she’d fail; having people “impose their ideas” even when they weren’t consulted; and the questioning or undermining of her decisions); patient and family violence against nurses
(for example, being yelled at); the role of discharge teaching in emergency nursing; plus, the frustrations with management, health care politics and some of the other health care personnel encountered. The participant was one of two nurses in the interviews that discussed the perception that they provided a different type of nursing compared to that of younger nurses in the ED. The participant was also one of three nurses who spoke about the need to develop a relationship with some physicians. The participant provided valuable insights and participated in a second interview. During the time of the participant’s first interview, she had been an EN for one year. The participant’s level of job satisfaction had decreased since starting as an EN. At the time of the second interview, six months later, the participant’s level of job satisfaction had increased. After our first interview, Participant 1A intended to take additional courses in emergency nursing and hoped to work as a rural outpost nurse. At the time of our second interview, the participant had sustained a work related injury and was contemplating a career change based on the advice of her physician.

Participant 2A was in the 40 to 49 year age range and had less than three years of registered nursing experience and 10 years of care aide experience prior to entering emergency nursing. Participant 2A worked as an EN in a large urban hospital. As a care aide, Participant 2A worked on several various wards of this large urban hospital; the participant’s previous RN experience consisted of working in the ED and providing care for stable admitted patients who were waiting for beds on the units. The participant had been working as an EN for less than two years at the time of the interview, had a general nursing diploma and had completed the core courses of an emergency speciality program. Participant 2A referred to herself as a junior nurse in the ED and discussed the confusion that resulted because of her mature age. She commented that some people would assume she had been
nursing for a longer period of time than she actually had and would assume that she had more
experience and knowledge than she actually had in the ED. Participant 2A openly discussed
her experiences in the ED and was an animated speaker. She was adamant in her comments
that when starting emergency nursing she was overwhelmed. Topics discussed included:
developing emergency nursing experience; the stress and increased workload of working
with noncritical care nurses in the ED; her perception that the admitted patients being held in
the ED greatly increased her workload and stress; the acuity and the volume of clients; the
huge workload of the EN; the mental and physical demands of emergency nursing; the
differences between working in a large urban hospital ED and a smaller community hospital
ED; her intent to stay in the ED and the disturbing behaviours she experienced from SENs
(for example, being bullied and having people refuse to help her) in the ED.

At the time of the interview, Participant 2A worked in both a community and an urban
ED; she discussed the differences between nursing in the two EDs. Although she commented
that in larger EDs there was a larger availability and access to support services; she also
commented that the ENs working in the community ED were she worked were less transient
and had been working in the ED for a greater length of time than many of the ENs in the
urban ED; consequently, it was a more settled environment. Participant 2A enjoyed
emergency nursing however; she commented that she did not think she could stay in ED due
to the mental and physical demands of the work. At the time of the interview, she rated her
job satisfaction as higher than when she initially started emergency nursing.

Participant 3A was in the 30 to 39 years of age range and had no previous nursing
experience prior to entering EN. She was hired into a community hospital ED directly from
an undergraduate nursing diploma program and discussed the challenges this experience
presented for her. At the time of this interview, Participant 3A had a general diploma in
Registered Nursing, had a Bachelor’s degree in a science field, had completed the core
courses of an emergency speciality care program and had obtained her emergency nursing
speciality certification. She had been working in the ED for 30 months when first
interviewed. She presented as being nervous during the initial interview. She openly
discussed: the unfavourable behaviour she experienced from SENs (for example, bullying,
being tested to see if she’d fail; having people “impose their ideas” even when they weren’t
consulted; having people embarrass her in front of others; the questioning or undermining of
her decisions; or people not speaking too her); the difficulties of working short of staff; the
lack of orientation and mentorship when she initially started; her perception than the ED was
misused by some patients; the abuse she experienced from patients and their families (for
example, being yelled at); her perception of the unrealistic expectations of some patients and
families; the collegially and teaching relationship she experienced with the EPs; her
disappointment at what she perceived to be missing fundamentals in her general nursing
diploma program; the difficulty she experienced with the transition from her general nursing
education program to emergency nursing; and the treatment of new graduate nurses in the
ED. A large amount of the interview consisted of a discussion regarding the disturbing
behaviours she experienced from SENs when she first started in the ED; in addition, this
participant recognized that her lack of nursing experience created a challenging situation for
the SENs and her patients. At the time of the interview, she rated her level of job satisfaction
as being the same as when she first started emergency nursing. At the conclusion of our
interview, Participant 3A anticipated that in a year from the interview time, she would
continue to work in the community ED because of her young children and would move to a larger ED when they were older.

Participant 3A was interviewed for a second time 5 months after her initial interview. She appeared more settled and comfortable in her role as an EN. She rated her job satisfaction a half a point higher than her rating at her first interview. She attributed this to the fact that she perceived that she was more accepted by her co-workers at this time. She felt that she was “fitting in” and had more support among the other ENs. Interestingly, this participant also discussed the number of NENs that had started in the department since the first interview and expressed frustration with them because they were slow and lacked experience. Although, she perceived that SENs were more accustomed to having NENs and new graduates in the department, she commented that their disturbing behaviours in the department continued. At the time of the interview, she continued to anticipate that she would stay at the small community ED because of her young children; however, she was now considering taking an advanced nursing education program in the future.

Participant 4A was in the 30 to 39 years of age range and had been working as an EN for 18 months. She was hired directly from a general nursing diploma and had no other nursing experience prior to entering emergency nursing practice. She had a diploma as a Registered Nurse, had completed the core courses of an emergency speciality program, had a Bachelor degree unrelated to nursing and had a career in emergency services prior to entering nursing. Participant 4A talked freely during the interview and presented a perspective of what she would like to see in emergency nursing. During the interview, she did not initially discuss the challenges she faced in emergency nursing; however, the challenges became more transparent as the interview progressed. She discussed: her disappointment and what she
perceived to be missing fundamentals in her undergraduate nursing program; the disturbing behaviours she encountered from SENs (for example, being pushed out of the way so that the SEN could admit a new emergency client; having people refuse to help her, having people "impose their ideas" even when these weren’t consulted; and the questioning or undermining of her decisions); her relationship with the EPs; some challenges she had experienced working with medical residents in the department; the overcrowding in the ED; challenges as a NEN; the abuse she experienced from patients (for example, being yelled at); and her lack of support in her perceptorship and orientation to the ED. Participant 4A had a vision of what she would like to see in an ideal mentorship program in the ED. This mentorship program consisted of a long term mentor and mentee relationship that existed formally in the ED and informally out of the ED. She also had a vision for the educational and clinical development of ENs. She anticipated that in a year from the time of the interview she would continue to remain in the same ED that she was currently employed; however, her future plans consisted of becoming an outpost nurse and she was utilizing her emergency nursing experience as a stepping stone to this future career goal. Her level of job satisfaction had decreased since beginning in the ED.

Participant 5A was in the 20 to 29 year age range and practiced in a large urban ED. She had two years of general nursing experience before entering emergency nursing and had been an EN for 2 years at the time of the interview. She had completed a Bachelor of Nursing degree and had completed the core courses of the emergency speciality program, as well as, the emergency nursing speciality certificate. She talked openly about her experiences as a NEN during the interview and at times appeared sad about her experiences. She commented that she experienced stress related health problems at work or when she thought about work.
She discussed the following: the chaotic work environment; the understaffing in the ED; the large workload concerns; what she perceived to be ethical dilemmas as an EN practicing in the current work environment; the abuse she experienced from patients and their families (for example, being yelled at and being insulted); the reputation of ENs; the insufficient orientation and the difficulty finding mentors in the ED; the collegial relationships with EPs; the number of new graduate nurses starting in the ED; the difficulty retaining ENs; her perception of management; and the disturbing behaviours she experienced from SENs in the department (for example, being pushed out of the way so that the SEN could admit a new emergency client; having people embarrass her in front of others; and the questioning or undermining of her decisions). She discussed that she would have liked to have had some previous exposure to emergency nursing prior to taking the emergency speciality program and commented that she may not have entered emergency nursing if she had had this experience. She commented that in the ED where she practiced she felt the ENs were “over our heads” in attempting to deal with the workload. At the time of the interview her level of job satisfaction had increased. Her areas of concern had shifted from concerns about her skills and confidence when she started in the ED to her current concerns regarding staffing, safety and ethical practices. She commented that she did like emergency nursing however the work demands were too great. At the time of the interview, the participant anticipated leaving emergency nursing and starting a career in another area of nursing.

Participant 6A was in the 20 to 29 years of age range and had two years of medical-surgical nursing before entering emergency nursing. She had been practicing in the ED for 11 months at the time of the interview. She had obtained a general nursing diploma, a Bachelor of Nursing degree and had completed the core courses of an emergency speciality
program. She appeared comfortable during the interview and initially commented that she did not have anything negative to say about her emergency nursing experience. As the interview progressed areas of concern became apparent. She discussed: her experience with abuse from patients and their families (for example, being yelled at); the difficulties in learning to manage the violence; overcrowding in the ED; her collegial relationship with the EPs; and her experience of disturbing behaviours from SENs (for example, being pushed out of the way so that the SEN could admit a new emergency client; having people “impose their ideas” even when these weren’t consulted; having people embarrass her in front of others; the questioning or undermining of her decisions; or people not speaking to her). At the time of the interview, she rated her level of job satisfaction the same as when she first started in the ED and she anticipated that in a year from the interview date she would be on maternity leave. She and her husband also had plans on moving to another region of BC and anticipated doing so as soon as her husband was able to secure a new employment position.

Participant 7A was in the 20 to 29 years of age range and had practiced as a medical-surgical nurse for two years before entering emergency nursing practice. She had been practicing in the ED for 15 months, at the time of the interview, in a community ED. She had a general nursing diploma and had completed the core courses of an emergency speciality program. During the interview, Participant 7A discussed her experiences as a Registered Nurse and as an EN openly. She appeared sad during the interview. She discussed what she perceived to be: a lack of leadership in nursing and emergency nursing; a lack of support for the ENs; the disturbing behaviours from SENs (for example, being pushed out of the way so that the SEN could admit a new emergency client; having people “impose their ideas” even when they weren’t consulted; and the questioning or undermining of her
decisions); deficiencies in the ED departments orientation; the challenges she faced being accepted into the ED; the abuse experienced by patients and their families; short staffing in the ED; burnout among ENs; overcrowding; and her perception that she was not taken seriously as a RN in society. Participant 7A also worked in another emergency services field in a nonnursing capacity. Although she had undertaken less education and had received less pay to work in this position, she felt that this work gave her greater power, influence and prestige. She commented that she felt that power, influence and prestige were missing in nursing and that nursing as a profession was devalued. She commented that she felt that she was burning out. At the time of the interview she rated her level of job satisfaction as being less than when she originally started emergency nursing. She discussed that she was seriously thinking about leaving nursing and was contemplating moving to a profession that had greater influence and prestige than nursing.

Participant 8A was in the 40 to 49 years of age range and had 20 years of nursing experience before entering emergency nursing practice. She had been working as an EN for 20 months at the time of the interview. She had a general nursing diploma and had taken all the core courses of an emergency speciality program. Her discussion included her perceptions that: her former nursing experience was not valued in the ED; that management was not supportive of ENs; the disturbing experienced behaviour from SENs (for example, being pushed out of the way so that the SEN could admit a new emergency client; having people refuse to help; having people “impose their ideas” even when they weren’t consulted; having people embarrass NENs in front of others; and the questioning or undermining of her decisions); the collegial relationship with the EPs; the need to build a trusting relationship with some EPs; the challenges with medical residents in the ED; the lack of autonomy and
power of ENs; the lack of power of administration; the violence in the ED; burnout and anger of ED staff; the lack of consequences for RN exhibiting unprofessional or unsafe behaviour; the lack of avenues for debriefing and the lack of mentorship. Participant 8A openly discussed her concerns and experiences as a NEN. She discussed that she perceived that the manager and the nursing educator in the ED did not value her previous nursing experience. Although she had concerns regarding her practice in the ED, she rated her level of job satisfaction as being greater during the time of the interview than when she initially started as an EN. She anticipated that in a year from the time of the interview she would move into another position in the ED and would no longer work as a staff nurse.

A copy of the demographic information questionnaire is presented in Appendix D. An overview of the findings is presented here. The average age of the participants was 35.9 years of age and their ages ranged from 25 to 45 years. The eight participants interviewed consisted of one male and seven female NENs. They had been practicing in the ED for an average of 18.63 months, with a range of experience from 11 to 30 months. This range of experience is appropriate for this study because the inclusion criteria required that participants had to have been practicing in the ED for 3 years or less. There was a large range in the number of years of practice and the areas of practice among the participants prior to entering emergency nursing. Two participants had no nursing experience prior to entering the ED, four participants had two years of nursing experience, one nurse had 14 years of nursing experience and one participant had 20 years of nursing practice; hence, the range was 0 to 20 years and the average years of practice, prior to entering emergency nursing, was 5.2. The range of nursing experiences varied from no nursing experience, to one nurse who had solely practiced in a general surgical area and to those who had a wealth of experience that
included medical-surgical, neurological, pediatric, geriatric and special care nursery nursing. Seven of the NENs had a diploma in general nursing, two had a Bachelor's degree in Nursing and two had a nonnursing Bachelor's degree. All eight participants had the core courses of an emergency speciality education program, which was specified in the inclusion criteria for this study. None of the participants had taken the core courses of a critical care speciality education program. The critical care speciality education program includes courses in intensive care nursing. This may be due to the fact that all of the nurses were funded by their institutions; and hence, expected to work in the ED once the core course of the program was completed. Two participants went on to complete their speciality certificates in emergency nursing. Participants were asked to rate their level of job satisfaction when they first started emergency nursing and at the time of the interview. These results are presented in Chapter 5.

Summary

In this chapter, a brief description of each of the eight participants interviewed in this study was provided in order to give a picture of the participant and give depth to his or her contributions. A brief overview regarding the content of their interviews was also provided. The demographic information collected at the time of the interviews was also presented. The presentation and a discussion of the findings of this study are presented in Chapter Five.
Chapter 5

Presentation and Discussion of Findings

In this chapter, the findings of this study are presented and discussed. As outlined in Chapter 3, eight participants were interviewed and provided descriptions that addressed the study's research questions. The research questions are: How do new emergency nurses describe their experiences as they make the transition from being a new to becoming a more experienced emergency nurse and what are their needs as they make this transition? Several themes were found within the interviews. Thorne et al. (2004) writes that when using the interpretive description approach, "patterns and themes within the data are ordered into a story, or a professional narrative, in order that we might make sense of the most important ideas to be conveyed and access their meaning in a new manner" (p. 15). In order to present the findings of this study in a manner that conveys its most important ideas, the themes have been organized into categories and presented in chronological order according to what a NEN would typically be exposed to as they entered emergency nursing practice and then what they experienced as they progressed in their development as an emergency nurse. Each theme has been compared to the existing literature. The literature is interwoven into the findings and a discussion of how the findings either support or contribute to the existing literature is presented. Two unexpected findings are presented in the latter section of the chapter. A discussion of the NENs intent to leave is presented at the end of the chapter. A brief overview regarding the organization of the themes presented in this chapter is provided below.

The first category presented is orientation, ongoing learning and mentorship. Orientation is the first theme of this category. When a NEN begins practicing in the ED, most
organizations usually provide an orientation. This orientation program often consists of an introduction to the physical layout, the team members and the ED routines. Once completed, NENs continue to learn in their new environment and encounter various behaviours that either help or hinder their learning. The behaviours of health care personnel that were unhelpful and helpful for the NENs learning are presented as themes under the category of orientation, learning and mentorship. How the participants attempted to assist brand new emergency nurses entering the ED and what one participant visualized as an ideal emergency nursing mentorship program are also presented as the final themes in this category.

The next category presented is learning to be a NEN. Once the participants had completed their orientation, they needed to learn how to become more comfortable with their knowledge, their skills, and their role as an emergency nurse. Several themes are presented in this category. The themes include: feeling overwhelmed and unprepared for emergency nursing practice; distinguishing the difference between medical-surgical nursing and emergency nursing; identifying and addressing their own learning needs; and for those who entered emergency nursing without any prior nursing experience, identifying and overcoming some missing fundamentals in their general nursing education programs.

The next category presented is the realities of emergency nursing. As the NEN continued to learn and become more comfortable with their knowledge and skills, they were confronted with the realities of working in the ED. The first theme discussed is the nursing shortage. Hospital administration attempted to staff their EDs in creative ways. The experiences of NENs, as they attempted to work with noncritical care registered nurses and newly graduated general nurses in the ED are presented as subthemes under the nursing shortage. In addition to the nursing shortage, several other themes arose as the participants attempted to survive
the realities of emergency nursing. These themes include: the lack of resources; perceptions of management; the patient acuity and volume; the organizational and technical changes; the participant’s ability to meet professional practice standards; what they perceived to be the difference between community and urban EDs; and the expectations of patients and their families.

Although overcrowding is also a reality of emergency nursing, it has been presented here as a category in and of itself for two reasons: first of all, overcrowding was discussed in every interview conducted; secondly, overcrowding had a huge influence on the work place environment and the behaviours of staff in the ED. Once the participants encountered the realities of emergency nursing, they needed to engage in strategies to help them cope. How the participants debriefed is the next category discussed.

Two themes that were identified from the interviews were unexpected findings and presented under the category of surprises. The category surprises encompass the themes regarding the relationship between nurses and physicians and the horizontal violence experienced from SENs. The final category presented is the NENs intent to leave the ED. The rewards of emergency nursing are listed as a subtheme under this theme. The summary of the study’s findings; the implications for nursing practice, education and further research; in addition to the study’s conclusion are discussed in Chapter 6.

Orientation, Learning and Mentorship

“I felt scared initially.”

Orientation

During this study, the participants used the terms orientation, preceptorship and mentorship interchangeably. The orientation programs described by the participants varied.
The majority of orientation programs described by the participants, consisted of 48 to 96 hours with an EN; however, three participants described receiving no formal orientation and were orientated as they worked in the ED. While some participants remained with one nurse during the entire orientation, others experienced orientations shared among three or four ENs. One participant who did not have an orientation prior to starting her initial shifts in the ED described how difficult the experience was for her:

I guess she (the manager) thought because I worked there the previous summer as a summer student, just as workload, just helping out... she figured she didn't need to give me orientation because I knew my way around and we'd do the mentorship in January when everyone was back.... It was sort of tough because I worked a lot over Christmas and I was sort of thrown in with the wolves.

During their orientation, NENs were buddied with ENs who familiarized them with the unit routines, the unit layout and basic information required to work in the ED. Beyond the basics, some ENs attempted to find experiences and skills that the NEN had limited opportunities to observe or practice before. Some participants commented that their ENs engaged in teaching during the orientation while other participants stated that their ENs were unable to teach due to their busy workload. Finally, participants described what they perceived to be deficiencies in their orientations. In addition to not receiving teaching due to the workload of the EN, some participants commented "I did not get enough orientation in the paper flow...". Others described having received orientation to some sections of the ED, but not others.

Good orientation programs are designed to include the skills and the knowledge needed to provide quality care in the area of practice (Boswell, Lowry, & Wilhoit, 2004). The volume of new information that nurses need to learn, when starting in an environment as chaotic as emergency, can be overwhelming (Proehl, 2002b). In order to ensure emergency nursing
competency in NENs, Proehl recommends that the length and type of orientation be adapted to the NEN’s current knowledge and experience. Nurses without previous critical care experience, or new graduate nurses in the ED setting require three to six months orientation time and the complexity of the learning material increased over the time of the orientation. The orientation also needs to be staged over multiple areas of the ED. Preceptors need to be chosen who want to orientate new staff, have a sound knowledge base and have the support of other staff when their own assignment is busy (Gurney, 2002). While some participants in this study described receiving an adequate orientation, others did not. The participants who did not receive an adequate orientation discussed feeling scared and frustrated. These reactions were also discussed in the literature. Proehl has discussed that short orientation programs compromise patient safety, frustrate the new nurse, and ultimately frustrates the emergency staff. These staff then have to work with the new nurse who initially does not function well.

*Unhelpful behaviours for learning*

The participants interviewed described behaviours of SENs that they perceived to be unhelpful in assisting them in adapting to their role as an EN. The first consisted of being prevented from having experiences; for example, access to interesting cases, cardiac cases, or trauma cases, even when the patient was in the NEN’s assignment. The majority of participants discussed having this experience. One participant explained: “...one thing I didn’t like is that because you’re new, the senior nurses would, you know, take over...and here they’re just imposing. It just bothers me”. SENs may take over interesting cases due to concerns regarding the severity of the case, concerns regarding whether the NEN can handle the complex case, or because they are interested in the case themselves. If the latter is the
case, then this behaviour is an example of horizontal violence in which the SEN undermines the NEN’s knowledge and ability to provide care in interesting or more complex cases (Farrell, 1997; 1999). Horizontal violence is discussed in more depth later in this thesis.

Another participant went on to describe the effects that this behaviour had on her learning: “... Sometimes you need to learn things in your own way. You need to make your own mistakes as long as they’re not critical mistakes”. When discussing mentoring, Fawcett (2002) states that nurses who are good at mentoring understand that there are several ways to perform a task; hence, when new nurses, with a sound knowledge base, are given the opportunity, they will develop their own style of doing things.

Although expert nurses may have superior knowledge and skills, they may not always be the best preceptors for NENs (DiMeglio et al., 2005). Expert nurses may use their intuition, skip steps, or be unable to explain their actions. Participants discussed that they did not find it helpful if they were being taught short cuts that weren’t explained to them or when the EN was teaching too quickly. One nurse discussed her experience with an EN who was not a good teacher and the impact that it had on her:

...I had one of the older nurses whose just kind of very quick. “Oh, you put the stuff there, this is what you do.” So you have to seek out people who are more knowledgeable, more experienced and better teachers to show you, which I ended up doing, because I didn’t feel comfortable with what she had shown me. I didn’t feel like I was doing it right.

New nurses want to emulate nurses who have a sound knowledge base, are enthusiastic, are respectful, are patient, and who have non threatening communication skills (Fawcett, 2002). The participants in this study described incidents of working with nurses who did not exhibit these characteristics; consequently, the NENs considered these nurses to be poor teachers. One participant said: “There’s some people that weren’t, weren’t good teachers.
They’re kind of flighty on their own and they... just would teach bad habits or something or
not get the right information I needed”. Another NEN discussed the experience she had of
having an EN who demonstrated unprofessional behaviour towards patients and how this had
hindered her learning:

Dealing with people (emergency nurses) who have a bad attitude has been a negative
experience in terms of my learning curve.... You don’t really pursue anything else because
you feel kind of stumped .... You don’t want to be with them, so you just kind of stop....
You don’t go any further.

As described in the previous quote, the NEN did not pursue new opportunities or progress in
her learning when she worked with ENs who exhibited unprofessional behaviour. The
participants engaged in conversations with other NENs that they were either working with or
whom they had completed the emergency nursing education program with. One participant
described her perception that some of her colleagues had not had good experiences as a NEN;
consequently, “they felt scared and they feel, you know, you can’t ask anybody questions
because they’re looked at like...an idiot if they ask”. Finally, one NEN stated that what she
experienced was “a lack of [a] nurturing environment for someone who is new, who is
nervous. There’s a need for, ‘Oh, you’re OK’”.

Helpful behaviours for learning

SENs act as role models for NENs. New nurses look for role models who have a sound
knowledge base, a positive attitude, patience, enthusiasm, are respectful, have a good sense
of humour, have effective communication skills, advocate for patients and practice
professionally (Fawcett, 2002; Proehl, 2002a). The participants in this study described
several behaviours that they perceived to be helpful for them while they were orientating.
Observing role models was the most frequently described behaviour the participants used
when attempting to learn in the ED. One participant stated: “I just watched and learned from
them...you take things from the various nurses that you’re watching, you know, I like how she does this and I like how she does that”. Participants stated that they would seek out ENs who they perceived as being good ENs, had experience and were good teachers. Observing how activities were performed and being guided through new activities were also discussed as being helpful. One NEN commented that the attitude and behaviours she found helpful when working with SENs were:

...a positive attitude. If something (an emergency patient) came in, I knew I could go to them (SENs) if I didn’t know how to do something or didn’t know what I was supposed to do. They helped, they guided me through it instead of making me feel inadequate.

Asking questions was a strategy that many of the NENs employed. The participants discussed that over time they had learned who to ask for help. Having ENs ask, “do you want my help?” and allowing the NEN to make that decision was also discussed as being helpful. ENs who had a sense of humour and provided compliments were also helpful for some NENs. One NEN commented that the charge nurse “…had complimented what I said and a doctor complimented my charting. It’s the little things like that that makes your day and makes you feel that you do know what you’re doing”. Some authors in the literature support the impressions expressed by this participant. Coworkers play a vital role in contributing to a new nurses sense of belonging in the new workplace (Boswell et al., 2004).

Working with new emergency nurses

The participants emphasized with newer ENs that entered the ED after themselves. All of the participants attempted to be helpful and assist these newer ENs in learning the ropes. As previously presented in Chapter 2, mentors who have recently graduated themselves have been found to be preferred by younger mentees because these mentors have a greater understanding of the mentees’ experience (Andrews & Wallis, 1999). The participants in this
study commented that when they worked with ENs who were less experienced than themselves, they: encouraged them, offered support, welcomed them, answered their questions, buddied with them and conveyed a positive attitude. One NEN, who had not initially been treated well by SENs in the ED she worked in, stated:

I make an effort when there’s new grads come into our department to be supportive because here they are, they’re fresh and they’re motivated. You want to capture that now before [they] get jaded like all the other old ones.

All of the participants interviewed stated that they attempted to be helpful for NENs starting in their EDs.

*Mentorship programs*

One participant described what she would like to see in a mentorship program for NENs. Not only did she describe a mentorship program that consisted of a prolonged orientation and teaching component, it also consisted of support and a continued relationship with a mentor. She commented:

I would love to see more of a mentorship program like a true mentorship program. I had four shifts of mentoring (orientation) before I was on my own... Wouldn’t it be lovely if you would work with another nurse for six weeks or the six blocks before being put out alone and [if you received] the help needed like a buddy system....I don’t know how many nurses would volunteer their time, but they’re assigned to a new nurse for six months. You’re with that nurse... [You’d go] twice a month for coffee to discuss what you’re seeing, your experiences and sort of become available by telephone.... [You’d talk over,] “Uh, I had a really crummy day” and “I didn’t do this”, “I didn’t do that”, “somebody yelled at me”....

This participant described a mentorship program that existed over a long period of time and fits the more traditional definitions of mentorship. As described in the literature review, traditionally, mentorship has consisted of a long term relationship, with a mentor who is more mature and experienced than the mentee (Andrews & Wallis, 1999). The mentor is concerned with the mentee’s wellbeing and career advancement. The mentor serves as a
counsellor, an advocate, a teacher and a confident (Klein & Dickenson-Hazard, 2000; Watson, 1999). The mentor contributes a large personal and time investment in the relationship in order to guide the mentee in their adaptation to the reality of the workplace environment and the profession (Andrews & Wallis; Green & Puetzer, 2002). The mentee benefits from the support and role modeling demonstrated by mentors. Women benefit from peer mentoring that has a friendship component (Byrne & Keefe, 2002). The personal support has a positive impact on the mentee’s mental health and self-esteem. No formal mentorship programs were found to exist in the ED settings, in which the participants worked, at the time of this study.

Learning to be a NEN

“It’s a hard transition.”

Once the NEN has completed their orientation to the department, they continue to develop their knowledge and skills in emergency nursing. Several themes were identified from the interviews. They include: feeling overwhelmed and unprepared for emergency nursing practice; distinguishing the difference between medical-surgical nursing and emergency nursing; identifying and addressing their own learning needs; and for those who entered emergency nursing without any prior nursing experience, identifying and overcoming some missing fundamentals in their general nursing education programs. These are presented and discussed in the following section.

Feeling overwhelmed and unprepared

The participants experienced mixed emotions as they started their practice as NENs. Their emotions varied from being enthusiastic and excited to scared, nerve racking,
uncomfortable, challenged, frustrated and overwhelmed. One participant described her feelings as she started her emergency practice as follows:

*Overwhelming!* So you’ve just learned all your new things...the monitors, you didn’t ever use it before...[I had] two days and an afternoon and one night shift as orientation into the cardiac section, the trauma section and into peds. I’ve done a piece of this before, but you know ...[in] the course, you learn different things and it was just so much! The cardiac monitors—they’re a lot. It’s a lot to watch and listen and you know you’ve got to listen to a lot of things. It’s quite overwhelming.

Another participant, who started working in the ED after graduating from a general nursing program stated: “I guess I as a bit naïve when I first started there. I was excited to be working right away in the emergency and thought I could handle it”. The perception of being unprepared was also expressed by a participant who had two years of surgical nursing experience before taking the emergency core courses and moving to the ED: “…it would have been to my benefit that I had a bit more exposure to the type of work emergency, well just what emergency nursing is all about, before actually diving into the [emergency] course and diving into [the] critical care component”.

The participants in this study were not alone in their feelings of being overwhelmed and having concerns that they were unprepared to function independently. The large volume of information that new nurses must master while practicing in a frequently chaotic emergency environment can be overwhelming (Proehl, 2002b). New graduate nurses may feel this more acutely (Proehl). During a emergency nursing mentorship program of new graduate nurses, the new nurses reported feeling overwhelmed and unable to function independently despite being mentored by a senior EN (Betts, 2003). New nurses in critical care areas are required to multitask and make decisions quickly. Hall (2004) found that new graduate nurses had difficulty with this initially. In addition, new graduate nurses had high expectations and were frequently critical of their own performance (Hall). In evaluating emergency nursing
competency, Proehl has found that it takes two to three years to fully develop emergency knowledge, attitudes and skills.

**Difference between Emergency and Medical-Surgical nursing**

The participants discussed their perceptions of the difference between medical-surgical nursing and emergency nursing. One participant commented that one of the differences between emergency nursing and floor nursing was that in the ED:

...everything can change in a second ... [there's] no real control over the flow of patients through. Your expected to be able to make critical decisions and to think on your feet a lot more than you are on the ward.

Another participant stated that “… in emerg, we can be fine one minute and then all hell can break lose...it’s brutal... learning to cope with that, learning to prioritize...”. The comments of these participants echo the findings previously discussed in the literature review. The ED is an environment in constant turmoil. The EN practices in an environment where there is a constant preoccupation in regards to what may be coming through the door, where efficiency is valued and where priorities have to be set (Varcoe, 1997). The constant flow of patients in and out of the department means that ENs and EPs must be efficient and attentive to the priorities of the patient’s presenting condition (Varcoe). Focus on the physiological condition and a lesser emphasis on the psychosocial aspects of a patient’s health enables health care practitioners to refocus the patient’s condition into a manageable case for treatment (Varcoe). NENs need to adapt their nursing care to meet these conditions.

One participant commented that another difference between medical-surgical and emergency nursing was that as an emergency nurse, “…you become a detective…the type of knowledge base, the type of relationship, the relationships with colleagues, the relationships with doctors…is different than on the floor.... The doctors, they do actually listen to what
you say...”. Another participant explained that as an EN, “...your focus changes... You’re looking after less people and in more detail...”. Participants discussed that “as an emergency nurse your assessment is considerably different to being a medical-surgical nurse... there are signs and symptoms that you learn as a emergency nurse and that you can pick up quite quickly...”. Finally NENs commented that they were using their knowledge and skills to a greater extent in the ED, than as a medical-surgical nurse.

Proehl (2002a) has described that rapid and accurate assessments are key in emergency nursing. She states that when an emergency patient enters the ED, they come in with a chief complaint. The emergency nurse then needs to perform a limited, focused and specialized assessment, plus implement interventions based on this assessment. Eventually a diagnosis of the patient’s condition is made; hence, the emergency nurse does become a detective as the first participant has discussed. As previously discussed in the literature review, Gurney (2002) has written that the EN reassesses the patient intermittently and communicates significant findings to the EP during the course of the patient’s stay. Nurses new to emergency nursing need to be collaborative and assertive when working with EP’s, they need to ask the EP’s their impression of the patient’s condition and the plan of care. ENs and EPs negotiate for each other’s time and attention. Although in her work Varcoe (1997) had found that SENs were more successful at negotiating for the EPs time than NENs, Gurney found that EP’s were appreciative of the new nurses communications and reciprocated, this latter finding is similar to that reported by the participants in this study.

Learning Needs

Learning the role of the EN, the skills and the drugs frequently used in emergency practice was identified as being a challenge by the NENs interviewed. Two participants, who
had not completed the emergency core courses prior to starting emergency nursing, commented that "the learning curve was very high"; in addition, all of the participants interviewed indicated that there was a great deal to learn when starting their emergency nursing career. Participants discussed learning to adjust their nursing care to the varying levels of acuity and the variety of patients seen in the ED. Learning how to prioritize their nursing care and adjust their nursing assessment to accommodate the efficient treatment of the emergency patient was also discussed. One participant stated:

[Your assessment] in emerg needs to be really focused. In general, it’s superficial. They’re looking for major problems and exploring the chief complaint, that’s it. I don’t really have time to explore your childhood with you and your self concept, you know, all that nursing focus… I’m going to find out why you’re here....

The need to learn the typical patient presentations, the commonly used drugs, the usually treatments and how to assess the acuity of a patient, were also discussed as learning challenges by the participants. It took time for them to learn these aspects of emerging nursing care; however, once the participants became more familiar with them, they express a greater confidence in their role as an EN. This is demonstrated by one participant’s comments:

When you first start, the drugs are all new to you. You’re constantly looking things up and after awhile you know everything by heart. All the knowledge that you’ve acquired and you don’t have to look things up anymore. It makes your work quicker and gives you more confidence. Knowing how to read an ECG. Knowing what to do with a renal colic when there’s a long line up of people, the doctor isn’t going to get to them for an hour, you know what to do. Just knowing all the interventions that you’re expected to do.

A second participant expressed that while developing her skills and knowledge as an emergency nurse, she lacked the experience to assess the acuity of the patient’s condition. She went on to say:

…and that’s another learning experience, because sometimes you don’t realize how sick they are because you don’t have that nursing gut (experience) for emergency yet...So
sometimes you don’t know when to ask for help and they (the other health care professionals) don’t know you’re overwhelmed. So, that was a learning experience too.

The NENs discussed that they had to adjust their nursing care to meet the increased pace, workload and acuity of ED patients. One participant stated:

The drugs and stuff, it took me a long time to get a handle on all that and that’s just experience. You have to work with them over and over and over again. I found the work was definitely challenging.... You know trying to manage, four beds wasn’t hard but then I had two Mls and a present patient plus a rotating bed, it was a little much... I mean still sometimes the workload is challenging although I find I’m better able to cope with it, kind of.

Nursing pediatric patients was “very intimidating” for some of the NENs. In addition, understanding the system; that is, the flow of paperwork and who to report concerns to in the ED were also identified as a learning need for the some participants. One participant said:

It’s a learning thing. Aside from the skills to learn, in the beginning, there was how the system worked like where does the chart go? Who do we contact for certain stuff? Who am I supposed to be talking to or informing? I mean, now I know that the charge nurse is to be informed at all times about anything that’s going on.

The participants also discussed the need to learn the different members of the team, their functions, plus how and when to access them. One participant stated that for her “learning to work as a part...of a larger team was challenging” due to her pervious health care experience in which she worked alone with a partner. Another participant commented that she had to learn “…how the relationships with doctors was suppose to be because it’s different on the floor...”. A third participant commented on her lack of familiarity with the role of other members of the health care team. She commented that:

I wasn’t told until fairly recently, [that] a patient coming in; they need [a] social work consult and all those other references...to other parts of the health care team. So all those little details that nobody ever tells you about, yet you’re expected to know. Then it comes back to haunt you. “You mean you didn’t consult the social worker on that lady?” She got sent home. “How was I supposed to know?”
As NENs obtained experience in the ED, they became more comfortable with their practice and began to develop a broader perspective of what was occurring in the ED. One participant who had been nursing in the ED for 16 months explained how experience had helped her become more proficient at developing the recognition of her client’s presenting condition:

With the more experience… the more you ask questions and the more you look things up, you start to understand where people are coming… [from] and what they need when they get there. You get on the right track quicker. You’re never fast and there’s always a surprise. You always get humbled at some point in the day; but I think your nursing gut (experience) gives you that idea of where you’re going when the patients first come in. I think you get a quicker connection with those patients. You can get on the right track earlier with them. I think when you’re new you’re unsure so you’re looking at everything and everywhere. You’re not honing down so quickly.

After 2.5 years of emergency nursing practice, another participant described how her experience had helped her become more comfortable in her practice and had broadened her view of what was happening in the department.

I’ve really noticed the transition in the last year… I do know what’s going on in the whole department and you can’t teach that. It’s just experience and being able to keep track of all those people in your mind. You don’t have to write anything down like you do when you first start, this comes from experience.

The experiences and perceptions expressed by the participants are not unique and they parallel the experiences of nurses and nurse educators in the literature. As discussed in the literature review, new nurses to emergency nursing need to shift their focus to a physiologic focus of care, learn how to negotiate in a collaborative relationships with team members and need to be proactive in an environment where expedient flow is valued (Gurney, 2002; Varcoe, 1997). The NEN now practices in an environment were there is a constant preoccupation in regard to what’s coming through the door, where efficiency is valued, where priorities have to be set and were the subtleties in communication and expertise among team
members are not easily recognized (Gurney; Varcoe). With experience, ENs developed expectations regarding their work. These expectations include: the types of patient who will be seen in the ED; the type of care patients will receive; the type of work their colleagues will provide and the flow of patients in and out of the department (Sbaih, 2001; Varcoe). With experience ENs develop patterns of knowledge and expectations of care which then becomes the basis by which they practice their nursing (Sbaih). Based on previous experience, ENs develop ideas about the normal case scenarios; for example, the “normal” ankle injury, the “normal” chest pain and so on, which then directs how they conduct their nursing care (Sbaih). Establishing these patterns of knowing enables the EN to allocate the amount of time, care and space allocated to the ED patient, which then ultimately facilitates safe care and patient flow out of the department. This efficiency also creates a sense of having done a good job and working as a team. New ENs need to learn the patterns of knowing, the normal case scenarios and how to facilitate the patient flow through the department (Sbaih; Varcoe). They need to learn how to prioritize, become efficient and recognize when patients do not meet the normal case scenario (Gurney, 2002). Proehl (2002b) has written that it takes two to three years to fully develop and function as a competent emergency nurse.

**Missing Fundamentals in General Nursing Education**

Participants who had recently graduated from an RN program expressed concerns regarding what they perceived to be deficiencies in their basic nursing education and how these deficiencies did not help them prepare for emergency nursing practice. One participant commented that: “In basic nurses training, we don’t get a lot of theory education, I don’t think. There’s a lot of fluff that we take…”. She further went on to say:

I found the education, when you came out of the nursing program, just wasn’t there. I was never really even taught how to do a proper head to toe assessment in nursing school.
They said do a head to toe... "Well what am I looking for?" Yet we spent a three hour lab on brushing a person's teeth and feeding a patient in their bed, but a head to toe assessment is given five minutes mention in lab. I don't know, the priorities just seemed all mixed up. So then you're thrown into your emergency, you're expected to know all that... "Go do a head to toe assessment on this person that's just come in with a decreased level of consciousness". "Well what am I looking for?"

The transition from student nurse to registered nurse can be a stressful and difficulty experience (Hall, 2004; Holland, 1999). No literature was located that discussed the curriculum of a general nursing program and how they prepared new graduate nurses for emergency practice. Proehl (2002b) has found that new graduate nurses have the greatest learning needs, when compared to other nurses, when they enter emergency nursing. She recommends an extensive orientation for this group of nurses that includes instructions on assessments and priority setting.

Realities of Emergency Nursing

"I enjoy emergency nursing as it is, but the amount of work is just too overwhelming."

As NENs continued to learn and become more comfortable with their knowledge and skills, they were confronted with the realities of emergency nursing. The nursing shortage; the lack of resources; their perceptions of management; the patient acuity and volume; the organization and technical changes; the difficulty meeting professional practice standards; the difference between community and urban EDs and the expectations of patients and their families were identified as themes of this category. The nursing shortage and the expectations of patients and their families have secondary themes that further provide valuable information regarding the experiences of NENs. All eight of the participants interviewed for this study described how they found it difficult meeting the challenges they were expected to deal with as a NEN. For one participant, one of the biggest surprises she
experienced as she entered emergency nursing was that "it's hard work". Two other participants also stated that they thought emergency nursing was hard work and every participant interviewed discussed elements of their job that made the work hard. The challenges that the participants identified are presented below.

Nursing Shortage

All participants discussed the impact the shortage of ENs had while working in the ED. A condition that has significantly influenced emergency practice is the nursing shortage (Robinson, 2003; Zimmerman, 2000). There are multiple factors that contribute to the shortage (Aiken, 2001; Duffield & O'Brien-Pallas, 2003). Participants discussed that ED management attempted to fill the vacancies in various ways. Some solutions employed included: having ENs working overtime (OT); utilizing medical-surgical nurses in the department; attempting to close beds in the ED; hiring newly graduated RNs in the department; utilizing float nurses; or working short staffed. The solutions employed often created difficulties for participants. One participant commented that because the EN worked OT, they "burned themselves out". Working with newly graduated RNs, medical-surgical RNs, or noncritical care educated float RNs created additional work for the ENs because they also had to cover aspects of patient care that these nurses could not, for example, monitoring cardiac monitors. Attempting to close beds was futile because as one participant explained: "...they try to close sections, right, because there's no staff, but if somebody with an MI (myocardial infarction) comes, they have to open...". Working short staff created stress for ENs. The combination of the stress of emergency nursing work, the workload and the short staffing has resulted in ENs leaving their jobs. One participant commented:

... it's very difficult with the amount of stress, with the lack of staffing, the amount of workload that's gone up. It's very difficult for the nurses that are there already to be
supportive to the newcomers, but it has to happen because the later are emergency nurses that came after me who have already left ... or who have become part time nurses. There's a lot of senior nurses that are leaving again because it's just a stressful environment. I mean there needs to be more staffing... even the senior nurses can't handle it....

Participants went on to say that they understood that emergency department managers were having difficulties staffing their departments; however, one participant called hiring new or recently graduated nurses a "band-aid" solution.

The nursing shortage has created occupational stress for nurses as they are unable to give safe or adequate patient care (Hall, 2004). As discussed in my literature review, nurse dissatisfaction over increasing workload demands, inflexible work schedules, plus the challenges of working with acute and complex patients in an unfavourable work environment has contributed to the nursing shortage (Aiken, 2001; Duffield & O'Brien-Pallas, 2003). While "experienced and dedicated nursing staff are the backbone of emergency care" (Anonymous, 2001, p. 82), hospitals cannot attract enough nurses to staff their emergency departments. Working without enough nursing staff and in conditions of hospital overcrowding has created a situation in which ENs are frustrated with their work environment; therefore, they are burning out and leaving their jobs (Carpenter, 2001). In attempts to staff the ED with nurses, hospital administration has attempted to utilize staff of various backgrounds. ENs' experiences of working with these nurses are described below.

Working with noncritical care nurses

As a result of the nursing shortage, many hospital administrators attempted to be creative in how they staffed their EDs. One method they employed was the use of noncritical care nurses in their EDs. One participant described the challenges she experienced working in an ED that utilized staff with different levels of expertise. In the ED that she worked, the RN
staff consisted of those educated in medical-surgical nursing only and those who had further
education in critical care or emergency nursing. Critical care or emergency educated nurses
were expected to take on the tasks that medical-surgical nurses were unable to do. She
commented:

…it is hard to work with people without the emerg course. It’s hard to work with people
who don’t do the monitors, because I have too take responsibility for those people now.
Even though my coworker is looking after them, if they don’t know how to read the
monitor and they have a cardiac patient, I have to take that responsibility.

Because this participant was now monitoring the patients of the medical-surgical nurse, her
perceptions were that her workload had been doubled. Although she stated that she knew the
medical-surgical RNs were responsible for their own practice, the participant’s perception
was that “for the patients’ sake, I need to watch”. One participant described how the focus
of the medical-surgical nurses and the emergency nurse was different and how this created
stress and a greater workload for her as she monitored the patients of the medical-surgical
nurse. She said:

…and then you get the new nurses come down; who I don’t think they have their nursing
down yet. They’ve been nursing for two months and think, “Oh it’s fine, I think I’ll just
go to emerg”. They’re more worried about an IV [that] has come out [rather] than
worrying about the guy’s heart rate that was 160 and his temperature was 38.5. They
focused on something that wasn’t… “You know what? We can put another one of those
[in]. We need to focus on something different right now.” Your focus changes once you
go into emerg, after you’ve worked on the medical wards, your focus just totally
changes….

In the literature there is discussion that because of nursing shortages, there are not enough
nurses to provide care for the increasing number of patients seeking care in the ED;
consequently, hospitals are utilizing nurses from other areas of the hospital who were
unfamiliar with the ED or emergency care (Derlet & Richards, 2000). As discussed in
Chapter One of this thesis, emergency nurses are required to have the ability to provide care
for a wide spectrum of patient problems and conditions; in addition, they must also be familiar with a multitude of policies, equipment, supplies and processes (Gilbert, 2003; Proehl, 2002a, 2002b). ENs must also have the skills, knowledge and the ability to safely, efficiently and expediently move a patient through their emergency visit. No research was found that explored the use of noncritical care or float nurses in the ED and the effects the use of these nurses had on emergency staff, patient care, or flow through the ED; however, two authors have discussed, in their analysis of the causes and effects of hospital overcrowding, that these nurses were not efficient at delivering emergency care because of their lack of emergency nursing knowledge and the fast pace of the emergency nursing care (Derlet & Richards).

*Newly Graduated General Nurses in the Emergency Department*

As a result of the nursing shortage, another way hospital administration attempted to staff the ED was by hiring new graduate nurses into the ED. Participants expressed mixed thoughts regarding having newly graduated nurses, from a general nursing education program, start their nursing practice in the ED. Two of the participant’s interviewed were newly graduated RNs who were hired into the ED without having the core emergency courses first. While one participant had extensive experience in the health care field, the other did not. Both participants commented that the learning curve was extremely high for them. One of these participants said this about hiring new graduate nurses in the ED:

The reality is there are no nurses, so they (staff in the ED) work short.... In my point of view, it’s better to have an extra set of hands there that you may have to help out, but at least you’ve got another set of hands. You can do the basic stuff straight out of school.
Some participants did not agree with having new or recent graduates in the department. One participant discussed that in the ED she work in, RNs with six to eight months experience were taking the emergency core courses and then working in the ED. She went on to say:

I would not recommend someone with no nursing experience prior [to starting in the emergency].... I have a co-worker that did the course with me. He had eight months nursing experience and did the [emergency] nursing course. I don’t agree with that. I don’t care if they have their degree or not. [They] shouldn’t be coming into acute or specialty courses. To me, you need a year, at least, of hands on assessments on medical-surgical patients... I consider it unsafe.... It takes time to gain experience and to be comfortable with just basic things.

As the nursing shortage progresses, it has become more difficult for EDs to locate and hire RNs who have previous medical or surgical experience; consequently, there is an increasing trend for specialty areas to hire new graduate nurses in positions that once required nursing experience (Bowles & Candela, 2005; Gurney, 2002). New graduate nurses have the greatest learning needs, when compared to nurses who have prior medical-surgical experience, because they need to learn: how to make rapid assessments; how to problem solve; plus how to work in a fast paced and volatile environment (Gurney; Proehl, 2002b). In addition, they may have difficulty communicating with physicians due to their concerns regarding their knowledge base and confidence (Bowles & Candela). Making the transition from a student nurse to a practicing RN is difficult for most newly graduate Registered Nurses as they need to focus on the patient’s physical condition, need to manage the workload, need to develop their technical skills and need to become accustomed to the nursing work environment (Greenwood, 1993). Authors in the literature have recommended that new RNs hired into the ED need to be screened carefully for their ability to problem solve and work in a fact pace, high risk and volatile environment (Gurney). In addition, Boswell, Lowry and Wilhoit (2004) have found that new RNs, hired into nonspeciality departments of a hospital, required
six months of orientation time. Nurses hired into speciality care areas required at least one year of orientation time to make the transition from a novice to a staff nurse. Given the amount of orientation time that the participants in this study experienced, EDs in the lower mainland may need to reexamine their orientation programs when hiring new graduate nurses in order to promote their success.

The lack of resources

The lack of resources was a reality that NENs faced as they practiced in the ED. It became a concern for ENs, especially when they worked on night shift. One participant discussed the fact that ENs were expected to adapt to the reduction in services by providing these services themselves or by doing without; consequently, this increased their workload, increased their stress and reduced the availability of ENs available to provide care in the department. The lack of resources was a concern for NENs in general. One NEN stated: “I was surprised how many sort of duties, fall on nurses. There should be someone else doing [them]”. She described some of the nonnursing chores she was expected to do in the community hospital ED in which she worked. These nonnursing chores included: housekeeping chores; changing all beds; cleaning beds; changing the linens and emptying linen carts. She went on to say that performing these tasks were “a real misuse of our time”. In urban hospital EDs, some of the non nursing chores that participants stated that they performed included: acting as a housekeeper, acting as a porter and acting as a unit clerk. A participant from a larger hospital ED discussed her frustration with trying to cope with the expectations of her work and the effects it had on all the people involved:

Everybody is stressed... in the treatment area there’s two nurses and there’s no clerks so we end up becoming the porters, cleaning ladies, nurses, and clerks now. Yeah, we even have to type in requisitions so there’s more job and...[patients]. It’s become a norm that patients have to wait for four hours, it’s become a norm... It’s not right and it’s not right
for the patients. It’s not right for the staff because we’re just in over our heads, it’s just crazy.

The participants are not alone in their frustration of performing nonnursing duties, the experience of increased stress and the increase in workload that these chores bring. Hall’s (2004) found that RNs experienced occupational stress when they worked with a lack of resources. These lack of resources included: the lack of medical supplies, the lack of equipment and the lack of other staff. It was found that the level of occupational stress was the highest among RNs who were the most inexperienced. In their study of nurses in five different countries, Aiken et al. (2001) found that RNs were spending a great deal of time performing duties that did not require their professional training; as a result, many of the activities that required their skills were left undone. Finally, in their survey of ENs, Keough, Schlomer, and Bollenberg (2003) discovered that ENs were performing janitorial work or the work of unit clerks and that they could not attend to the basics of nursing care. Short staffing was described as a contributing factor for these results. The ENs, who participated in this survey, reported that performing nonnursing chores contributed to the stress and dissatisfaction they were experiencing in their work.

Management

The participants’ experiences with those in management positions was also a reality that they encountered while nursing in the ED. All of the participants discussed the role of management. While two participants thought management was doing what they could to assist the ED, six of the participants commented on their frustration with management. Of those participants who had concerns about management, one stated that there was a lack of leadership in the ED; one discussed her perception that management did not listen to the EN’s concerns; one discussed her frustration with not being able to access the nurse educator
for her learning needs and her frustration with not receiving any feedback or performance appraisal since her employment as an EN; one expressed her concerns that management was not supportive of ENs; and one discussed her perception that both the nurse educator or nurse manager had unrealistic expectations of the ENs as they practiced in the current emergency environment. When trying to deal with the overwhelming workload in the ED, one EN stated:

It's just impossible ... my perceptions of the management and just the hospital and the educator expects [us] to be on the ball in that area. It's just... impossible!

The nursing manager has been found to have one of the most overburdened positions in health care today (Anthony et al., 2005). ED managers must manage resources and people in an unpredictable and stressful environment. Many of the frustrations expressed by the participants, in this thesis study, were also present in the literature. The perception that people in management positions were not listening to them has also been found in research with new graduate nurses and with RNs studied in five different countries (Aiken et al., 2001; Bowles & Candela, 2005). Researchers and authors on leadership have expressed that being responsive to their staff’s concerns is a necessary characteristic of a good manager (Brunce, 2002; DiMeglio et al., 2005; Upenieks, 2002). The participants’ perceptions that those in leadership positions were not accessible have also been found by Cline, Reilly, & Moore (2003) who interviewed RNs as to reasons they left their jobs. Researchers and authors have written that those in leadership positions need to be visible and accessible for their staff and that this is a necessary characteristic of a good leader (Brunce; DiMeglio et al.; Upenieks).

The need to promote staff development and promote a culture that in turn would enhance the practice environment were described as being essential by managers in DiMeglio’s et al. research study. The NEN’ perceptions that they had little or no support from management
was also found in Keough’s, Schlomer’s, & Bollenberg’s (2003) survey of ENs in Illinois.

RNs believe that they need the support of management in order to provide quality care (Kramer, Schmalenberg, & Maguire, 2004). Support by management is critical in retaining nurses (Anthony et al.) The participant’s perceptions that people in positions of leadership had unrealistic expectations of them has also been found to be the experience of other ENs (Keough et al.)

One participant expressed that it was her perception that there was a lack of leadership in emergency nursing. The participant stated that, “...I need leadership and I need people to nurture me to be a leader”. This participant expressed her frustration over what she perceived to be the lack of knowledge, skills and experience of her nursing manager. She commented:

...my department is the emergency. They’re trying to implement what you call a PCC, which is a Patient Care Coordinator, I have no idea what that really means.... They’re in the position because of their educational background or experience. I mean for years they’ve been a nurse, but they’ve never had any leadership training. I think they’ll be sending them to some sort of leadership course.... They’ve been nurses for so long, you know, now they’re put into a position as a PCC and I see them lost.

She went on to express her ideas regarding what makes a good leader and how it was lacking in the ED:

The system that we have is not working, like the flow of how the department works. If there’s a system in place, a PCC’s job is to say: “Well, if the system is bad, lets make it good. If the system is good, let’s make it better. If the system is better, lets make it excellent”. That’s what I believe should be implemented, it’s lacking for sure.

Finally, she stated that what she believed some of the good characteristics of a good leader were are as follows:

Leaders need to communicate well. Leaders listen. Leaders are about change and they are able to implement change effectively. Leaders are people who I wish to follow, bottom line.
Authors and researchers have described several characteristics of a good leader/manager. Good leaders/managers need to have the following characteristics: they need insight, have vision, be a change agent, be a good listener, have good communication skills and promote accountability in their staff (Brunce, 2002; Heath, Johanson, & Blake, 2004). Good leaders/managers need to build collaborative relationships (Heath et al.; Upenieks, 2002); coach and mentor staff (Anthony et al., 2005); support staff (Anthony et al.); value the profession of nursing and be clinically relevant (Heath et al.). Good managers/leaders are responsible for setting the tone and the standards of practice in their environment; need to promote teamwork and are respectful of their staff (Heath et al.). Finally, good managers/leaders need to give recognition to their staff for the work that they do and their accomplishments (Cline, Reilly, & Moore, 2003).

Nurse managers set the standards for practice and the tone of the work environment (Heath et al, 2004). Poor management contributes to unhealthy work environments (Heath et al.). As discussed in the literature review, when nurses are dissatisfied with their work environments, they have a greater intent to leave the organization; and hence, this further contributes to the nursing shortage and increased costs for the organization.

Patient acuity and volume

The high patient acuity and patient volumes were another reality that the NENs had to face as they practiced in the ED. In this study, one participant perceived that one of the major differences between floor nursing and emergency nursing was that while ENs had fewer patients, the acuity of those patients was higher. Initially, the high acuity of the patients’ conditions is what drew the participants to emergency nursing. One participant said of emergency nursing, “I like the pace, I like the variety. I’ve always liked different
things.... You get all sorts of different things that come in during the day. That’s the biggest appeal of it. I don’t want to do the same thing all day”. However, all of the participants discussed the high levels of patient acuity, the large variety of patient conditions, the high volumes of patients and the fast pace in which they were expected to perform their nursing care. All of the participants discussed that these factors, compounded by the nursing shortage and hospital overcrowding, have created a work environment that places high mental and physical demands on them. The following two quotes were provided by a participant who worked in an ED that was short staffed, utilized noncritical care nurses in the department and was overcrowded. She described a day in the life of an EN in her department and that her experience was of being constantly pulled by competing demands.

I go to work, I get report. We’ll talk about [the] med-surg [area of the ED] because I find that’s the most challenging. [I have] four people to keep track of, 2 partners [RNs], sometimes they’re critical care, sometimes they’re not. We have breaks all day long so sometimes you’re really looking after 8 patients because that other person is on their break. There’s no break relief..... So I get there and my patients change and now I’m kinda lost, cause they’re four of them. I try and keep track, but sometimes .... If my partner isn’t critical care and needs an IV started, or if there’s a cardiac patient over there and that cardiac patient needs to be looked after right now, off I go.... [The] cardiac [section] is foil, so I get that cardiac patient... so off I go and I get that patient all admitted. I do all their stuff, I do all the paper work, order for order. I’ve entered the E8 (blood work) and we’ve got the cardiac stuff started even before the doc gets there because I’ve seen something on EKG. Then I stand in the middle of med-surg and I think ‘What was I doing?’, because I’ve been pulled....

She continues,

I’ve got another new patient, so I do that and then I get pulled again because someone needs some help on the other end. You get pulled all the time and I think that that’s mentally exhausting. Physically, you’re on your feet all day. There’s no place to sit there. The (name of urban hospital) doesn’t have a place to sit, unless you go on a break. Mentally you’re dragged how many different ways? On nights, the same thing can happen in med-surg. You get burn patients in, you get pulled into the trauma room, because we’re the ones with critical care, so we leave the med-surg [patients] out there in the med-surg [area]. Now I’m in the trauma room with a burn patient and it takes six of us to do that ... and I’m thinking the guy in 218 needs a glucometer, did I ask her to do
that before I came in here? OK.... it's a constant pull; it's a constant pull.... Sometimes under control, sometimes not. Sometimes you get help, sometimes you don't.

As demonstrated in the previous quotes, the effects of high patient acuity, overcrowding and working with noncritical care staff creates a situation in which NENs are constantly pulled to provide care for the most acute patients; have competing demands for their time and expertise; and are physically and mentally tired. Admitted patients held in the department creates a situation in which the ED ends up holding acutely ill patients for long periods of time creating stress for the personnel working in the department. The descriptions and perception of the participants in regards to the increasing volume and acuity of patients seeking emergency care are supported in the literature. Economic and societal changes have resulted in patients that previously were immediately admitted to critical care units now remaining in the ED and under the care of ENs and EPs (Holleran, 2002; Trzeciak & Rivers, 2003). The volume of patients utilizing the ED for care has increased (Drummond, 2002). Patients presenting to the ED for care are increasingly more complexity and their conditions acute (Drummond; Trzeciak & Rivers). The population is aging and as they age, they present to the ED with exacerbations of chronic diseases that require complicated and time consuming care (Drummond; Trzeciak & Rivers). Patients with AIDS, substance abuse concerns, homelessness, domestic violence, mental illness or those having complications following day surgery also increase the complexity and time required for treatment in the ED (Drummond). The nursing shortage and the increasing volumes of acutely ill patients have contributed to ENs feeling overburdened, overstressed, overwhelmed, unsafe, dissatisfied, and unappreciated in their jobs (Keough, Schlomer, & Bollenberg, 2003). Researchers have found that in an environment in which nurses are dissatisfied with their jobs, high levels of nursing turnover results (Aiken et al., 2002).
Organizational and technological changes

Three participants discussed the challenges they had in attempting to adjust to the organizational and technical changes occurring in their organization while attempting to perform their nursing care. In an environment that was short staffed and in which patient volume and acuity were high, participants had difficulty understanding the rationale for the changes and had difficulties in their implementation.

Two participants discussed the challenges they had keeping up with the organizational changes. When considering the announcement of a new program offered by the hospital one participant said:

The stress level in the department is high and they're (the health region/hospital) always putting a paper out to you that there's new resources for (name of hospital)... why would you introduce all this when you haven't got the basic resources to be running an emergency department? I find them quite, quite hypercritical that way....

When attempting to implement a new computer system in a section of the ED that did not have a unit clerk, a second participant stated, "It's chaotic because you're, you're understaffed and (name of hospital) is undergoing a new computerized system". This participant was 26 years of age. She indicated that she found the new computerized system difficult to learn and that she had to manually enter requisitions. She commented that it added to her workload resulting in less time for her to attend to nursing care.

Although organizational and technical changes are important for the advancement of health care, they also increase the job demands of nurses plus they contribute to nurses emotional and physical exhaustion (Demerouti, Bakker, Nachreiner, & Schaufeli, 2000; Hall, 2004). In order to be smoothly and successfully implemented, the appropriate supports; that is, technical, personnel, and supplies, need to be in place (Demerouti et al.). In this time of staff shortages, nurse have had to take on the work that they were not professional trained for;
are not able to provide the nursing care they were educated to perform and are experiencing occupational stress (Aiken et al., 2001). Researchers have found that nurses are experiencing increasing stress, increasing job demands and increasing exhaustion, resulting in an increase in job dissatisfaction and intent to leave the organization (Demerouti et al.).

*Ability to meet professional practice standards*

All of the participants discussed the challenges they had in attempting to do their work and meet their professional practice standards (RNABC, 2003). Three participants discussed their concerns regarding the quality of care they were able to deliver in addition to the legal and ethical dilemmas they faced. One participant expressed her concerns by saying:

There’s major, major safety and professional and ethical issues and its just, it’s just not right... Oh it’s very difficult, it’s not right because, like I said, somebody is going to get in trouble. Somebody is sure going to get in trouble. Sometimes you can’t even finish your charting appropriately. Even though you’ve done it or attempted to, it’s just difficult to complete it and I mean when you’re called to court, that’s the thing, nothing is an excuse right. Or you might not remember, you did it but you don’t remember... It’s just really scary.

There are several reasons why EDs and emergency personnel are under stress and overburdened. The reasons include: the increased complexity and acuity of emergency patients; the increase in ED patient volume; hospital overcrowding; the emergency personnel’s ability to perform greater intensive therapy in the ED; delays in service provided by others; the nursing shortage and the need for good medical record documentation (Derlet & Richards, 2000; Drummond, 2002). The participants in this study are not alone in their concerns regarding patient safety and their ability to practice professionally. A recent article in the December 2004, BCNU magazine, entitle “ER Crisis” describes the concerns and the actions of ENs in the Fraser Health Authority Region and the Nanaimo Regional Hospital ER. The ENs have adamantly called for the Government to address the situation in their EDs
because they state that they are unable to provide safe patient care and are concerned that they cannot meet their professional practice standards as outline by Registered Nurses Association of British Columbia (RNABC, 2003). Finally, researchers have found that recent RN graduates were found to have a large amount of stress when they believed that patient care was unsafe (Bowles & Candela, 2005) and that RNs left their jobs when there was inadequate staffing; they believed patient safety was at risk; or they believed that their licence was at risk (Cline et al., 2003).

**Differences between community and urban emergency departments**

The NENs, who worked in smaller community hospital EDs had varying opinions regarding the experiences of their work environments. While one participant stated that she felt well supported others commented that the work was more difficult because of the lack of resources and the greater expectations place on all of the ENs. As an EN working in a smaller community ED, the ENs were expected to perform more skills than their counterparts in urban EDs; for example, they collected their own arterial blood gases and performed the 12 lead EKG’s. In addition, during the evening and night shifts, the availability of support staff, for example, respiratory technologists, became limited and community hospital ENs were expected to take on these support staff roles. Community ED nurses also became members of the cardiac arrest team that covered the entire hospital during the evening, night and weekend shifts. One participant stated that she would not recommend that NENs start their emergency nursing careers in a small community ED because she thought there was too much for a NEN to learn. She said this was especially true if they did not have a lot of medical-surgical nursing experience prior to coming into the ED. One participant, who worked in both a community ED and an urban ED, stated that while she was expected to
perform more activities in the community ED, the patient acuity and the number of resources were greater in the urban ED.

I did not find any literature that explored the differences between community and urban EDs and their impact on ENs; however, one research study was found that examined hospital nurse’s intent to stay with the organization in northern and rural hospitals (Tallman & Bruning, 2005). The authors found that hospital nurses who had ties to the community had a greater intent to stay with the organization. Further research is needed to determine whether these findings are applicable to smaller community EDs in general.

*Expectations of Patients and Families*

"...if I can keep people from yelling at me, my stress level stays low...."

*Verbal Abuse*

Participants expressed several challenges as a NEN when working with patients and their families in the ED. The overcrowding in the ED, the waits to be assessed and treated, plus the limited time nurses had to spend with patients created an environment in which patients were frustrated and the health care personnel stressed. The NENs conveyed that because they were visible, some patients and their families would take their frustration out on them. Some of the participants found the situation challenging. One NEN commented that:

...people are disappointed in you.... You know disappointed in the system. You happen to be standing there. A lot of people yell at you or they’re snarky or complaining, so that can be a challenge sometimes.

Hospital overcrowding, increasing patient acuity and the nursing shortage has resulted in an environment in which nurses have limited time to spend with patients and their families; consequently, patients and their families are frustrated and unsatisfied with the care they receive (Drummond, 2002). When patients or their families concerns are not met, violence
can erupt (Morrison, 1999). Patients and their families express their dissatisfaction by making complaints and becoming verbally abusive; unfortunately, these complaints and abuse are directed towards nurses (Aiken et al., 2001).

The participants had different levels of comfort and expertise handling the difficult situations. One nurse who had been practicing for 11 months described her challenges as she attempted to cope with the needs of the patients, the limitations of the system and her frustration regarding how to deal with them. She commented:

I think dealing with patients sometimes can be a challenge because they don’t understand. It’s not by any means their fault, but they don’t understand that there are no beds… There’s only two of us here right now, it might take me twenty minutes to get you some Tylenol for… simple things…. People get frustrated when they wait for two hours or something and… that is a challenge for me because I feel bad about it. Maybe with some years I’ll get a little bit more hard nosed about it, but that is something I’ve struggled [with] because I feel like I have to make excuses or I have to explain to people why this has happened.

A second participant described how she attempted to inform and reassure patients while she was assigned to the treatment or walking wounded section of the emergency. She commented that on this particular day, the participants were “angry because they’ve been [t]here for eight hours, they are waiting to get stitches…. I think the quality of care goes right down”. In addition to providing care for the ED treatment patients, the NEN was also providing care for the admitted patients in the treatment area. She attempted to manage the situation by communicating with the patients in the ED waiting room. She stated that she would:

…try to go into the waiting room quite regularly saying, “I know that you are all frustrated, it’s a long wait. I’m sorry there’s one nurse and one doctor back here... We’re trying to get through as fast as we can.” I find that that little bit of communication helps diffuse things...
Another participant described the verbal abuse she was subjected to by participants and her perception that she needed to endure it and could not change the situation.

Starting a shift...you see the [chart] racks are so full and that the room is overcrowded.... Anybody coming into the hospital... they're frustrated because they can't come in so they get pissed, right. They've been waiting for hours on the other side and they complain to us. You might be verbally abused, they insult you. You can't do anything so you, you shrug your shoulders and give them a card to complain and encourage them to complain that maybe something can be done.

Nurses are often the target of anger and discourteous behaviour from patients, patient's families and other health care personnel (Aiken et al., 2001; Sofield & Salmond, 2003). The participants in this study also reported that they experienced a large amount of disruptive behaviours from SENs. This is discussed in the horizontal violence section of this thesis. The majority of nurses do not have the skills and do not know how to cope with verbal abuse (Sofield & Salmond). When nurses cannot advocate for themselves, they withdraw from the abusive situations and feel powerless; consequently, nurses who are verbally abused experience a high level of occupational stress and a higher level of intent to leave the organization (Hall, 2004; Keough et al., 2003; Sofield & Salmond).

Some participants discussed the challenges they had attempting to meet the needs of patients and their families. Despite the fact that they understood the importance of meeting their needs, their workload often made it difficult. At times, participants perceived the patient’s or family’s request as being unreasonable. One participant described her perception that some of the patients and family members may have:

...unrealistic expectations a lot of times. I mean they usually know how busy we are... They (patients and their family members) think [they] deserve more attention than we can give them. It makes you feel like they think you have no one... else to look after. Constant demands for, you know, a cup of tea or this or that when I’ve got...something else going on that’s a little more important than a cup of tea is. Those kinds of things are hard to deal with because you don’t want to be rude, but at the same time you want them to understand that there’s more going on in the ward than just them.
This participant is not alone in her expression of frustration. Hospital overcrowding, increasing patient acuity and the nursing shortage has resulted in an environment in which nurses have limited time to spend with patients and their families (Drummond, 2002). As working environments become increasing complex and patients or their family members becoming increasing dissatisfied, nurses are burning out (Hall; Keough et al.). As nurses become burned out and dissatisfied with their jobs, they have a greater intent to leave the organization (Aiken et al., 2001).

Perceptions of Misuse of Emergency

The final theme, under the category of the realities of emergency nursing is the perception of misuse of the ED. The perception that the ED was being “misused” by the hospital, the patients and their families plus other organizations were expressed by half of the participants in this study. One participant discussed what she perceived to be “just needless inefficiency” of the hospital system as she would have a “constant battle with the floors” when trying to transfer admitted patients out of the ED so that the ED could attempt to accommodate its other patients. Another participant discussed that as a floor RN she didn’t appreciate the environment and stresses the ED was working under until she started working in the ED. Participants also discussed their frustration at their perception that patients and their families were using the ED inappropriately; for example, one participant commented that: “We have a lot of people ... [who] consider the emergency as a clinic”. In addition, another participant expressed her frustration over what she perceived to be inappropriate admissions of patients to the hospital for “social reasons”. She commented:

I just think there’s a lot of people out there that they really take advantage of the medical system and it’s not the same as it was forty years ago when they were young.... The social admits, (pause) that’s really bothering me because I just think its such a misuse of
This participant further went on to explain that:

...there's a lot of grumpy people, you know, and people that, families refuse to take them home. "Oh no, I think they need to stay overnight." or "You discharge someone at two in the morning? You can't send them home at two in the morning. They can't go home, it's too late. I can't come and get them at two in the morning." You know, things like that and you think, "This is emergency, you know, we're not a hotel".

Participants also discussed that they perceived that the ED was being used as a "dumping ground" because the floors would not take extra patients to help relieve the overflow of admitted patients in the ED. Finally, one participant discussed the perceived inappropriate use of the ED by another organization. The participant expressed her frustration regarding her perception that the emergency personnel and the public were being placed under unnecessary danger. She described an incident in which a prisoner was discreetly being brought to the ED for intravenous (IV) antibiotic treatment. Although she conveyed that the police and the jail security officers were escorting the patient, she expressed concern because the patient was being brought into the ED at unscheduled times and was being treated in separate areas of the emergency department. She explained that: "We're hiding in the background somewhere and giving the IV antibiotics so we can get him out again...". She commented that she did take her concerns to administration. She further went on to say, "why would you not have paid the prison nurse or something or whatever to do the IV therapy at the prison? Why would you allow the man to jeopardize people's lives?... We are putting ourselves at such risk, why?".

The ED personnel delivers treatment for those patients needing emergency care for acute conditions, in addition, the ED also acts as a safety net for those people who may not have
access to health care from other sources. The ED provides care for the marginalized and the disenfranchised populations in our society (Drummond, 2002; Holleran, 2002; Marsden, 2003; Varcoe, 1997). In addition, facilities in the community may be unable to meet patient’s needs (Anonymous, 2001; Drummond). Many hospitals have a double standard in which the ED is burdened with admitted patients and hospital units are protected from the stress and workload that hospital overcrowding creates (Affleck, 2003). Although EDs may see a large number of nonurgent or “inappropriate” patients, experts now believe that this population utilizes a small portion of ED resources and does not contribute to hospital overcrowding (Anonymous; Drummond). In addition, there are concerns that attempting to divert these clientele to other settings may in fact increase health costs elsewhere in the healthcare system and divert attention away from the real problems that are effecting EDs at this time (Anonymous; Drummond).

_Hospital Overcrowding_

“I think the biggest problem we have in emergency right now is the admitted patients staying too long.”

Overcrowding is a reality of emergency nursing. It is placed as a category, in and of itself, because it was identified in every interview as being a concern for ENs, in addition, it has a huge influence on the work environment and the behaviour of staff in the emergency department. Every NEN interviewed for this study discussed the concerns and the challenges that holding admitted patients in the ED created. Admitted patients referred to a patient who had come into the ED, had been seen by the EP and then referred to a medical service in the hospital; for example, the renal service, the medical service, the surgery service, and so on. Once the referring service had seen the patient and accepted their care, the patient was then
admitted to the hospital and the accepting service. The next step in the admission process was to have the patient transferred to the appropriate unit where they would then receive the appropriate care for their condition. The participants discussed that at this time, many units did not have available beds to accept admitted patients, as a result, the admitted patients stayed on the stretchers in the ED.

Hospital overcrowding, or the volume of admitted patients held in the ED, has been called the “most serious issue confronting Canada’s EDs” (Affleck, 2003, p. 82), at the present time, by the Canadian Association of Emergency Physicians [CAEP] & the National Emergency Nurses Affiliation [NENA]. Although there is no single definition of ED overcrowding, CAEP and NENA have defined it as “a situation in which the demand for emergency services exceeds the ability of a department to provide quality care within acceptable time frames” (Affleck, p. 82). The reasons for ED overcrowding are complex and multifactorial. The lack of beds for admitted patients in the hospital; the lack of access to specialists physicians; the lack of access to practitioners; the lack of access to primary care resources; the shortage of nursing and medical staff; the increasing complexity and acuity of patients coming to the ED for care; and the volume of clients presenting to the ED for care are a few of the factors that have contributed to the problem (Carpenter, 2001; Derlet, 2002; Derlet & Richards, 2000; Derlet et al., 2001; Laskowski-Jones, 2005; Trzeciak & Rivers, 2003). The participants, in this study, discussed that it was their experience that different EDs managed the dilemmas of admitted patients in their department in different ways. While some EDs handled admitted patients on their ED stretchers, in the main ED department, others placed them in vacant hallways in attempts to make the main ED stretchers available for emergency patients that came to the ED. Other EDs attempted to create special sections
in the ED that were designated for admitted patients; unfortunately, due to the number of admitted patients in the department, these sections filled quickly and the admitted patients overflowed into the main ED. Some EDs made no special arrangements for the admitted patients in the ED. As emergency department stretchers became occupied with admitted patients, fewer stretchers became available for the emergency patients who came to the ED; as a result, these ED patients now had to wait in the ED waiting rooms or on stretchers in hallways to be seen by an EP. If the ED patient's condition required immediate attention, then arrangements were made to move the patient to a stretcher in the main department where they could be appropriately assessed and treated. One participant explained the situations as follows:

If they need to be inside because they are having a heart attack or something... they finally do get into a bed at the back where the monitors are because they have to or they get to the trauma bay; but other than that they stay in the hallway.

Hallway and waiting room care has become a common scenario in the current environment in which EDs may be operating at over 100% capacity (Innes, 2001; Innes, Grafstein, Christenson, Prussel, & Stenstrom, 2003). Under these conditions patients may receive inadequate assessments and symptom relief (Derlet et al., 2001; Innes, 2001). Two participants discussed the disposition of ED patients waiting for care in the ED waiting room. One of these participants discussed that in her ED, ENs were not responsible for assessing or providing care for ED patients in the waiting room; conversely, the EPs did see patients in the ED waiting room and would order the appropriate tests and treatments. The participant conveyed that the ENs were not responsible for carrying out the patient treatments because they had not assessed the patient and were providing care for the patients already seen and placed in patient care areas of the ED. The ENs would assist in ordering tests as necessary.
The second participant conveyed that ENs in her ED did provide ED waiting room care due to the fact that the ED stretchers were full of admitted patients that and the ED patients in the waiting room were acutely ill. She describes the situation the ENs were coping with as follows:

...a couple of weeks ago we had three chest pains...in our waiting room for twelve hours. Now two of the nurses out of ten spent their whole time being in the waiting room...their troponins (cardiac blood test) were positive, not very elevated but they were positive.

The participants described that in addition to the number of patients they were expected to provide care for, the acuity of the patient has also increased. These perceptions were supported by authors in the literature (Derlet et al., 2001; Trzeciak & Rivers, 2003). The participants also discussed that not only was there a shortage of beds on the floors, there was also a shortage of intensive care unit (ICU) beds. One participant described a recent experience in which ENs were nursing critical ill patients in the ED while also attempting to provide care for the other patients who were also in the department:

...and we’ve had a run of them recently. We had three in a week, all at night. I didn’t want to go to work. So we’ve got 2 -- 1 intubated patients... It’s actually like an ICU, we’re running an ICU in an emergency department.... I’ve seen them stay there for twenty-four hours and we’re an ICU basically... It wouldn’t increase [your stress] if you didn’t have to deal with all the admits and the other ones coming through the door. I mean you have a trauma bay, so you’re using the trauma bay... I find that really pushes your stress level up... Not... one [ICU patient] because I still do the assessment and everything, but what about the next one who comes through the door?

She further went on to say:

Right and you can just see that everyone is on edge when you’ve got that intubated patient [and] that trauma [bay] completely taken up. Even the doctors are getting stressed because they’re like: “This is ridiculous, this person needs an ICU bed. What are we doing? What are we doing?”

As the two previous quotes highlight, providing care for critical ill patients in the ED, while attempting to provide care for the other patients in the ED, creates stress for all of the
emergency personnel involved. The lack of critical care beds has resulted in ICU patients remaining in the ED under the care of the EP and the EN; consequently, the ED has becoming a defacto ICU in many circumstances (Derlet, 2002; Derlet et al., 2001). The expectation that ED staff provide care for acutely ill admitted patients, critical care patients and the new emergency patients results in staff feeling overwhelmed and burned out (Carpenter, 2001; Derlet). Decreased nurse and physician satisfaction has resulted in negative productivity; negative staff morale and high staff turnover (Derlet & Richards, 2000; Drummond, 2002).

Participants described difficulties and postponements in transferring the patient to the floor even though a bed for the admitted patient was available on the floor. Participants described their frustration at their perception that the floors were not assisting the ED to help deal with the number of admitted patients they held in the ED and the resistance they met trying to transfer patients to the floors. One participant described how her understanding of the ED and why the ED was trying to move patients to the floor had changed as she moved from being a medical-surgical nurse to an EN. She discussed that when she worked on the floor, the floor nurses had the perception that “emergency nurses [we]re witches”. She went on to explain that the reputation came about because the ED was seen as a separate entity from the rest of the hospital. She further went on to describe how she now could see both the floor nurse’s and the EN’s perspective:

When I was on the floor people would get upset that emergency nurses were sending patients up as the shift was changing, that the emergency department gets away with everything. You don’t realize, and I didn’t realize either, that emergency, it’s overflowing. They are overworked. Its not like they’re sending patients up because, so that they can dump other responsibilities on other nurses. They need to do that so they can accommodate other patients coming in and the rest of the world doesn’t recognize that.
Not only did the NENs discuss the frustrations they had with the floors, difficulties with transferring patients to the intensive care unit were also discussed. Participants discussed their perception that the other units in the hospital did not understand the pressure that the ED was under. When discussing the number of admitted patients in the ED and the response from the rest of the hospital, one participant stated that:

We (the ED) do end up being the dumping ground, we're overflowing. The last night I worked we had nineteen admitted patients in the department. So if something comes in, we can't deal with it. The floors won't take any extra people even though we're (the ED) are expected to take extra people.

A “double standard” (Affleck, 2003, p. 83) exists in many hospital systems in which administrators feel it is unsafe to manage admitted patients in the hallways of their units, however, the ED is expected to manage these patients in their area. The Canadian Association of Emergency Physicians and NENA (Affleck) have commented, in their position statement on overcrowding, that managing an extra 1 or 2 admitted patients in the hallways of the inpatient units of the hospital increases the unit’s workload by 5% to 10%. When these same patients are kept in the ED, these 10 to 20 patients increase the workload of the ED staff by 50% to 100%. Various authors in the literature have called for the recognition that hospital overcrowding is a system problem and that all parties in the system do their part to manage the problem (Howard, 2005; Trzeciak & Rivers, 2003).

The ED is designed to address the immediate life threatening care plus the urgent diagnosis and treatment of patients presenting with medical and surgical emergencies. EDs were not designed to be inpatient units; as a result, the environment is not conducive to inpatient care. It is an environment in which the lights are on, the noise doesn’t stop, normal sleeping patterns of patients are disrupted and there is a lack of bathroom facilities (Affleck, 2003). In their joint policy statement, on ED overcrowding, CAEP and NENA have said that
these are not "reasonable, safe or humane conditions for sick people" (Affleck, p. 81). The participants interviewed, in this study, empathized with the admitted patients. When considering the perspective of the admitted patient, one participant said: "...the poor people, well it's loud, you have no privacy because it's just curtains, and I think that the quality of care isn't as good...". One participant was aware that admitted patients, in the ED, did not get the same level of nursing care as they would on a unit because the ENs were caring for both admitted patients and emergency patients at the same time. Participants discussed that EN's could only address what they assessed to be the priority care for admitted patients, such as, providing medications on time. Some of the other needs of admitted patients were left unmet. One participant commented, "We don't do that, realistically, pain management. You get the medications out on time.... Mobilizing a patient, I'm sorry I don't have time to spend twenty minutes trying to get you up and mobilized".

Howard (2005) has called the current situation an overcrowding crisis in which it is difficult to meet the needs of patients; consequently, patients are dissatisfied with their care. Patient dissatisfaction could then lead to physical and verbal abuse directed towards health care personnel by both patients and their families, in addition to, prolonged pain and suffering of the patient (Derlet et al., 2001). The NENs discussed that they were aware admitted patients were not receiving the type of care they would on the units while in the ED. One NEN described her dilemma as she attempted to deal with the frustration of admitted patients and their families while also providing care for the "true" emergency patients:

...I would say the families come at you because some of the admitted patients aren't getting the care that they deserve and then something really ugly will come through the door. Literally the people who are admitted are just, they don't exist for us because we're so focused on the true emergency patients. I can see some people they just completely forget about the rest of the department and zone in on that true emergency patient. They
might be having an acute MI, they could be a multitrauma, but then having said that, that’s really what we’re there for.

Another NEN commented: “...I think the [admitted] patients lose out”.

The responsibility of having to nurse both admitted and emergency patients was a concern for the participants. The participants expressed that they felt stressed or frustrated because they were trying to nurse ED patients in a limited space and as quickly as possible in order that a greater number be assessed and treated. Because admitted patients filled the majority of beds in the ED, the ED personnel often found themselves providing care for ED patients in the few available ED beds left. One NEN commented: “…we were holding sixteen admitted patients so we were… rotating out of a couple of beds”. Admitted patients may be labour intensive and require a higher level of care that needs to be provided by the EP and the EN in order to diagnosis and treat their condition (Derlet, 2002; Trzeciak & Rivers, 2003). The quality of care for these patients may be compromised due to the fact that the ED staff may feel pressured when trying to provide care for both the admitted patients and the new patients coming into the ED; consequently, both admitted and new ED patients may not receive the necessary attention they need from the EPs or the EN’s (Derlet et al., 2001; Trzeciak & Rivers, 2003). Admitted patients may also receive a delay in treatment regimes when they are cared for in the ED (Clark & Brush, 2002).

Overcrowding is a system problem and has created a situation in which medication errors and threats to patient safety exist despite the proficiency of the ED staff (Trzeciak & Rivers, 2003). The professional and legal concerns, in addition too, the expectations that were placed on ENs were highlighted by one participant’s comments. The participant was working in the treatment or walking wounded area of the ED during night shift. This section of the ED also contained a section for admitted patients called the HUB beds. The HUB beds were suppose
to close during the night and the admitted patients moved to other areas of the hospital; unfortunately, due to the unavailability of hospital beds, the HUB beds were not closing at night. The participant’s assignment consisted of being the EN for both the treatment and the HUB beds. She describes her predicament as follows:

There’s way too many patients and treatments for one nurse to handle. Now HUB beds aren’t closing and the HUB patients are getting left. I went back to give a treatment one night at 2330, I became the only nurse back there. I was holding six admitted patients, I had all of my treatment, I’m swamped and a waiting room full of people. I counted, I think there were eighteen patients that I was trying to cover so at three o’clock in the morning when I finally got to the point where I could sit down and look at the charts for the admitted patients, I realized that nobody had done vitals on them since 6:30 the previous morning and nobody had charted on them since noon the previous day. That’s not right, you know. Not only is it not right for the patients, but its not like the HUB nurse was being lazy. They were just sort of swamped in treatment and so I feel like that the nurses who work back in treatment are going to get hung out to dry.

ED overcrowding is a system problem that creates a high risk environment for medical errors and threats to patient safety despite the proficiency of the ED staff (Trzeciak & Rivers, 2003). A policy statement, by the RNABC, regarding overcrowding was not found; however, in a article written by a nursing practice consultant and a lawyer regarding providing care in the waiting rooms of emergency departments, recommendations were made that can apply to nurses attempting to provide care in EDs experiencing overcrowding in general. The authors stated that nurses are “responsible for providing the care that a reasonable and prudent registered nurse would provide in a similar situation” (Willson & Warrington, 2004, p. 20). The expectations of the RN would be to: minimize the immediate risk to the patient under their care; to document their patient assessment; to perform observations and interventions; to communicate their concerns to appropriate person(s); and to advocate for improvement in how care is delivered in the ED (Willson & Warrington).
Hospital overcrowding is also a system problem (Howard, 2005; Trzeciak & Rivers, 2003). Overcrowding can result in long waits for patients and the risk of adverse outcomes (Derlet et al., 2001). Its causes are multifactorial; consequently, the ED cannot manage the problem alone. Hospitals must play their role by adopting a philosophy in which patient care is shared equally throughout the hospital system (Affleck, 2003). Public policy is needed to address the problem on a national basis (Derlet et al., 2001). Finally, further research is needed to explore the phenomena of overcrowding, its consequences and possible solutions (Howard).

Debriefing

All participants interviewed discussed debriefing events that occurred while nursing in the ED. After a stressful event at work, the majority of participants spoke to their co-workers to debrief. Participants indicated that they talked to their co-workers because they understood what emergency nursing consisted of and wanted to talk to people who had experienced similar situations. Two participants stated that they stopped thinking about the events that occurred while at work once they left the ED at the end of the day. The majority of participants did not discuss their work events at home with their spouses, families, or friends. Only one participant interviewed discussed the events of her work with her husband who also was in the health care field. Three of the participants discussed the events of work with a close friend. Of those friends, two were in health care related fields and the other was a RN. One participant stated: “...I find it hard to discuss certain areas of my job with people who just really have no insight as to what we’re going through”.

Hospital overcrowding, high patient acuity and the nursing shortage has resulted in a work environment that is chaotic, busy, stressful, exhausting and has a high potential for violence.
(Derlet & Richards, 2000; Drummond, 2002; Fernandes et al., 1999; Levin et al., 1998). The participants are not alone in their actions of debriefing with coworkers. Fernandes et al. and Laposa, Alden, & Fullerton (2003) have also found that emergency personnel sought support from colleagues after a stressful event at work and that they infrequently sought the assistance of professional debriefing services.

Two of the participants had exposure to professional debriefing services. One participant expressed disappointment with the services due to its brevity. While not directly involved in the incident or the professional debriefing services, another participant expressed concern that allied staff were forgotten and not included during the sessions. Two participants discussed that other events, apart from those considered critical, needed to be debrief more formally. One participant stated: "Yea, we get the 22 year old who died and we know that needs to be debriefed, but there are other things too.... I would have liked to debrief that day that I had the three ICU patients". When stressful events are not managed well or when they receive debriefing that is not appropriate for their needs, nurses can develop emotional exhaustion or posttraumatic stress (Garrett & McDaniel, 2003; Hall, 2004).

While one participant conveyed that getting to know her coworkers and socializing with her coworkers helped her cope with the stressful events of her work, another participant preferred not to attend social functions with coworkers leaving her working relationships at work. Some other activities that the participants found helpful for debriefing work events included: walking, watching TV, bike riding, swimming, smoking, laughing with son and spouse, shopping and striving for balance in life. One participant experienced headaches after having a stressful day at work. Another participant stated that it was the individual nurses responsibility to get professional help, for example, seeing a psychologist, instead of
keeping “it trapped up and you don’t talk about it”. Overall, participants utilized each other for support. One participant said, “It’s good to talk to somebody who actually understands”, while another stated, “we look after each other”. Social support and the reliance on other colleagues are vital in helping nurses cope with the stress of their work (Hall). In times of uncertainty and stress, a positive social climate can buffer nurses from the negative effects of crisis (Garrett & McDaniel). When nurses lack social support they become dissatisfied with their jobs (Keough et al., 2003).

Surprises

Two themes were identified that were unexpected findings in this study. These are the nurse-physician relationship and horizontal violence. They are discussed below.

Nurse-Physician Relationship

Every participant interviewed for this study discussed the nurse-physician relationship. A review of the nursing literature indicates that the relationship between nurses and physicians may not always be harmonious. Discrepant attitudes towards teamwork and collaboration, between nurses and physicians, have been found (Baggs et al., 1999; Greenfield, 1999; Hojat et al., 2001; Larson, 1999; Thomas, Sexton, & Helmreich, 2003; Thomas, Riegel, Gross, & Andrea, 1992). In addition, Rosenstein’s (2002; 2005) research regarding the disruptive behaviour of physicians indicates that 92.5% of RNs, physicians and executives surveyed witnessed physician’s behaviours that were inappropriate, confrontational or created conflict for others. After reviewing the literature, it was surprising that none of the participants in this thesis study discussed experiencing disruptive behaviours by physicians.

Two participants in this study described a slightly different perspective regarding the nurse-physician relationship than those of the other participants. Both these participants had
extensive nursing experience. One participant had been a Registered Nurse (RN) for 14 years prior to entering emergency nursing. She had worked in the ED as a medical-surgical nurse, nursing medical-surgical clients, prior to taking the core emergency courses and then working in the ED as an EN with emergency patients. This participant described that it took time for some of the physicians to get to know and trust a NEN. Some physicians would go to the SEN’s they knew instead of the NEN’s, as a result, some NEN’s found it difficult to work with these physicians. She commented:

…I’ve known some people who have left the department because they couldn’t take that. They didn’t like the fact that the doctor kept them out there, wouldn’t ask them to do certain things. They’d go and find a senior staff. I’m certainly not senior, but I can see it from a distance watching and having the nursing staff come and say to me, “Why do the doctors not come and ask me?” [I] just say to them, “Look, you have to understand they’re in an emergency department. The doctors have to be comfortable with you. They have to get to know you more…. I’ve been here two years and it’s a year and a half before some of them...[came to me]”.

The participant explained that there was a number of NENs or medical-surgical nurses working in the ED. She said that “I could see their (physician’s) frustrations with the inexperience of the department”. She went on to describe how she made the effort to get to know how each physician worked. The participant’s perception was that these physicians wanted to know the NEN’s knowledge base, would sometimes “challenge you” and would watch how the NEN worked before trusting or becoming comfortable with them.

Kramer and Schmalenberg (2003; 2004) have identified five types of nurse-physician relationships. The relationship discussed by this participant can be described as that of a friendly-stranger. In a friendly-stranger relationship there is a lack of trust between the nurse and the physician. Unequal power, a formal exchange of information and some physicians who do not acknowledge or receive information from nurses characterize the relationship. For nurses, the consequence is the perception that their input is not valued and the experience
of an unequal power differential. Ultimately communication is impaired and patient outcomes may suffer. Pavlovich-Danis, Forman, and Simek (1998) have reported that physicians have difficulty trusting the judgement of RNs for a number of reasons. They comment that the physicians' apprehensions may be due to the fact that it is difficult for them to distinguish the different type and education level of the nurse. Physicians respect education and clinical competence in nurses and it is through these avenues that nurses can build their relationships with physicians, to a collaborative and collegial level, in which mutual respect, trust and a greater equality in power exists (Kramer & Schmalenberg, 2003, 2004). The participant's descriptions of how she managed this type of nurse-physician relationship is similar to recommendations found in the nursing literature. Nurses need to take the first step by introducing themselves to physicians, making inquiries as to the plan of care for the client, and letting the physician know what their knowledge base is like. In this way physicians can become comfortable and begin to trust the nurse (Gurney, 2002; Kramer & Schmalenberg, 2003, 2004).

All of the participants interviewed generally felt supported by the majority of EPs that they worked with. They commented that their relationships with the majority of EPs were different than the relationship they had with physicians working on the floors. One participant described her relationship with the EPs in the ED as follows:

So it's a more supportive collegial kind of relationship, more of a partner than, than asking me, "Get me my gloves"... Then you're more inclined to be supportive, towards their needs... You finally get it, that you are not the doctor's assistant. I mean if they want to get their own stuff, if they want something, "You can go ahead and get it yourself, like you've got feet"... Because they are respectful and supportive, you support them back... I mean it's the same thing with your colleagues, your nurse colleagues, right?
The participants reported that the EPs were receptive to their feedback and would act on the EN’s requests. Every participant discussed that many of the EPs would make the effort to explain or teach the participant relevant or interesting information pertaining to their client when time permitted. One participant commented:

The doctors have been good in terms of, they know that it’s something I may not have seen. They’ll say, “Oh come over here and take a look at this or that”. They’ll explain what they’re doing and show me what they’ve done and all that kind of stuff.

Another stated:

...I can ask them questions, I ask them questions all the time. I drive them nuts, I’m sure.... I’m like, “Okay, I want to see this x-ray. Can I see this x-ray? What makes you think its this and that and...not the other thing?” ...We go through CTs together.

Participants felt comfortable asking many of the EPs their rationale for their orders and felt comfortable asking them questions to enhance their learning.

Kramer and Schmalenberg (2003; 2004) have described this type of nurse-physician relationship as being that of a student-teacher. In student-teacher relationships physicians discuss, explain and teach the nurse. Nurses often describe this relationship favourably. Nurses benefits from this relationship because they learn new information and physicians benefit from this relationship because they hold most of the power. The student-teacher relationship can be an antecedent to collaborative and collegial relationships. In a collaborative relationship, physicians and nurses work together in an atmosphere of mutual trust and respect. Nurses have greater power in this relationship, although there is still inequality of power. Nurses derived their power from the extensive time they spend with clients, their knowledge, experience and longevity as a nurse (Kramer & Schmalenberg, 2003, 2004). The last and optimal type of the nurse-physician relationship is that of the collegial relationship. In collegial relationships, both parties have equal power and their
mutual knowledge is respected. As mentioned previously, physicians respect education and clinical competence in nurses and it is through these avenues that nurses can build relationships with physicians to a collaborative and collegial level in which mutual respect, trust and a great equality in power exists (Kramer & Schmalenberg, 2003, 2004).

Horizontal Violence

Another unexpected finding in this study was the level of disrespectful behaviour that the NENs experienced from SENs. All eight of the participants interviewed in this study discussed the challenges that they had working with senior emergency nurses (SENs). Some of the NENs had witnessed and all had experienced disturbing behaviours from SENs. One participant, who had started in the ED after graduation from her basic nursing program stated:

I guess I was a bit naïve when I first started there. I was excited to be working right away in emergency and thought I could handle it and everything, and I did. I didn’t kill any patients or anything, but the older more experienced nurses definitely gave me a hard time. They were constantly testing me and not necessarily helping me to learn.... Whether that’s a female thing or whether that’s a nursing thing... apparently there was some study done around nurses eating their young and definitely I felt like that. They weren’t helping me to learn and they’re constantly testing me to think that I failed.

Some examples of the disturbing behaviours that the NENs in this study experienced included: bullying, for example, being pushed out of the way so that the SEN could admit a new emergency client; being tested to see if she’d fail; having people refuse to help when they were busy; having people “impose their ideas” even when they weren’t consulted; having people embarrass them in front of others; the questioning or undermining of their decisions; or people not speaking too them. One participant described how some SENs ignored her and she believed this to be because she was young in age. This participant had completed two years of practice in a medical-surgical setting, had taken the core emergency nursing course and had been nursing in the ED for 11 months when she made this statement:
I think being a new nurse and generally being younger, sometimes people question... whether you know enough or that kind of thing.... I think just being a new nurse in general because I only graduated in 2001...some people question that or they brush you off because you’re new.... I don’t find it with a lot of people, but there’s just a few people that brush you off because you’re new. That’s been a challenge.... Just because I’m new doesn’t mean I don’t know anything.

The disturbing behaviours that the participants described in this study are similar to those found by researchers studying horizontal violence. The horizontal violence discussed by the participants and the descriptions of behaviours exhibited was a surprising finding in this study; however, after a review of the literature, it became apparent that the disturbing behaviours experienced by NENs, from senior emergency nursing colleagues were not unusual (Farrell, 1997, 1999; Jackson, Clare, & Mannix, 2002; Randle, 2003). In the literature, researchers have shown that nurses are subjected to horizontal violence on regular basis in the workplace and are concerned about its ramifications (Farrell, 1997, 1999; Henderson, 2003; Jackson et al.; McKenna, Smith, Poole, & Coverdale, 2003; Randle; Stevens, 2002). The disturbing behaviours directed towards nurses have been called various names including: intranurse abuse (Farrell, 1997), horizontal violence (Farrell, 1997), “nurses eating their young” (Randle) and bullying (Randle). In this paper the disturbing behaviours described will be referred to as horizontal violence. Horizontal violence can be defined as “overt and covert non-physical hostility, such as, criticism, sabotage, undermining, infighting, scapegoating and bickering” (Farrell, 1997, p. 502). Oppression theory has been used to explain why horizontal violence occurs in nursing (Farrell, 1997; Freshwater, 2000; Randle; Roberts, 1983, 2000). Oppression theory contends that nurses have been oppressed by dominant groups such as physicians, male administrators and marginalized nurse leaders (Farrell, 1997; Roberts, 1983, 2000). Consequently, nurses have had a lack of control over their destiny and have internalized the norms of dominant groups resulting in feelings of
inferiority, powerlessness and self-hatred. Feelings of powerlessness have resulted in nurses resorting to aggression amongst themselves and the inability to unite to challenge the inequity of the powerful groups (Farrell, 1997; Roberts, 1983, 2000). The term of “nursing eating their young” was described by three of the thesis participants. These participants indicated that they had learned about this phenomenon when taking their basic nursing education.

Nurses are exposed to horizontal violence as students, as new graduate nurses and well into their careers as a Registered Nurses (Farrell, 1997, 1999; McKenna et al., 2003; Randle, 2003). Farrell (1997, 1999) studied the experience of aggression with university based nurse lectures and clinically based staff nurses. The majority of participants reported that intranurse aggression was a frequent occurrence; in addition, all the participants thought that the intranurse aggression was more upsetting and more problematic to deal with than aggression from their patients. The participants expressed concerns about the number of intranurse aggression encounters they faced and about an “all pervasive hostile undercurrent of what can be described as professional terrorism” (Farrell, 1997, p. 504). Farrell’s (1999) research findings indicated that in intranurse abuse, the nature of aggression consisted of rudeness, abusive language and humiliation. Some examples of aggressive behaviour experienced by nurses described in the nursing literature included: raised eyebrows, snide remarks, turning away, talking behind their backs, withholding information, refusing to help, refusing to speak to colleagues, refusing to move out of the way and refusing to deny false rumours about others (Baron & Neuman, 1996; Farrell, 1997, 1999).

In a study conducted by McKenna et al., 2003, one-third of first year Registered Nurses reported that they have had their learning opportunities blocked; felt neglected; had been distressed between the conflicts of others; or thought they were given too much responsibility
without appropriate support as a new nurse. The most distressing intercollegial incidents for the new nurses involved rude, abusive or humiliating comments and being given too much responsibility without supervision. The person participating in the conflict was someone the new RN was accountable to, for example, the charge nurse, the nurse coordinator, the supervisor, the unit manager, the clinical coordinator, the senior nurse and the preceptor. The participants, in this study, experienced horizontal violence from preceptors, SENs, charge nurses, nurse educators and their managers. One participant, who had 20 years of nursing experiences prior to emergency nursing, described one incidence of horizontal violence that she encountered as a NEN:

The manager was very negative. She’s extremely smart, completely, extremely smart. Unfortunately, her people skills aren’t always that good and she is very much one to talk about, she’s the biggest one to talk about her staff to the other staff. I would stand there and listen to her berate some of the other girls... in front of everybody and it was a very negative, negative environment. So it was tough for all of us coming in, everybody who had gone through that [emergency specialty] program, it was very difficult.

As this quotes reveals, when horizontal violence exists, it sets a tone of fear in the environment. Another of the participants, in this study, described her experience of intimidation by a charge nurse as follows:

There’s only one that is a bit bully and a problem and has been for years. I haven’t had a problem with her and I could probably stand up too her, but I haven’t had too. So it’s OK, but I’ve been warned not to stand up to her because I’ll be the one to lose.

Randle (2003) studied students from a pre-registration nursing program in the United Kingdom over a three year period. During their education, students are socialized to the norms, values and rules of the profession (Suominen, Kovasin, & Ketola, 1997). Students in Randle’s study found the process of becoming a nurse was distressing. Nurses exercised their power over the students and undermined their self-esteem. Although students identified that the nurses had bullying attitudes, they did not have the personal and professional
resources to challenge the behaviours. Over time the students adopted the actions, attitudes and beliefs of their nurse role models; consequently, they experienced low self-esteem and began to practice bullying behaviours towards their patients.

In this thesis study two participants were reinterviewed. In her first interview, one of these participants, who had no nursing experience prior to entering emergency nursing, reported that she had experienced a great deal of horizontal violence initially as an EN. She conveyed that she had empathy for NENs and attempted to help them when she was able. In her second interview, five months later, she discussed that she was now more comfortable in her role as an EN and with her colleagues. She attributed this change to having changed her working rotation from eight hours to 12 hours shifts, having greater confidence in her skills and feeling that she was “fitting in” with the other SENs. Interestingly, her tolerance of the NENs had changed. She now found working with NENs:

...frustrating. They just look like they don’t have a clue! I’m working with a student right now that is actually very good, but I still tend to get frustrated at times.... [Researcher: What is it that frustrates you?] Just their slowness. I mean I don’t mind if they ask me questions, that’s fine, but they’re a lot slower and it seems they sort of dwell on... I guess it’s things they been taught to dwell on... Just their lack of experience. I find that I’m trying to quickly try and do something and they’re just a lot slower.

This participant further went on to discuss that horizontal violence continued to be practiced in the ED among SENs; however, she still did not feel comfortable confronting it.

I do hear the more senior nurses talking about the new girls behind their backs and I find that really hard to hear because it hasn’t been so long for me and I think, “What did they used to say about me?” I don’t think that’s right; I mean I should step up and say something. I do, to a certain extent. I say, “You know, it’s not really fair. We need the bodies and this is the way to the future, but I don’t really do too much about it.”

Although not a student nurse, this participant exhibited some of the behaviours and feelings discussed in Randle’s, 2003, study of new student nurses. She initially found becoming a NEN distressing and that SENs undermined her self-esteem. Although she could
identify bullying behaviours, she was developing her professional and personal resources to
deal with them. Whether she will adopt the actions, attitudes and beliefs of the SENs,
experience low self-esteem and begin practicing horizontal violence behaviours towards
others, as Randle’s participants did, is still undetermined.

In this study, the NENs rationalized that SENs behaved the way they did either because
they were experiencing difficulties in their personal lives, or it was a characteristic of their
personality, or they were burned out. One participant commented that a SEN, who she found
difficult to work with, had “lost here drive to nurse and enjoy it”.... Another NEN stated
this of SENs:

...most are helpful and the rest are, I would say perhaps shouldn’t be a nurse anymore.
They’re smart nurses and all that; but my perception of them, and I’m not saying it’s true,
my perception of them is that they’re lazy and don’t care anymore.

The unsupportive and abusive behaviour, characteristic of horizontal violence, has an effect
on NENs. One NEN commented that, “there were a lot of days I felt like just going home
and crying because they were so mean to me”. The NENs commented that the SEN’s
behaviours undermined their confidence and created an unsupportive environment. One
participant, who had a previous career in emergency health care services; had completed a
year preceptorship in the same emergency she was now working in while a general nursing
student and had had previous cardiac and trauma experience, discussed her fear when
working with the SENs in the ED because of the way she was hired. She commented:

It took me a long time to begin to trust some people... but especially because of the way I
was hired... I think that a few, especially the older emergency nurses were very up in
arms about the fact that I was hired into the critical care beds, the acute beds, right out of
nursing school. Regardless, they had seen me work and they knew that I could do it. I was
afraid to expose myself to them in any way.... I just heard snippets and rumours.
Another participant described the effects that horizontal violence had on her and how she attempted to ameliorate them by seeking “good” nurses to assist her. She commented:

...for a newcomer all I remember are the ones [SENs] that would bite your head. There’s a lot of good, good nurses... I attach myself [to them] and make someone my mentor whether they like it or not. So somebody you respect and somebody you get along [with] and there are great staff that do that, but there’s also staff that put you down. It makes it hard to come in everyday for your shift.

The reactions experienced by the participants in this study are similar to those found by other researchers. Nursing researchers have found that nurses who are exposed to horizontal violence have experienced fear, anxiety, sadness, depression, frustration, mistrust, nervousness, loss of confidence and low self-esteem (Jackson et al., 2002; Kivimaki et al., 2003; McKenna et al., 2003). In addition, they may experience physical symptoms of weight loss, fatigue, headaches, and possible cardiovascular disease (Kivimaki et al.; McKenna et al.). After exposure to an aggressive incident, nurses feel demoralized and that they lack value in the workplace, as a result, they develop a negative attitude towards their work environment (Jackson et al.). Links have been found between aggression and sick time, alcohol and drug use, burnout, decreased commitment to the workplace, decreased productivity, a higher intent to leave the organization and higher staff attrition (Farrell, 1999; Jackson et al., 2002; Salin, 2003).

Finally, while some SEVs exhibited disruptive behaviours, they also assisted NENs with acutely ill patients to ensure that the patient was safe. One NEN commented that when she received an acutely ill client:

I would get someone else to help me and even though there were these mean nurses that weren’t very supportive, they were always there because they didn’t trust you anyway.... You were never on your own because they didn’t want to see the patient die.
The lack of experience of NENs and the concerns for patient safety may have been two reasons that contributed to the behaviour of SENs. When one of the participants reflected on her career as a NEN, she came to the realization that there was a great deal she did not know when she first started and that this created stress of SENs. She commented that when she started in the ED that:

I didn’t really [think]... it wasn’t so bad; but, when I look back now and I think how much I didn’t know, I can understand why the experienced nurses were worried.

SENs were not interviewed for this study; therefore, their perceptions, experiences, or insights are not available to add to the interpretation of this study’s findings. Further research to explore the perceptions, experiences and insights of SENs would be beneficial. In addition, further research exploring the transition of NENs as they become SENs may provide insights as to why SENs behave the way they do in the workplace.

Intent to Leave

“It’s just, it’s sad to see that a lot of really good nurses are going and it’s scary because it’s like new nurses, very, very fresh nurses, two years, you know or less.”

The participants interviewed were of differing ages and different stages in their lives. All but one was married. One participant was single and had no children, two had young families, two were planning on starting a family and three had children who were adolescents or young adults. The participants’ intent to stay in the ED varied. In one year from the time of the interview, six of the eight participants anticipated leaving the ED as a full time EN or changing their status there. Changes the participants anticipated they would make included: moving to a community hospital full time; moving to an urban hospital, being on maternity leave, being promoted to a charge nurse, leaving the ED to practice in another area of nursing and leaving the profession all together.
In five years from the time of their interview, one participant stated she anticipated remaining as an EN in her current ED due to her young family; in addition, she commented that she anticipated moving to a larger urban ED when her children were older. A second participant stated she anticipated being in her ED as a charge nurse in five years time. Of the remaining participants; two anticipated working as an outpost nurse, one anticipated being an ICU nurse; one anticipated working as a EN in the interior of BC; one anticipated being enrolled in an advanced nursing program and one anticipated having left the profession. The two participants, who had follow up interviews, had changed their plans in regards to their intent to stay with the ED. One participant who originally wanted to become an outpost nurse was now on sick leave due to an injury incurred at work and now was reconsidering her career options. She had been advised by her physician to consider less physical demanding work. The second participant, who originally stated she would stay in the community ED until her children became older and then she would work move to a larger ED, was now investigating the possibility of pursuing advanced nursing education. Participants stated that they anticipated leaving their current emergency nursing time positions for a number of reasons. Two of the nurses considered emergency nursing as a step to larger goal, for example, outpost nursing. The overwhelming workload, safety concerns and questions regarding the ethics of practice were some reasons one participant gave for wanting to leave emergency nursing practice. The perception of a lack of leadership, a lack of respect for nurses and the large workload were reasons another participant gave for her decision to leave the profession. One participant anticipated leaving her current position due to the possibility of her husband being transferred outside of the lower mainland of B.C. The final participant made this comment about her emergency nursing career:
I wonder if maybe I’ll have enough of emerg. I’ve talked to a few nurses in ICU who say I can finish my career in ICU. I could never finish it in emerg. It’s too hard. It’s too mentally and physically demanding.

No literature was located that specifically studied job retention or the intent to leave in emergency nursing. In a recent study of new RNs, job stress associated with high patient acuity, unacceptable nurse patient ratios and concerns regarding safety were the main reasons these nurses left their jobs (Bowles & Candela, 2005). Their concerns regarding their work environment, management, lack of support and guidance, plus being given too much responsibility were also listed as reasons for leaving (Bowles & Candela). These authors found that 30% of the new nurses, participating in their study, left their job in the first year of employment and 57% left by the second year. Two of the NENs, in this thesis study, were new nurses to the profession and all eight of the participants were new to emergency nursing. Six of the eight NENs did not intend to be working as a staff nurse, in the ED they were currently employed, in a year from the time of the interview. The average amount of time these nurses had been practising in the ED was 18.63 months. The NENs had been practicing as an RN for an average of 5.2 years prior to entering emergency nursing. Six of the eight participants had graduated from their general nursing programs within five years. In a study of medical-surgical and ICU nurses, one group of researchers found that RNs who had graduated within five years or less had a higher intent to leave their jobs when compared to other nurses. In addition, they found that job dissatisfaction was the greatest predicator of intent to leave (Larrabee et al., 2003). In this thesis study, participants were asked to rate their level of job satisfaction when they first started emergency nursing and at the time of the interview. They were asked to rate their satisfaction on a scale of 0 to 10 with 0 being no satisfaction and 10 being the most satisfied. When they first started emergency nursing, their
job satisfaction ratings ranged from 4 to 10 and the average rating was 7.4. When asked to rate their job satisfaction at the time of their interview, the ratings ranged from 5 to 9 with an average rating of 7.5. Three of the participants had lower job satisfaction scores at the time of the interview when compared to when they first started emergency nursing; two participants scores remained the same and three participants scores had increased. One participant, who rated her job satisfaction the lowest of all the participants when she first started emergency nursing and at the time of her interview, commented that her low satisfaction rating when she first started emergency nursing was related to her concerns regarding her confidence and her skills. Although her self-job satisfaction rating had increased at the time of the interview, from a 4 to a 6, she commented that her concerns now revolved around the staffing, safety and ethical issues she experienced as she practiced in the ED. The participants in this thesis study discussed several aspects of their working situation that made their work difficult; they expressed feelings of frustration, feelings of stress, feelings of being overwhelmed, in addition to, physical and mental exhaustion. When nurses experience high workloads they experience burnout, become dissatisfied and plan to leave their jobs (Aiken et al., 2002; Aiken et al., 2001; DiMeglio et al., 2005). Nurses often leave their jobs within a year of making the decision to leave (Duffield, Aiken, O'Brien-Pallas, & Wise, 2004).

Participants commented that when working with NENs they attempted to make them feel welcomed, attempted to establish a relationship with them and attempted to give them large amounts of feedback. One participant commented that “we’ve got to keep people impassioned” through learning and education. Another participant said that when NENs came into the department:
Another participant expressed her concern for the retention of NENs this way:

…it’s very difficult with the amount of stress with the lack of staffing, the amount of workload that gone up. It’s very difficult for the nurses that are there already to be supportive to the newcomer, but it has to happen, because they’re emergency nurses that came after me, who have already left.

Finally, one participant commented that nurses attracted to emergency nursing liked variety both inside and outside of work; consequently, she perceived this to be one of the reasons that explained the transient behaviours of emergency nurses. No literature was found that explored whether ENs were a more transient group when compared to other nurses; authors have found that nurses, in general, are using their nursing backgrounds as a stepping stone to other careers (Duffield et al., 2004). Registered Nurses, whom are 30 years of age or younger, are leaving the nursing profession at a higher rate than nurses of other age groups (Aiken et al., 2001). Finally, younger nurses and nurses of future generations may chose to have more than one career in their lifetime; consequently these factors may contribute to the transient behaviour of ENs (Duffield et al.).

**Rewards of Emergency Nursing**

Participants described the constant learning; the type of nursing; the emergency nursing knowledge; the relationships they had with team members; and “saving lives” as the rewards they experienced as a NEN. One participant described what she liked about being an EN this way:

I go to emergency and you’re treated like you do matter. Your suggestions are taken into consideration. I just like my role as an emergency nurse because you’re certified; you have additional information; [and] the relationship with your colleagues. You do stuff that actually makes a difference.
Summary

In this chapter, the findings of this study are presented and discussed. Several themes were found within the interviews. The themes were organized into categories and presented in chronological order according to what a NEN would typically be exposed to as they entered emergency nursing practice and then what they experienced as they progressed in their development as an emergency nurse. The categories were: orientation, ongoing learning, and mentorship; learning to be a NEN; realities of emergency nursing; hospital overcrowding; debriefing; surprises and intent to leave. The literature was interwoven into the findings and a discussion of how the findings either supported or contributed to the existing literature was presented. Two unexpected findings; that is, the nurse-physician relationship and horizontal violence, were presented in the latter section of the chapter. A discussion of the NENs intent to leave was presented at the end of the chapter. The summary of findings; implications for nursing practice, education and further research; and the conclusions of this study are discussed in Chapter Six.
Chapter 6

Summary of Findings; Implications for Nursing Practice, Education and Further Research; and Conclusions

In this chapter, a summary of the findings of this study, the implications for nursing practice, the implications for nursing education and recommendations for future research are presented and discussed.

Summary of Findings

In this study, NENs were interviewed for the purpose of identifying what is was like to be a new nurse in the ED; what were their needs; what health care personnel, educators and administers could do to help them; and their intent to leave the emergency department. The research questions for this study were: how do NENs describe their experiences as they make the transition from being a new to becoming a more experienced nurse in the ED and what are their needs as they make this transition? Interpretive description was the research approach utilized to provide a framework for the study. Eight NENs were interviewed. These participants came from the lower mainland and Vancouver Island of British Columbia. All of the participants had three years or less of emergency nursing practice and had completed the core courses of an emergency speciality program. Their level of nursing experience, prior to entering emergency nursing varied from no previous nursing experience to twenty years of nursing experience. The average length of time they had been nursing in the ED was 18.63 months and the ages of the participants ranged from 25 to 45 years of age. They worked in a variety of both urban and community EDs. Of the eight participants, six did not intend to remain in the ED, they were currently working in as a staff nurse in a year from the time of the interview. The participants intended to leave their current ED jobs for a
variety of reasons including: lifestyle changes; intent to change to another ED; concerns over
the work environment situation; or intent to leave the profession all together. Two of the
participants intended on using their emergency nursing experience as a stepping stone to
another health related career. Several categories and themes were derived from within the
data. The themes have been organized within the seven categories of this study and a
summary of the findings is presented in this chapter. Implications and recommendations for
nursing practice, nursing education and research are also discussed.

Orientation, Ongoing Learning, and Mentorship

Orientation, ongoing learning, and mentorship was the first category of this study. The
themes within this category consisted of orientation, unhelpful behaviours for learning,
helpful behaviours for learning, working with NENs and mentorship programs. There was a
large amount of inconsistency in the structure, time allotment, content, type of instruction and
support during the orientation programs. Participants felt scared, frustrated and unprepared
as they started in the ED. Authors in the literature have found that these feelings are not
uncommon among NENs as they started their emergency nursing practice. NENs can
initially feel frustrated, scared and overwhelmed as they start their practice in the ED. They
recommend designing orientation programs that are adapted to the NEN’s level of knowledge
and experience. Nurses without critical care experience may require three to six months of
orientation time to emergency nursing and the ED. Newly graduated nurses may require up
to a year of orientation. Authors in the literature also recommend that the content covered in
the orientation be designed to increase in complexity over time and includes orientation to
multiple areas of the department. Orientation programs that do not meet the new nurse’s
needs can compromise patient safety, frustrate the new nurse and ultimately frustrate the
emergency staff who then have to work with the new nurse who initially may not function well. During and after orientation the participants encountered several unhelpful behaviours by other ENs. Being prevented from having experiences; being taught short cuts without having the proper instructions; being exposed to ENs who were poor role models; and feeling unsupported were some of the unhelpful behaviours that the participants described. The disruptive behaviours experienced by the NENs are further discussed in the horizontal violence section of this thesis. Behaviours that the NENs found helpful, as they adapted to their role as an emergency nurse included: seeking out and emulating role models; asking questions and receiving complements from members of the health care team. Authors in the literature recommend choosing staff to oriented new nurses who have a sound knowledge base and have the support of other staff in the department. The use of expert nurses to teach NENs may not always be beneficial as these nurses may use their intuition, skip steps, or be unable to explain their actions. The NENs, in this study, looked for and emulated senior emergency nursing role models who had a sound knowledge base, a positive attitude, patience, enthusiasm, were respectful, had a good sense of humour, had effective communication skills, advocated for patients and practiced professionally. Authors in the literature have found that nurses who had recently graduated themselves could act as positive role models and as teachers for new nurses because they could identify with the experiences of the new nurse.

The participants attempted to be helpful and assist newer emergency nurses who entered the ED after them. No formal mentorship programs were found in the EDs that the participants were employed; however, one NEN described a mentorship program that she would have liked to have been a part of. This mentorship program consisted of an ongoing,
long term and supportive relationship with a SEN. The relationship would have existed both
formally and informally. The type of mentorship program the participant described is similar
to descriptions of an older and formal type of mentorship relationship that has occurred
historically. Further research is needed to determine the benefit and the structures of
mentorship programs that would be effective in the ED.

*Learning to be a New Emergency Nurse*

Learning to be a new emergency nurse was the next category in this study. Once the NEN
had completed their orientation, they then continued to develop as an emergency nurse. The
themes located within this category included: feeling overwhelmed and unprepared; the
difference between emergency and medical-surgical nursing; learning needs and missing
fundamentals in their general nursing education.

Regardless of the number of years of nursing experience prior to entering emergency
nursing, all of the participants felt overwhelmed and unprepared as they entered their new
area of practice. Authors in the literature have found that NENs may have feelings of being
overwhelmed and have concerns that they were unprepared to function independently. The
large amount of information that NENs must master while practicing in the unpredictable
emergency environment can also be overwhelming. For those participants who had previous
nursing experience, there were differences in their role as a nurse as they moved from
medical-surgical to emergency nursing. The NENs found it difficult to adjust to the patient
volume, patient acuity and the unpredictably of the emergency environment. These
participants were not alone. Authors in the literature have found that is not uncommon for
NENs to have difficulty adjusting to these facets of emergency nursing as they learn their
new role.
All of the participants commented that the learning curve was high and those participants who had no prior nursing experience found that the learning curve was "very high". In addition to learning to adjust to the acuity and the variety of patients, NENs had too learn to adjust their nursing assessments, prioritize their nursing care and become efficient in the delivery of their interventions. The participants discussed the need to learn the typical patient presentations, the commonly used drugs and treatments regimes, plus how to assess the acuity of the patient. One participant also discussed that NENs could misjudge the acuity of a patient and occasions when experienced staff did not recognize that she was overwhelmed. The participants needed to learn the flow of the paperwork and the patients in the department; in addition, they needed to learn the roles of the team members and how to access them.

With further experience, the participants discussed becoming more comfortable with their practice and that they developed a broader perspective of what was occurring in the ED. The experiences and perceptions expressed by the participants are not unique and they parallel the experiences of nurses and nurse educators found in the literature. One author has written that it takes two to three years to fully develop and function as a competent emergency nurse.

The participants who had entered emergency nursing directly from a general nursing program and had no previous nursing experience had the greatest learning needs of all to the participants interviewed. These participants discussed concerns that they perceived to be deficiencies in their basic nursing education and that these deficiencies contributed to them being unprepared for practice in the ED. Authors in the literature have found that newly graduated nurses have the greatest learning needs of all of the nurses entering emergency practice. Extensive orientation programs that include instructions on assessments and priority setting are recommended for this group of NENs.
Realities of Emergency Nursing

The realities of emergency nursing was the third category of this study. The themes within this category consisted of: the nursing shortage; working with noncritical care nurses; working with newly graduated general nurses in the ED; the lack of resources; management; patient acuity and volume; organizational and technical changes; the difference between community and urban EDs and the expectations of patient and their families. An overview of each theme is presented below.

As NENs continued to learn to become comfortable with their knowledge and skills they were confronted with the realities of emergency nursing work. The nursing shortage was one reality that the participants were confronted with. Emergency department administrators attempted to manage the nursing shortage in several ways. Some solutions employed included: having ENs working overtime; utilizing medical-surgical nurses in the department; attempting to close beds in the ED; hiring newly graduated RNs in the department; utilizing float nurses; or working short staffed. The solutions employed often created difficulties for participants. Working with newly graduated RNs, medical-surgical RNs, or noncritical care educated float RNs created additional work and stress for the ENs because they also had to cover aspects of patient care that these nurses could not. Critical care or emergency educated nurses were expected to take on the tasks that medical-surgical nurses were unable to do. Participant’s expressed mixed thoughts regarding having newly graduated nurses, from a general nursing education program, start their nursing practice in the ED. While some participants thought that these nurses were helpful because they could perform basic nursing care, other participants did not think they had the knowledge or experience to safely practice in the ED. Two of the participant’s interviewed were newly graduated RNs who were hired
into the ED without having the core emergency courses first. Authors in the literature have found that as the nursing shortage progresses, it has become more difficult for EDs to locate and hire RNs who have previous medical or surgical experience; consequently, there is an increasing trend for specialty areas to hire new graduate nurses in positions that once required nursing experience. Noncritical care nurses lack emergency knowledge and the experience of working in the fast pace of the ED; ultimately, this creates stress for emergency personnel.

With increasing occupational stress and workload, nurses become dissatisfied with their work situation and thus have a greater intent to leave their jobs.

The lack of resources is the next theme within the category of the realities of emergency nursing. It became a concern for ENs, especially when they worked on night shift. Participants were expected to adapt to the reduction in services by providing these services themselves or by doing without; consequently, this increased their workload, increased their stress and reduced the availability of ENs available to provide care in the department. Some of the nonnursing chores that the participants were expected to perform included:

housekeeping chores; changing all beds; cleaning beds; changing the linens and emptying linen carts; acting as a porter and acting as a unit clerk

The participants were not alone in their frustration of performing nonnursing duties, their experience of increased stress and their experience of an increase in workload that these chores brought. Researchers in the literature have also found that RNs experienced occupational stress when they worked with a lack of resources. It has also been found that the level of occupational stress was the highest among RNs who were the most inexperienced. Researchers have found that RNs were spending a great deal of time performing duties that did not require their professional training, as a result, many of the activities that required their skills were left undone. As
nurses perform nonnursing chores, they experience occupational stress and nursing job dissatisfaction; consequently, this results in a decrease in their intent to stay in their job.

The participant’s experience with those in management positions was also a reality that they encountered while nursing in the ED. Six of the eight participants commented on their frustration with management. The concerns regarding management included: that there was a lack of leadership in the ED; that management did not listen to the EN’s concerns; frustration with not being able to access the nurse educator for her learning needs; frustration with not receiving any feedback or a performance appraisal since employment as an EN; that management was not supportive of ENs; and that both the nurse educator or nurse manager had unrealistic expectations of the ENs as they practiced in the current emergency environment. While the nursing manager has been found to have one of the most overburdened positions in health care today, ED managers must manage resources and people in an unpredictable and stressful environment. Many of the frustrations expressed by the participants were also present in the literature. Researchers and authors on leadership have expressed that being responsive to their staff’s concerns is a necessary characteristic of a good manager. In addition, researchers and authors have written that those in leadership positions need to be visible and accessible for their staff and that this is a necessary characteristic of a good leader. It is essential that managers promote staff development and promote a culture, that in turn, will enhance the practice environment. RNs believe that they need the support of management in order to provide quality care. Support by management is critical in retaining nurses. The participant’s perceptions that people in positions of leadership had unrealistic expectations of them have also been found to be the experience of other ENs discussed in the literature. Authors in the literature have found that good
managers/leaders are responsible for setting the tone and the standards of practice in their environment; need to promote teamwork; are respectful of their staff; plus, they need to give recognition to their staff for the work that they do and their accomplishments. Poor management contributes to unhealthy work environments. As nurses become dissatisfied with their work environments, they have a greater intent to leave the organization; and hence, this further contributes to the nursing shortage and increased costs for the organization.

The high patient acuity and patient volumes were another reality that the NENs encountered as they practiced in the ED. Initially, the high acuity of patient conditions drew the participants to emergency nursing. However, all of the participants discussed the high levels of patient acuity, the large variety of patient conditions, the high volumes of patients and the fast pace in which they were expected to perform their nursing care. All of the participants discussed that these factors compounded by the nursing shortage and hospital overcrowding created a work environment that placed high mental and physical demands on them. Admitted patients held in the department created a situation in which the ED ended up holding acutely ill patients for long periods of time creating stress for the personnel working in the department. The descriptions and perceptions of the participants, in regards to the increasing volume and acuity of patients seeking emergency care, are supported in the literature. Economic and societal changes have resulted in patients that previously were immediately admitted to critical care units now remaining in the ED and under the care of ENs and EPs. In addition, the volume of patients utilizing the ED for care has increased and their conditions are increasingly more complex and acute. Authors in the literature have found that the nursing shortage and the increasing volumes of acutely ill patients have contributed to ENs feeling overburdened, overstressed, overwhelmed, unsafe, dissatisfied,
and unappreciated in their jobs. Researchers have also found that in an environment in which nurses are dissatisfied with their jobs, high levels of nursing turnover results.

The organizational and technical changes that were occurring in the ED was another reality that the NENs encountered as they practiced. Some of the participants discussed the challenges that they had in attempting to adjust to the organizational and technical changes that were occurring in their organization while attempting to perform their nursing care. In an environment that was short staffed and in which patient volume and acuity were high, participants had difficulty understanding the rationale for the changes and had difficulties in their implementation. Researchers have found that although organizational and technical changes are important for the advancement of health care, they also increase the job demands of nurses plus they contribute to nurses’ emotional and physical exhaustion. In order to be smoothly and successfully implemented, the appropriate supports; that is, technical, personnel, and supplies, need to be in place. In this time of staff shortages, nurses have had to take on the work that they were not professional trained for, are not able to provide the nursing care they were educated to perform and are experiencing occupational stress. Researchers have found that with increasing job demands, nurses are experiencing increasing levels of occupational stress and job dissatisfaction; consequently, their intent to leave the organization also increases.

All of the participants discussed the challenges they met in attempting to do their work and practice as professional ENs. Some participants discussed their concerns regarding the quality of care they were able to deliver, in addition to, the legal and ethical dilemmas that they faced. Authors in the literature have written that there are several reasons why EDs and emergency personnel are under stress and overburdened. These reasons include: the
increased complexity and acuity of emergency patients, the increase in ED patient volume, hospital overcrowding, the emergency personnel’s ability to perform greater intensive therapy in the ED, the delays in service provided by others, the nursing shortage, and the need for good medical record documentation. The participants in this study were not alone in their concerns regarding patient safety and their ability to practice professionally. In a 2004 publication, ENs in the Fraser Health Authority Region and the Nanaimo Regional Hospital ED adamantly called for the Government to address the situation in EDs because they stated that they were unable to provide safe patient care and were concerned that they could not meet their professional practice standards as outlined by the RNABC (2003). Researchers have found that recent RN graduates had a large amount of stress when they believed that patient care was unsafe. RNs left their jobs when there was inadequate staffing; they believed patient safety was at risk; or they believed that their licence was at risk.

The differences between community and urban emergency departments was also a theme under the category of the realities of emergency nursing. The NENs interviewed had varying opinions regarding their experiences of working in community and urban emergency environments. While one participant stated that she felt well supported as a NEN in a community ED, others commented that it was more difficult because of the lack of resources and the greater expectations placed on all of the ENs. ENs working in a smaller community ED were expected to perform more skills than their counterparts in urban EDs; in addition, they were expected to take on the role of support staff when these staff were not available. One participant who worked in both a community ED and an urban ED stated that while she was expected to perform more activities in the community ED, the patient acuity and number of resources were greater in the urban hospital ED. No literature was found that explored the
differences between community and urban EDs and their impact on ENs. Authors of one study researched nurses practicing in rural areas. They found that rural hospital nurses, who had ties to the community, had a greater intent to stay with the organization. Further research is needed to determine whether these findings are applicable to smaller community EDs in general.

The expectations of patients and their families is the last theme within the category of the realities of emergency nursing. Participants expressed several challenges as NENs when working with patients and their families in the ED. The overcrowding in the ED, the waits to be assessed and treated, plus the limited time nurses had to spend with patients created an environment in which patients were frustrated and the health care personnel stressed; consequently, some patients and their families took their frustration out on the participants. The participants had different levels of comfort and expertise handling the difficult situations. Authors and researchers in the literature have found that hospital overcrowding, increasing patient acuity and the nursing shortage has resulted in an environment in which nurses have limited time to spend with patients and their families; consequently, patients and their families are frustrated and unsatisfied with the care they receive. Patients and their families expressed their dissatisfaction by making complaints and becoming verbally abusive; unfortunately, these complaints and abuse were directed towards nurses. The participants in this study also reported that they experienced a large amount of disruptive behaviours from SENs. This is discussed in the horizontal violence section of this thesis. Researchers have found that the majority of nurses do not have the skills and do not know how to cope with verbal abuse. When nurses cannot advocate for themselves, they withdraw from the abusive situations and feel powerless; consequently, nurses who are verbally abused experience a
high level of occupational stress and a higher level of intent to leave the organization. Some participants discussed the challenges they had attempting to meet the needs of patients and their families. Despite the fact that they understood the importance of meeting their needs, their workload often made it difficult. At times, participants perceived the patient’s or family’s request were unreasonable. Participants were not alone in their expressions of frustration. Hospital overcrowding, increasing patient acuity and the nursing shortage have resulted in an environment in which nurses have limited time to spend with patients and their families. Researchers have found that as working environments become increasing more complex and patients or their family members become increasingly dissatisfied, nurses are burning out as they attempt to address the patients’ and their families’ needs; consequently; as nurses become burned out and dissatisfied with their jobs, they have a greater intent to leave the organization.

Finally, half of the participants had the perception that the ED was being “misused” by the hospital. Participants described: having difficulty transferring admitted patients out of the ED so that the ED could attempt to accommodate its other patients; had a perception that the ED was inappropriately being used to hold the admissions of patients to the hospital for “social reasons”; that the ED was being used as a “dumping ground” because the floors would not take extra patients to help relieve the overflow of admitted patients in the ED; and that other organizations were using the ED inappropriately. Authors in the literature support the participant’s perception that the burden of hospital overcrowding is being placed in the ED and is not being shared equally among the other units of the hospital. Many hospitals have a double standard in which the ED is burdened with admitted patients and hospital units are protected from the stress and workload that hospital overcrowding creates. This is
discussed in the hospital overcrowding section of this thesis. The authors in the literature do not support the participant’s perception that patients and other organizations are misusing the ED. The ED personnel delivers care for those patients needing emergency care for acute conditions and the ED also acts as a safety net for those people who may not have access to health care from other sources. In addition, facilities in the community may be unable to meet patient’s needs. Although EDs may see a large number of nonurgent or “inappropriate” patients, experts now believe that this population utilizes a small portion of ED resources and does not contribute to hospital overcrowding. Greater education of emergency nurses regarding the functions of the ED, in addition to, the needs of patients and outside organizations may be helpful in correcting this misconception.

Hospital Overcrowding

Hospital overcrowding is a reality of emergency nursing. It was placed as a category, in and of itself, because it was identified in every interview as being a concern for ENs, plus it has a huge influence on the work environment and the behaviour of staff in the emergency department. Every NEN interviewed for this study discussed the concerns and the challenges holding admitted patients in the ED created. The Canadian Association of Emergency Physicians and the National Emergency Nurses Affiliation have called hospital overcrowding the “most serious issue confronting Canada’s EDs” (Affleck, 2003, p. 82). The lack of beds for admitted patients in the hospital; the lack of access to specialists physicians; the lack of access to practitioners; the lack of access to primary care resources; the shortage of nursing and medical staff; the increasing complexity and acuity of patients coming to the ED for care and the volume of clients presenting to the ED for care are a few of the factors that have contributed to the problem. The participants, in this study, discussed the different ways in
which EDs attempted to manage the dilemma of admitted patients in their department. As EDs operated at over 100% capacity, patients receiving care in the hallways and waiting rooms was a common scenario.

The participants described that: the number of patients they were expected to provide care for had increased; the acuity of the patients had increased and there was a shortage of beds on the floors and intensive care units. Authors in the literature supported these perceptions. Providing care for critical ill patients in the ED, while attempting to provide care for the other patients in the ED, created stress for all of the emergency personnel involved. The expectation that ED staff provide care for acutely ill admitted patients, critical care patients and new emergency patients resulted in staff feeling overwhelmed and burning out. Authors and researchers have found that these conditions have contributed to: decreased nurse and physician satisfaction; negative productivity; negative staff morale and high staff turnover. Participants described difficulties and postponements in transferring the patients to the floors and intensive care units even though a bed for the admitted patient was available; in addition, participants expressed frustration that the floors were not assisting the ED with the number of admitted patients they held in the ED. The participants perceived that other units in the hospital did not understand the pressure that the ED was under. Authors in the literature have found that a double standard exists in many hospital systems in which administrators feel it is unsafe to manage admitted patients in the hallways of their units. Various authors in the literature have called for the recognition that hospital overcrowding is a system problem and that all parties in the system need to do their part to manage the problem.

The ED is designed to address the immediate life threatening care plus the urgent diagnosis and treatment of patients presenting with medical and surgical emergencies. EDs
were not designed to be inpatient units; as a result, the environment is not conducive to inpatient care. The participants interviewed empathized with the admitted patients. They recognized that admitted patients, in the ED, did not receive the same level of nursing care that they would on a unit because the EN was caring for both admitted patients and emergency patients at the same time. Participants discussed that EN's could only address what they assessed to be the priority care for admitted patients. Authors in the literature have called the current situation an overcrowding crisis in which it is difficult to meet the needs of patients; consequently, patients are dissatisfied with their care. Patient dissatisfaction can then lead to physical and verbal abuse directed towards health care personnel by both patients and their families, in addition to, prolonged pain and suffering of the patient. The NEN's discussed that they were aware admitted patients were not receiving the type of care they would on the units while in the ED. They also discussed the verbal abuse that they were subjected to by patients and their families. The participants expressed that they felt stressed or frustrated because they were trying to nurse ED patients in a limited space and as quickly as possible in order that a greater number be assessed and treated.

Authors in the literature have written that overcrowding is a system problem and has created a situation in which medication errors and threats to patient safety exist despite the proficiency of the ED staff. Participants discussed the professional and legal concerns they had as they attempted to provide care for both admitted and emergency patients. The Registered Nurses Association of British Columbia does not have a policy regarding overcrowding. The causes of hospital overcrowding are multifactorial; consequently, the ED cannot manage the problem alone. Authors have called for hospitals to adopt a philosophy in which patient care is shared equally throughout the hospital system. Public policy is needed
to address the problem on a national basis. Finally, further research is needed to explore the phenomena of overcrowding; it's consequences and possible solutions.

*Debriefing*

Debriefing was the fifth category of this study. All participants interviewed discussed debriefing events that occurred while nursing in the ED. After a stressful event at work, the majority of participants spoke to their coworkers to debrief. Participants indicated that they talked to their coworkers because they understood what was involved in emergency nursing and wanted to talk to people who had experienced similar situations. The majority of participants did not discuss their work events at home with their spouses, families or friends. Hospital overcrowding, high patient acuity and the nursing shortage has resulted in a work environment that are chaotic, busy, stressful, exhausting and has a high potential for violence. Researchers in the literature have also found that emergency personnel seek support from colleagues after a stressful event at work and that they infrequently sought the assistance of professional debriefing services. Two of the participants had exposure to professional debriefing services and were disappointment with the services. Some of the participants discussed that other events, apart from those considered critical, needed to be debriefed more formally. Researchers have found that when stressful events are not managed well or when nurses received debriefing that was not appropriate for their needs, they developed emotional exhaustion or posttraumatic stress. The participants expressed varying levels of comfort when considering socializing with their co-workers. While some participants thought it was helpful, others did not want to socialize with coworkers outside of work. Researchers have found that social support and the reliance on other colleagues are vital in helping nurses cope with the stress of their work. In times of uncertainty and stress, a positive social climate can
buffer nurses from the negative effects of crisis. When nurses lack social support they become dissatisfied with their jobs.

**Surprises**

Two themes were identified that were unexpected findings in this study. These are the nurse-physician relationship and horizontal violence. These themes are discussed below.

*Nurse-Physician Relationship*

Every participant interviewed for this study discussed the nurse-physician relationship. Two participants, who had extensive nursing experience prior to entering emergency nursing, described a slightly different perspective regarding the nurse-physician relationship than those of the other participants. One participant described that it took time for some of the physicians to get to know and trust a NENs knowledge and skills; consequently, some NENs found it difficult to work with these physicians. The participant went on to explain that there were a large number of inexperienced staff in the ED and that these EPs needed to trust the EN before they became comfortable working with them. Authors in the literature have identified five types of nurse-physician relationships (Kramer & Schmalenberg, 2003, 2004). The relationship described by this participant can be described as that of a friendly-stranger. In a friendly-stranger relationship there is a lack of trust between the nurse and the physician. Unequal power, a formal exchange of information and some physicians who do not acknowledge or receive information from nurses characterize the relationship. For nurses, the consequence is the perception that their input is not valued and the experience of an unequal power differential. Ultimately communication is impaired and patient outcomes may suffer. These authors write that physicians respect education and clinical competency in nurses. It is through these avenues that nurses can build collaborative and collegial
relationships with physicians in which mutual respect, trust and a greater equality in power exists.

All of the participants interviewed generally felt supported by the majority of EPs that they worked with and that their relationships with the majority of EPs were different than the relationship they had with physicians working on the floors. The participants reported that the EPs were receptive to their feedback; would act on the EN’s requests and would make the effort to explain or teach the participant relevant or interesting information pertaining to their client when time permitted. Participants felt comfortable asking many of the EPs their rationale for their orders and felt comfortable asking them questions to enhance their learning. Authors in the literature have described this type of nurse-physician relationship as being that of a student-teacher. In a student-teacher relationship physicians discuss, explain, and teach the nurse. Nurses often describe this relationship favourably. Nurses benefit from this relationship because they learn new information; however, physicians benefit from this relationship because they hold most of the power. Authors have written that nurses derive their power from the extensive time they spend with clients, their knowledge, experience and longevity as a nurse. Physicians respect education and clinical competence in nurses and it is through these avenues that nurses can build relationships with physicians to a collaborative and collegial level in which mutual respect, trust and a great equality in power exists.

*Horizontal Violence*

Another unexpected finding in this study was the level of disrespectful behaviour that the NENs experienced from SENs. All eight of the participants interviewed in this study discussed the challenges that they had working with SENs. Some of the NENs had witnessed and all had experienced disturbing behaviours from SENs. The horizontal violence discussed
by the participants and the descriptions of behaviours exhibited was a surprising finding in this study; however, after a review of the literature, it became apparent that the disturbing behaviours experienced by NENs were not unusual. In the literature, researchers have shown that nurses are subjected to horizontal violence on a regular basis in the workplace (Farrell, 1997, 1999; Henderson, 2003; Jackson et al.; McKenna, Smith, Poole, & Coverdale, 2003; Randle; Stevens, 2002). Researchers have also found that nurses are exposed to horizontal violence as students, as new graduate nurses and well into their career as Registered Nurses. Horizontal violence has been found to be more upsetting and problematic to deal with than aggression from patients. The participants experienced horizontal violence from preceptors, SENs, charge nurses, nurse educators and their managers. When horizontal violence exists, it sets a tone of fear in the environment.

Researchers studying student nurses have found that nurses exercised their power over the students and undermined their self-esteem. The students did not have the personal and professional resources to challenge the behaviours and over time adopted the actions, attitudes and beliefs of their nurse role models. Ultimately, they experienced low self-esteem and began to practice bullying behaviours towards their patients. One participant who was reinterviewed had changed her perception of NENs. During her first interview, she identified and empathized with NENs in the ED. During her second interview, she discussed that she found them frustrating to work with and slow. Although she continued to hear her coworkers speak in a derogatory manner regarding the NENs, she did not have the skills or courage to defend them. In this study, the NENs rationalized that SENs behaved the way they did either because they were experiencing difficulties in their personal lives, or it was a characteristic of their personality, or they were burned out. The unsupportive and abusive behaviours,
characteristic of horizontal violence, had an effect on the NENs. Participants indicated that they were scared, emotional upset, that their confidence was shaken, that they were fearful and that they had health effects. The reactions experienced by the participants in this study are similar to those found by other researchers. Researchers have also found that after exposure to an aggressive incident, nurses feel demoralized and that they lack value in the workplace, as a result, they develop a negative attitude towards their work environment. Links have been found between aggression and sick time, alcohol and drug use, burnout, decreased commitment to the workplace, decreased productivity, a higher intent to leave the organization and higher staff attrition.

Finally, while some SEN’s exhibited disruptive behaviours, they assisted NENs with acutely ill patients to ensure that the patient was safe. The lack of experience of NENs and their concerns for the patients’ safety may have been two reasons that contributed to the behaviour of SENs. When one of the participants reflected on her career as a NEN, she came to the realization that there was a great deal she did not know when she first started and that this created stress of SENs. SENs were not interviewed for this study; therefore, their perceptions, experiences, or insights were not available to add to the interpretation of this study’s findings.

Intent to Leave

The participants’ intent to leave is the last category of this study. The participants interviewed were of differing ages and different stages in their lives. The participants’ intent to stay in the ED varied. In one year from the time of the interview, six of the eight participants anticipated leaving the ED they were currently employed or changing their status there. Changes the participants anticipated that they would make included: moving to a
community hospital; moving to an urban hospital, being on maternity leave, being promoted to a charge nurse, leaving the ED to practice in another area of nursing and leaving the profession all together. In five years from the time of their interview, none of the participant anticipated remaining as a staff nurse in the ED they were currently working in. Participants stated that they anticipated leaving their current full time positions for a number of reasons. Two of the nurses considered emergency nursing as a step to larger goal. The other reasons the participants considered leaving emergency nursing included: lifestyle reasons; the overwhelming workload; safety concerns; questions regarding the ethics of practice; the perception of a lack of leadership and the perception that there was a lack of respect for nurses. A review of the literature did not yield any literature that specifically studied job retention or the intent to leave in emergency nursing. Researchers have found that when new RNs experience job stress associated with high patient acuity and unacceptable nurse patient ratios they left their jobs. Concerns regarding their work environment, management, lack of support and guidance, plus being given too much responsibility were also listed as reasons for leaving. These authors found that 30% of the new nurses, participating in their study, left their job in the first year of employment and 57% left by the second year. Two of the participants, in this thesis study, were new nurses to the profession and all eight of the participants were new to emergency nursing. Researchers have also found that medical-surgical and ICU nurses who had graduated within five years or less had a higher intent to leave their jobs when compared to other nurses. In addition, they found that job dissatisfaction was the greatest predicator of intent to leave. The participants in this thesis study discussed several aspects of their working situation that made their work difficult; they expressed feelings of frustration, feelings of stress, feelings of being overwhelmed and the
experience of mental and physical exhaustion. Researchers have found that when nurses experience high workloads they experience burnout, become dissatisfied and plan to leave their jobs. Nurses often leave their jobs within a year of making the decision to leave.

Participants commented that when working with NENs they tried to make them feel welcomed, tried to establish a relationship with them and gave them large amounts of feedback. Researchers have found that providing support and help when needed can help build a new nurses' confidence and help them cope with horizontal violence in the workplace. No literature was found that explored whether ENs were a more transient group when compared to other nurses; however, authors have found that nurses, in general, are using their nursing backgrounds as a stepping stone to other careers. Registered Nurses whom are 30 years of age or younger are leaving the nursing profession at a higher rate than nurses of other age group. Finally, younger nurses and nurses of future generations may chose to have more than one career in their lifetime; consequently, these factors may contribute to the transient behaviour of ENs.

In their interviews, participants described the constant learning; the type of nursing; the emergency nursing knowledge; the relationships they had with team members; and “saving lives” as the rewards they experienced as a NEN. One participant stated that what she liked about emergency nursing was that: “You do stuff that actually makes a difference”.

_Implications for Nursing Practice, Education and Further Research_

_Implications for Nursing Practice_

The findings of this study, in conjunction with a review of the literature, have yielded several implications for nursing practice. The content and quality of the orientations, experienced by the participants in this study, varied from institution to institution. While
some participant's experienced good orientations, others did not. Deficiencies in the content, type of instruction and the quality of instruction were found. Reassessment and restructuring of orientations programs to provide consistency in content and length of time during the orientation may be beneficial in assisting the NEN to become comfortable with their role and the ED. It would be beneficial for orientation programs to include the roles of the different members of the team in the ED and be staged over multiple areas of the ED. Depending on the experience and knowledge level of the NEN, orientation programs need to be adapted to the NEN's level of knowledge and experience. As the nursing shortage becomes worse and EDs are increasingly hiring new graduate nurses, or nurses with little previous nursing experience, into their departments, it would be beneficial for orientation programs to be increased in length and content to address their needs. Participants in this study experienced helpful and unhelpful behaviours during orientation and as they continued to learn their role as a NEN. Choosing nurses to oriented new nurses who have a sound knowledge base and have the support of other staff in the department would be beneficial. Avoiding the use of expert nurses to teach new nurses may be beneficial. New emergency nurses look for and emulate role models, it would be beneficial for SENs who have a sound knowledge base, a positive attitude, patience, enthusiasm, are respectful, have a good sense of humour, have effective communication skills, advocate for patients and practice professionally to be utilized as role models and ongoing teachers. Educating ENs that they act as role models for NENs, whether they are aware of this or not, would also be beneficial. Providing educational sessions in regard to effective teaching and mentoring of NENs would be beneficial. Finally, the development of mentorship programs in the ED would be beneficial for NENs. These programs could provide initial and ongoing education and support of the NEN and assist in
providing job fulfillment and satisfaction for both the mentor and mentee. Support has been found to be beneficial after a traumatic event or a stressful day at work. Mentorship programs may assist in providing support that can then buffer the negative effects of these disturbing events.

The findings of this study, in conjunction with a review of the literature, have demonstrated that the work environment has a huge impact on the NENs' ability to learn their role as an EN and their ability to perform their work. The NENs experienced abuse from patients, patient families and SENs. They experienced a large amount of occupation stress, experienced mentally and physically exhaustion and were dissatisfied with their jobs. These factors had an influence on their intent to stay in the ED. Because of the nursing shortage, organizations have attempted to staff their EDs using experienced and inexperienced noncritical care nurses; however, this created stress and increased the workload for the NENs. An examination of whether the use of noncritical care staff is an effective solution for the problem of short staffing in the ED and how these staff can be more effectively utilized in the ED, in order to decrease the burden they create for ENs, would be beneficial. It was found that NENs were performing nonnursing duties resulting in less time to perform nursing care. It would be beneficial for administrators to assess the type of support staff they have available and how these staff can most effectively be utilized in the ED. The effective use of support staff would then result in ENs having more time to attend to aspects of patient care; assist in reducing the level of stress ENs experience and enhance their job satisfaction.

A review of the literature, has demonstrated that the NEN’s frustrations with management was not a unique finding of this study. Although it is recognized that managers are overburdened with the expectations of their jobs, the perception that managers were not
listening to nurses and that managers were not providing leadership had a huge impact on the NENs' ability to perform their jobs and their intent to stay in the ED. It would be beneficial for managers to reassess their role and the impact that their behaviours has on the nurses they manage. In order to set the professional tone in the ED and promote the retention of nurses, managers need to be more accessible, responsive to staff concerns and be perceived to be supportive of ENs.

The participants discussed difficulties attempting to cope with organizational and technical changes as they attempted to deal with all the other stressors in their job. While organizational and technical changes are necessary for the development of the organization and health care, it would be beneficial for EDs and the hospital organization to pace the amount of new changes, to monitor how staff are managing and to monitor the effectiveness of the new changes introduced. In addition, providing the technical resources, personnel resources and the supplies necessary to support the changes or new technology would assist ENs in their implementation and reduce the workload and stress experienced by these nurses.

The findings of this study, in conjunction with a review of the literature, reveal that the experience of verbal abuse from patients and their families was not unique to the study participants. Hospital overcrowding, the large workloads of the EN, plus mental and physical exhaustion were some of the factors that contributed to ENs being unable to address the patients' and their families' needs; consequently, resulting in abuse. It would be beneficial for administrators to reassess and address the factors that contribute to the patients' and their families' frustrations, in addition to, factors that contribute to the EN's high workload. Providing and enforcing guidelines for patient and family conduct in the ED would be beneficial in order to reduce the abuse and provide a safe environment for ENs to conduct
their work. The findings that participants did not utilize professional services to debrief stressful or traumatic events and that they debriefed among colleagues were not unique to this study. Research indicates that a supportive work environment can buffer the effects of stressful events at work. It would be beneficial for administrators to reassess their EDs in regard to the level of support that exists among team members and engage in activities that promote and foster social support in the work environment.

Hospital overcrowding has resulted from a multitude of factors. It had an impact on the NEN’s level of job satisfaction and their intent to stay in the ED. Participants discussed the challenges they encountered as they worked in conditions of high patient acuity and volume; believed they could not meet professional and ethical standards and that they were subjected to abuse by patients, patient’s families and SENs. A review of the literature reveals that these challenges were not unique to this study. It would be beneficial for hospitals to adopt a philosophy in which patient care is shared equally throughout the hospital system. Public policy is needed to address the problem on a national basis. It would be beneficial for the hospital organization and the provincial nursing organization to develop a policy on hospital overcrowding; therefore providing guidance for the emergency nurses and other stakeholders in the workplace. Finally, creative solutions addressing the phenomena of hospital overcrowding must be found.

The participants in this study discussed two types of nurse-physician relationships. Some physicians engaged in a friendly-stranger relationship with NENs in which the physician did not communicate or utilize the information obtained by nurses. Physicians may have behaved in this manner until they established that the knowledge and skills of the NEN could be trusted. All of the participants discussed that the majority of EPs engaged in a student-
teacher relationship with the NENs. In a student-teacher relationship physicians discuss, explain, and teach the nurse; nurses often describe this relationship favourably; however, in both types of relationships, the physician holds the majority of the power. The student-teacher relationship can be an antecedent to collaborative and collegial relationships. A review of the literature indicates that nurses derived their power from the extensive time they spent with clients, their knowledge, their experience and their longevity as a nurse. Physicians respect education and clinical competence in nurses. It would be beneficial for administrators and educators to establish and to encourage avenues for interdisciplinary education in order for both nurses and physicians to gain a greater understanding of each other’s profession. It would also be beneficial for administrators and educators to provide avenues for ongoing education for ENs. Through these avenues, nurses can build relationships with physicians to a collaborative and collegial level in which mutual respect, trust and a great equality in power exists.

All of the participants in this study expressed experiencing horizontal violence from SENs. The findings of this study, in conjunction with a review of the literature, reveals that the experience of horizontal violence was not unique to the NENs. Researchers have shown that nurses are subjected to horizontal violence on a regular basis in the workplace and are concerned about its ramifications. The behaviours that the participants described in this study are similar to those found by researchers studying horizontal violence. The participants, in this study, experienced horizontal violence from preceptors, SENs, charge nurses, nurse educators and their managers. When horizontal violence exists, it sets a tone of fear in the environment. Researchers have found that after exposure to an aggressive incident, nurses felt demoralized and that they lacked value in the workplace, as a result, they developed a
negative attitude towards their work environment. Links have been found between aggression and sick time, alcohol and drug use, burnout, decreased commitment to the workplace, decreased productivity, a higher intent to leave the organization and higher staff attrition. The lack of experience of NENs and their concerns for the patient may have been two reasons that may have contributed to the behaviour of SENs.

It would be beneficial for provincial nursing organizations, national nursing organizations and NENA to develop policies regarding horizontal violence. At an administrate level; strategies to prevent the horizontal violence and to manage the abuse that exists must be implemented. Ensuring that health care personnel are aware that such abuse is unacceptable is necessary and enforcing a zero tolerance policy is necessary. Managers need to promote and ensure good relationships among staff and create an environment in which staff feel safe to report incidents of horizontal violence. It would be beneficial for managers, educators and staff to examine what role they place in horizontal violence. Finally, ENs may act in abusive ways due to heavy and stressful workload demands. It is necessary for administrators, nursing organizations and government to address the multitude of factors that results in this stressful and demanding work environment; thus, potentially reducing the incidence of horizontal violence that occurs.

As presented throughout this study, the NENs experienced high workloads; high patient acuity and volume; had concerns about their ability to meet professional practice standards; had concerns about their ability to practice ethically; and they experienced abuse for patients, patients families and SENs. Researchers have found that when nurses experience high workloads they experience burnout, become dissatisfied and plan to leave their jobs. Nurses often leave their jobs within a year of making the decision to leave. It is imperative that
hospital administrators and governments address the work environment factors that have contributed to nursing dissatisfaction in order to retain its nurses. Inability to address the workplace environment factors will further result in nurses continuing to leave their jobs and contribute to the nursing shortage.

*Implications for Education*

Several areas for greater education were identified in this study. As described in this thesis, participants received varying levels of orientation and support when they began in their jobs as NENs. They experienced behaviours that were helpful and unhelpful by SENs. As discussed in the previous section, it would be beneficial to design orientations according to the needs of the NEN. Educating ENs who orientate and provide ongoing education of ENs, in regards to effective teaching and learning strategies, would be beneficial. Educating staff that they act a role models, whether they are aware of it or not, and the impact that this has on NENs would also be beneficial.

The participants who had entered emergency nursing directly from a general nursing program and had no previous nursing experience had the greatest learning needs of all the participants interviewed. These participants discussed concerns that they perceived to be deficiencies in their basic nursing education and that these deficiencies contributed to their being unprepared for practice in the ED. Authors in the literature have found that newly graduated nurses have the greatest learning needs of all of the nurses entering emergency practice. Larger numbers of EDs are now hiring newly graduated nurses into their EDs. It would be beneficial for general nursing programs to review and reassess the content that they provide in their curriculum and how the content is delivered. It would also be beneficial for
emergency nursing educators and administrators to provide extensive orientation programs, for these nurses that include instructions on assessments and priority setting.

Participants expressed several challenges as they worked with patients, their families and SENs in the ED. Some patients, their families and SENS were abusive to the NENs. The participants had different levels of comfort and expertise handling the difficult situations. The participants also experienced horizontal violence from SENs, managers, and educators in the ED. Researchers have also found that the majority of nurses do not have the skills and do not know how to cope with abuse. When nurses cannot advocate for themselves, they withdraw from the abusive situations and feel powerless; consequently, nurses who are verbally abused experience a high level of occupational stress and a higher level of intent to leave the organization. Education regarding how to identify abuse, skills on how to deal with the abuse and skills on how to respond to episodes of abuse is needed. It would be beneficial for educational programs to teach nurses the avenues available to report abuse and how to document episodes of patient abuse and horizontal violence. Educators need to promote and ensure good relationships among staff and create an environment in which staff feel safe to report incidents of abuse or horizontal violence. It would be beneficial for educators to examine what role they play in horizontal violence. In addition, it would be beneficial for educational programs to assist nurses in becoming more aware of the existence on horizontal violence and the role that they may play in the abuse. It would also be beneficial for educational programs to provide information regarding support services available for nurses and how to access them. Finally, educating the public and the stakeholders as to the realities of the emergency work environment for nurses, in addition to, the occurrence and the consequence of abuse in the ED is needed.
Finally, half of the participants had the perception that the ED was being “misused” by the hospital. The authors in the literature do not support the participant’s perception that patients and other organizations were misusing the ED. The ED personnel delivers care for those patients needing emergency care for acute conditions and the ED also acts as a safety net for those people who may not have access to health care from other sources. In addition, facilities in the community may be unable to meet patient’s needs. Although EDs may see a large number of nonurgent or “inappropriate” patients, experts now believe that this population utilizes a small portion of ED resources and does not contribute to hospital overcrowding. Greater education of emergency nurses regarding the functions of the ED, in addition to, the needs of patients and outside organizations may be helpful in correcting this misconception.

Implications for Further Research

Several areas for greater research were identified in this study. The participants attempted to be helpful and assist newer emergency nurses who entered the ED after them. No formal mentorship programs were found in the EDs that the participants worked. Several authors in the literature have expressed the benefits of mentoring or mentor like programs in emergency nursing. Mentoring programs can assist NENs in learning the culture, the environment, their new role, in addition to, the integration of their knowledge and skills in the ED. Mentees benefit from the support and role modeling demonstrated by mentors. The concept of mentoring and the role of the mentor are not well defined in the nursing literature. Several authors have expressed the benefits of mentoring in emergency nursing and some examples of modified mentoring programs have been described in the literature; however, they have not been formally evaluated or studied. Mentorship programs may be beneficial in providing
ongoing education, support and buffering the NEN from the stresses of the work environment. Further research is needed to determine the most effective mentorship program designs for use in emergency nursing and their effectiveness.

The findings of this study, in conjunction with a review of the literature, reveals that the current emergency work environment contributes to abuse against nurses, occupational stress, nursing mental and physical exhaustion, nursing burnout, nursing dissatisfaction and an intent to leave the ED. No research was found that explored the use of noncritical care or float nurses in the ED and the effects the use of these nurses had on emergency staff, patient care, or patient flow through the ED; however, two authors discussed that these nurses were not efficient at delivering emergency care because of their lack of emergency nursing knowledge and the fast pace of the emergency nursing care. Further research is needed to determine whether noncritical care RNs are efficient at delivering emergency care and how the use of these nurses impact the ENs working in the ED. Further research to help determine the impact utilizing these nurses has on the quality of patient care would be beneficial. In addition, research to assist in determining how these nurses could most successfully be utilized in the ED is needed. Further research is needed to assist in determining how to effectively use newly graduate nurses in the ED, the pros and cons of having these nurses in the ED and the most appropriate method of educating them and supporting them in the ED. Further research is needed to help determine the impact that the current work environment has on new and senior ENs. Further research is needed to determine the most effective way to utilize support staff in the ED. Further research to determine the most effective methods of creating and maintaining a supportive work environment for emergency staff would be beneficial as support has been found to buffer the negative effects of stressful or traumatic
events. No literature exploring the differences between community and urban EDs and their impact on ENs were found. Authors of one study found that rural hospital nurses, who had ties to the community, had a greater intent to stay with the organization. Further research is needed to determine whether these findings are applicable to smaller community EDs in general. Further research exploring the expectations of patients and their families, while in the ED, would be beneficial. Finally, further research is needed to explore the phenomena of hospital overcrowding, its consequences and possible solutions.

Every participant interviewed for this study discussed the nurse-physician relationship. A review of the nursing literature indicates that the relationship between nurses and physicians may not always be harmonious. Discrepant attitudes towards teamwork and collaboration, between nurses and physicians, have been found. Two types of nurse-physician relationships were found in this study: the friendly-stranger and the student-teacher relationship. Two participants, who had extensive nursing experience prior to entering emergency nursing discussed the friendly-stranger relationship and the impact it on nurses. In a friendly-stranger relationship there is a lack of trust between the nurse and the physician. All of the participants discussed engaging in the student-teacher relationship with the majority of the EPs. In a student-teacher relationship, physicians discuss, explain, and teach the nurse. Nurses often describe this relationship favourably. Nurses benefits from this relationship because they learn new information and physicians benefit from this relationship because they hold most of the power. The student-teacher relationship can be an antecedent to collaborative and collegial relationships. Collaborative and collegial relationships are characterized by mutual respect, trust and a great equality in power between the EN and the EP. As ENs progress from being new to becoming more experienced, it would be beneficial
to study the nurse-physician relationship to explore whether ENs remain content to engage in a student-teacher relationship with physicians or whether, with more experience, they seek a relationship that consists of greater mutual respect, trust and equality power.

All eight of the participants interviewed in this study discussed experiencing disturbing behaviours from SENs. Researchers have shown that nurses are subjected to horizontal violence on regular basis in the workplace. Research is needed to explore what role the current ED workplace environment has in contributing to horizontal violence. While some SEN’s exhibited disruptive behaviours, they assisted NENs with acutely ill patients to ensure that the patients were safe. The lack of experience of NENs and the concerns for the patient may have been two reasons that contributed to the behaviour of SENs. SENs were not interviewed for this study; therefore, their perceptions, experiences, or insights were not available to add to the interpretation of this study’s findings. Further research to explore the perceptions, experiences and insights of SENs would be beneficial. In addition, further research exploring the transition of NENs into becoming SENs may provide insights as to why SENs behave the way they do in the workplace.

Six of the eight participants anticipated leaving the ED as a full time EN or changing their status in a year from the time of the interview. Participants stated that they anticipated leaving their current EN full time positions for a number of reasons. Two of the nurses considered emergency nursing as a step to larger goal. The other reasons the participants considered leaving emergency nursing included: lifestyle reasons; the overwhelming workload; safety concerns; questions regarding the ethics of practice; the perception of a lack of leadership and the perception that there was a lack of respect for nurses. A review of the literature did not yield any research that specifically studied job retention or the intent to
leave in emergency nursing. Research that explores emergency nurses intent to stay in the ED and factors that influence their decisions to stay or leave is needed. Researchers have found that when new RNs experience job stress associated with high patient acuity, unacceptable nurse patient ratios and concerns regarding safety, they left their jobs. Further research to determine whether newly graduated RNs hired into the ED leave their jobs earlier than more experienced nurses and what factors may influence their decision to stay or leave is needed. Researchers have also found that medical-surgical and ICU nurses who had graduated within five years or less had a higher intent to leave their jobs when compared to other nurses. Research to explore whether this is the same for ENs with less than five years of nursing practice would be beneficial. Researchers have found that job dissatisfaction was found to be the greatest predicator of intent to leave. The participants in this thesis study discussed several aspects of their working situation that made their work difficult: they expressed feelings of frustration, feelings of stress, feelings of being overwhelmed plus mental and physical exhaustion. Researchers have found that when nurses experience high workloads they experience burnout, become dissatisfied and plan to leave their jobs. Nurses often leave their jobs within a year of making the decision to leave. Further research is need to explore the work environment of ENs, the impact that it has on job satisfaction, and what impact it has on ENs intent to leave the ED. Younger nurses and nurses of future generations may chose to have more than one career in their lifetime; consequently these factors may contribute to the transient job behaviour of ENs. Further research exploring how younger nurses envision their career path and what influences them to stay or leave emergency nursing is needed. Finally, because this is a qualitative study, the findings are not generalizable to the larger population. Further research would be beneficial exploring the
experiences of new emergency nurses and senior emergency nurses and the findings of this study.

Conclusion

The purpose of this study was to describe the experiences and the needs of new ENs as they progressed from a new to a more experienced nurse in the ED. Eight NENs who had had three years or less of emergency nursing practice and had completed the core courses of an emergency specialty program, were interviewed. The NENs felt overwhelmed and unprepared as they started their emergency practice. Inconsistencies and deficiencies in the orientation programs delivered were identified. As they practiced in the ED, they encountered factors in the workplace environment that created challenges for them to practice safety and ethically. The nursing shortage; the lack of resources; frustrations with management; the high patient acuity and volume; the challenges of attempting to meet organizational and technical changes and the expectations of patients and their families were several of the workplace challenges they encountered. Hospital overcrowding created an environment in which the NENs experienced occupational stress; mental and physical fatigue and abuse from patients, patient families, and SENs. The participants did not utilized professional services to debrief stress or traumatic incidents at work. They described favourable relationships with the majority of EPs they worked with. All of the NENs experienced horizontal violence from SENs. Six of the eight participants anticipated leaving the ED as a full time EN or changing their status in a year from the time of the interview. The participants discussed several aspects of their working situation that made their work difficult; they expressed feelings of frustration, feelings of stress, feelings of being overwhelmed and exhaustion. Researchers have found that when nurses experience high
workloads they experience burnout, become dissatisfied and plan to leave their jobs. Nurses often leave their jobs within a year of making the decision to leave. Implications and recommendations for nursing practice, nursing education and research have been presented. It is imperative that policy makers, administrators, educators, and researchers work to improve the work place environment, address the abuse that ENs encounter and promote strategies that retain ENs in the ED. The retention of ENs is crucial for organizations because it will result in substantial savings in replacement costs and prevent a loss in efficiency, in addition, it will assist to prevent the expansion of the nursing shortage.

"Experienced and dedicated nursing staff are the backbone of emergency care" (Anonymous, 2001, p. 82). It is hoped that that the descriptions obtained from this study has informed nursing practice and has contributed to nursing knowledge which may then help promote the transition, the nursing satisfaction, reduce the nursing turnover and the improve retention of new nurses in the emergency setting.
References


Canadian Institute for Health Information. (2002b). *Workforce trends of Registered Nurses in Canada, 2002*. Ottawa, ON: Canadian Institute for Health Information.


Sample Information Letter for Initial Agency Contact

Thank you for taking the time to read this information letter. My name is Trish Rampersaud. I am a Registered Nurse and a graduate student completing my Master's degree in Nursing at the University of British Columbia.

For my thesis I am interested in learning more about what it is like to be a new Emergency Nurse. I hope that this study will provide health care professionals with information that will help them in assisting new Emergency Nurses as they make the transition into becoming a more experienced nurse in the emergency setting.

I am interested in talking to new Emergency Nurses with less than three years of emergency nursing experience. They can be working in the Emergency Department or recently have left. For those new Emergency Nurses interested in sharing their experiences with me for my research, I will ask them for up to 90 minutes of their time for an interview with the possibility of a second interview lasting approximately the same amount of time. The amount of time they might spend with this study is a maximum of three hours if they are involved in both interviews. The place and time for these interviews will be selected for their convenience and during times when they are not scheduled to work.

Letter of Introduction

Thank you for taking the time to read this information letter. My name is Trish Rampersaud. I am a Registered Nurse and a graduate student completing my Master’s degree in Nursing at the University of British Columbia.

For my thesis I am interested in learning more about what it is like to be a new Emergency Nurse. I hope that this study will provide health care professionals with information that will help them in assisting new Emergency Nurses as they make the transition into becoming a more experienced nurse in the emergency setting.

I am interested in talking to new Emergency Nurses with less than three years of emergency nursing experience. You can be working in the Emergency Department or recently have left. If you are interested in sharing your experiences with me for my research, I will ask you for up to 90 minutes of your time for an interview with the possibility of a second interview lasting approximately the same amount of time. The amount of time you might spend with this study is a maximum of three hours if you are involved in both interviews. The place and time for these interviews will be selected for your convenience and during times when you are not scheduled.
New Emergency Nurses Descriptions of Making the Transition to a More Experienced Emergency Nurse: An Interpretive Descriptive Study.

Consent

Your participation in this study is entirely voluntarily and you may refuse to participate or withdraw from the study at any time without jeopardy to your employment. You understand that the co-investigator (Trish Rampersaud) may stop your participation in the study.

Your signature below indicates that you have received a copy of this consent form for your own records.

Your signature indicates that you consent to participate in this study.

Participant Signature ____________________________ Date __________

Printed Name of the Participant signing above

Co-Investigator Signature ____________________________ Date __________

Printed Name of Co-Investigator signing above

Demographic Information

1. Age

2. Sex

3. Number of years nursing prior to entering emergency nursing?

4. Previous type nursing experience(s) and length of time in the experience(s)?

5. Amount of time as a full time emergency nurse?

6. Educational level (check all that apply)
   a. Diploma
   b. Degree
   c. Core emergency courses
   d. Emergency certificate
   e. Core critical care courses
   f. Critical care certificate

7. On a scale of 0 to 10 (where 0 is none and 10 is the best), how would you rate your
   level of job satisfaction when you first started emergency nursing?

8. How would you rate it now?
Appendix E

Interview Guide

Can you tell me what is like for you as a new Emergency nurse?

At what point did you begin to feel more comfortable as a new Emergency nurse?

Tell me more about the process of becoming more comfortable?

What are your plans in a year from now?
MEMORANDUM

TO: Ms P Rampersaud, Master's Candidate, School of Nursing, UBC
    Dr A Henderson, School of Nursing, UBC

FROM: Dr. M. Foulkes, Chairman
       Clinical Investigation Committee

DATE: 17 June 2004

SUBJECT: CIC Protocol 2004-17
How Do New Emergency Nurses Describe Their Experiences as They Make the Transition from Being New to Becoming More Experienced as an Emergency Nurse? What are the Needs of New Emergency Nurses as They Make the Transition?

1. The above-noted study was reviewed by the Clinical Investigation Committee on 14 June 2004 and it was APPROVED. A Clinical Trial Agreement is NOT REQUIRED: This approval is subject to you making any suitable logistical arrangements with the head nurses of the various emergency departments. A copy of the UBC approval is also required.

2. The consent does not require any changes except the "too" on the top of Page 2.

3. The Clinical Investigation Committee consists of: Chairman, Dr. M.R. Foulkes (Physician, Anesthesiologist, with a special interest in Medical Ethics); Dr. L. Meredith (Professor, Educator, Marketing Authority, Lay Member); Dr. M. Vince (Biochemist, Laboratory Scientist); Dr. I. Thordarson (Department of Emergency Medicine); and Mr. Ed Dillon, (Doctor of Pharmacy, Clinical Pharmacist to the Emergency Department, RCH). The Committee requests that you send a full financial report to the Vice President, Academic Advancement & Research detailing funds received and expenditures. This report will remain confidential information. You are also requested to inform the office of the Clinical Investigation Committee when the project has been completed, as well as forward any published material resulting from this study. Committee approval is not based on finite time but on the life-time of the project. Please submit requests for annual review, if this is required: Approval of the study includes approval of the locally generated consent form, unless otherwise stated. Copies of adverse event reports submitted to the investigator should be forwarded for review by the Committee Chairman.

Amendments or revisions of protocol, as well as all serious adverse events, must be submitted using the correct forms which can be obtained from the CIC office. All documentation for the Clinical Investigation Committee should be submitted through Administration and should clearly refer to the Physician Investigator and should be signed by the Physician Investigator. The Physician Investigator remains responsible to the subject through the physician-patient relationship; the optimum of physician supervision of patient care is expected. Similar ethical standards exist for Nursing
Reporting Form for Revision / Amendment of a Clinical Research Protocol or
Revision / Amendment of the Investigators' Brochure. (To be submitted in duplicate.)

CLINICAL INVESTIGATION COMMITTEE No.: _CIC 2004 - 17
Study Protocol No.:  UBC BREB B04-0388  Official Protocol Date: 17 June 2004

Study Name: ____How Do New Emergency Nurses Describe Their
Experiences as the make the Transition from Being New to Becoming More
Experienced as an Emergency Nurse? What are the Needs of New
Emergency Nurses as they make the Transition?

Revision / Amendment to:  X □ Protocol
□ Investigator’s Brochure

No. of Revision / Amendment:  Three

Date of Revision / Amendment:  __July 7, 2004__

COMMENT:
I would like to revise the name of the study to match the recommendations
made by the University of British Columbia’s Behavioural Research Ethics Board
(UBC BREB) to: New Emergency Nurses Descriptions of Making the Transition to
a More Experienced Emergency Nurse: An Interpretive Descriptive Study

I request that the witness signature be removed from the consent form.
The Emergency Nurse will receive an information sheet about the research study
prior to the interview. They will contact me to make arrangements for the
interview if they wish to participate. Prior to obtaining consent, I will explain the
purpose of the study and that they can refuse to answer any question or can
terminate the interview at any time. The interviews will be conducted at a
mutually arranged time and place; therefore, there may be no other persons
available to witness a signature. The interviews will be subjective and personal in
nature. No physical treatments/procedures will be undertaken. The participants
may not want others to know that they are participating in the study.
Consequently, asking for a witness signature from a third party will be difficult to
obtain and may potentially jeopardize the participants participation in the study
as they may wish to remain anonymous.