

One nurse's experience of providing care while working within an overcrowded emergency department – an autoethnographic study

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Abstract

Emergency Department (ED) overcrowding has been gaining increasing national and international attention in recent years, yet little research has examined the emergency nurse's experience of this phenomenon. Undertaking this study allows me to share my experiences of providing care within an overcrowded emergency department that emergency nursing colleagues may find relation with, and connect one nurse's experience with others in the ED nursing workforce. The experience of being an emergency nurse working within a demanding department cannot be adequately measured by statistics. The intensity of the experience and current working environment can be best understood by the sharing of my experiences. The aim of this study is to examine and highlight nursing issues associated with working within an overcrowded emergency department, and to examine my experiences of difficulties providing care. As a research methodology autoethnography allows me to use personal narratives as research data and by doing so give voice to my experiences of providing care in an overcrowded emergency department.

Three themes entitled 'What's the harm in waiting,' 'Too busy to care' and 'Feeling all used up' were established from the data analysis. These three themes all have many common characteristics and can be easily overlapped. The cultural theme that is identified through the data is that the notion of caring is at the root of my nursing practice and working within an overcrowded ED can compromise these values. This experienced distress is the painful feelings and the disequilibrium that happens when I am conscious of the appropriate action required but I am not able to carry it out due to barriers. This distress is a major problem in the nursing profession that affects nurses internationally and is described as moral distress.

I compared my experiences in narrative formation against published literature examining the issues that face ED nurses. I felt uncomfortable and simultaneously disappointed to uncover similar feelings of powerlessness and distress within my nursing culture. Like me many other emergency nurses ability to provide care is impacted by issues due to ED overcrowding. Writing and sharing my personal experiences using narratives and analysis has provided me with strength that I am not alone in this issue, and optimistically this will also educate and empower the reader,

who may also face similar issues within their workplace. The issues and difficulties associated with overcrowding in the ED are complex and multifaceted, and it is important that ED nurses at constant risk of moral and emotional distress are not forgotten in strategic attempts to manage and improve this issue.

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I always envisaged my mum and dad being at my graduation, but now I have now learnt that they are always with me guiding my way.

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Chapter One - Study Overview

Introduction to the study

This study is the examination of my experiences of a senior nurse working within an overcrowded emergency department (ED) in New Zealand. Internationally and within New Zealand nurses are faced with increasing demands on our emergency services and fulfilling our emergency nursing profession. As a senior nurse within an emergency department I am finding it more difficult to meet the demands asked of me. I have also witnessed these demands on my nursing team and find evidence of similar situations throughout nursing literature. Many ED nurses are working to full capacity, and with the current common state of ED overcrowding we are asking those nurses to provide additional care to a larger patient group in an environment with restricted or diminishing resources (Kilcoyne & Dowling, 2004).

The purpose of this research is to examine my experiences as a senior nurse and the impact that overcrowding has upon the care I provide, and to interpret my experience in relation to the wider emergency nursing profession. The foundation of this research is based around the research question, what are my experiences as a senior nurse providing care within an overcrowded emergency department? I will conduct a literature search examining the notion of care, the essence of emergency nursing and provide an overview of the problem of ED overcrowding. I have used self narratives to portray my own experiences of working within an overcrowded ED, and have used autoethnography to provide the tie between the wider cultures of ED nursing. According to Wall (2008) autoethnography is a research method that provides a way of giving voice to personal experience for the purpose of extending sociological understanding.

This chapter provides my personal interest and background for conducting this project, my responsibility of care within the ED, exploration of the essence of emergency nursing, ED overcrowding and discuss the notion of caring and its application to my role. I will also outline other conducted studies that are relevant to this work.

Personal interest in this study

On reflection I believe my interest in this research started several years ago. I felt as though my workload in a demanding emergency department was increasing with due to patient presentations and higher acuity levels, and the available resources were not expanding in the same manner. My experience and skills were at an expert level and I was engaged in higher levels of responsibility and seniority within my workplace. I felt this was the right thing to do for my career, but why was I left feeling that I was leaving my core values of nursing behind? I became feeling increasingly stressed and dissatisfied with my role and my profession and the care I was providing. I recognized that the care I provided within my emergency department did not meet the gold standard or optimum levels that I knew were the most beneficial for the patients and the staff, and even occasionally I was unable to meet basic patient's rights by not addressing their comfort and dignity as deserved. Continuous strategies to improve systems and multiple requests for further resources in the department were declined regularly by management due to financial and resource issues. I held a residual feeling of knowing what to do, knowing how to do it, but yet not having the inability to provide this great care due to restrictions on space, funding and many other organizational barriers. I am confident that these frustrations leading to my overall dissatisfaction are not an individual experience, but a common reality in my ED nursing world. This I believe is how my research started.

My designated senior nurse position is Clinical Nurse Coordinator (CNC) within the ED. My population of responsibility includes all patients and staff within the ED. The main purpose of my role is to provide direct clinical coordination and expertise while ensuring a safe effective practice environment which supports the management of patient flow in the ED. As the senior nurse in charge of shift I jointly hold the responsibility for care with the senior medical officer (SMO) in the ED as outlined by the Australasian College of Emergency Medicine (2003). However due to difficulties recruiting and retaining SMO's, this position is often filled with locum or junior doctors, therefore the responsibility of care for the department frequently is held solely by me. I have an overall accountability to bring together the physical aspects of the patient journey and process which include, reception, triage, initial assessment

and resuscitation, detailed assessment and investigation, progress evaluation and monitoring and the finally disposition (ACEM,2003). There are many members of different professions, specialties and locations throughout the hospital that I am required to communicate with and coordinate to facilitate the patient journey in a timely and safe manner. The roles and responsibilities of my clinical role are required to be visible, responsible and delivery of efficient care must be facilitated. The increase in requirements that I outline within this project are expected from our service which is difficult at a time when resources are limited and this presents the ED team with daily challenges.

I believe it is very important to protect and retain our workforce within the emergency nursing profession. By undertaking this study it allows me to share my experiences of providing care within a demanding ED that emergency nursing colleagues may find relation with, and connect one nurse's experience with others in the ED nursing workforce. The experience of being an emergency nurse working within a demanding department cannot be adequately measured by statistics. The intensity of the experience and current working environment can be best understood by the sharing of my experiences. What it is like being and ED nurse at this time in a health system with scarce resources and the increasing challenges of an aging nurse and patient population can be further understood by my personal nursing narratives that also support statistical and evidence within nursing literature. Nursing perspectives of their jobs and workplace matters greatly as it affects career patterns and the supply of registered nurses. If delivery of patient focused quality care in ED's is to be achieved it is imperative that nurses are listened to, and their expertise acknowledged and they are allowed to become more involved in decision making processes. Issues associated with overcrowding in the emergency department are complex and multifaceted and it is essential that nurses whom are at a constant risk of emotional, physical and moral distress are not forgotten about in strategic attempts to recognize and manage this issue. Therefore this becomes the justification for undergoing this study. Although this study is based upon my own personal practice narratives, the issues of ED nurses occur nationally and internationally, therefore the collection and analysis of these narratives of being an ED nurse in a busy department are also applicable and transferable within a wider nursing community. By using the methodological framework of autoethnography this allows me to bring together my experiences

within the culture of ED nursing. Lo-Biondo and Wood (1990) state that for research to be classed as significant, it should be applicable to nursing practice, the results will potentially formulate or alter nursing practices, will lend support to untested theoretical assumptions and potentially benefit society.

Emergency Nursing

I change into my comfy scrubs and secure my stethoscope around my neck as I mentally prepare for my day. I survey my work environment that only an emergency nurse would find normal. They were patients of all shapes, sizes and ages in various states of illness, and acuity. There is a disharmony of talking, crying and alarming equipment which I have become accustomed to. I can easily hear conversations from behind the bedside curtains including medical and nursing assessments and also patients and families discussing their frustration of waiting times. There are patient beds in the corridors and varied staff members hurriedly ducking in and out of patient spaces.

Emergency nursing is a specialty where nurses care for patients in the emergency or critical phase of their illness or injury. They are skillful at discerning life-threatening problems, prioritizing the urgency of care, and rapidly and effectively carrying out resuscitative measures. Emergency nurses act with a high level of autonomy and have the ability to initiate the required measures without outside direction, while simultaneously educating the patient and family with the information and emotional support needed as they cope with their new reality (ENA, 2009). Emergency nursing is the care of individuals of all ages with perceived or actual physical or emotional alterations of health that are undiagnosed or requiring further intervention. The care is episodic, primary and usually acute. The ED is the only health provider many people ever know and is a doorway into the wider hospital. It serves not only as a receiver for the critically ill and injured, but also a 24 hour service that treats the patient group where a general practitioner is inaccessible due to financial reasons or restrictions in after hour services (Australasian College for Emergency Medicine, 2004). While practicing in such a busy and diverse field of nursing I continue to apply my personal core caring values which I will now discuss.

The notion of caring and my personal core values of nursing

Florence Nightingale described in her diary receiving a calling from God which led her into her professional service of a nurse (Keith, 2002). As I reflect her ideas onto my own self I question, I don't believe this was my experience. However with all the professional opportunities available I was simply attracted to nursing by the inspiration of looking after people that needed me. Comparing my personal attributes to the Mosby's (1990) definition of a nurse there are many similarities. I believe the key aspects of nursing including being humanitarian, ethical, nurturing, personal and protective have been part of me prior to partaking in my nursing education and career.

Since the establishment of my nursing career the fundamental core goals that were taught and adopted into my practice are to protect the patient from harm, to provide care that prevents complication, and to maintain a healing psychological environment for patients and families. Due to the vulnerability of most patients they need protection as well as competent and timely care (Corley, 2002). Nursing is a relationship between patient and nurse where the nurse utilizes knowledge and skills to provide care and also commits to the caring of the patient as a holistic human being. Nursing is a valuable societal service and is based within the concept of human caring, and has the ability to affect how patients experience their life state (Nyberg, 1998).

Caring is the core focus of my practice and the reason as a profession we have acquired public trust and respect. It is an instinctual, natural part of our job that is unable to be taught (Hudacek, 2006). There are many nurses that have written about caring including Watson (1979, 1985) Leininger (1866), Ray (1989) and Gaut (1983). Each nurse holds their own vision on what the notion of caring is. Watson however was one of the key theorists utilized through my nursing education. Watson has published numerous works describing her philosophy and theory of human caring, which has influenced my thinking and views on nursing. I believe she has laid the groundwork on the theory of caring that I have adopted.

Bennel and Wrubel (1989) describe that caring is what makes the nurse notice when interventions help and when signs of improvement or deterioration in condition occur,

and being proficient in using technical equipment and monitoring to ensure the patient safety. Nyberg (1998) states that healthcare is frequently viewed as a business and caring can be the extra “fluff” that we can no longer afford to provide. Watson (1979) wrote that “caring is the moral ideal of nursing whereby the end is protection, enhancement and preservation of human dignity”. For me caring is not fluff. It is undeniably the need of the human soul and nursing can never give it up. It should not be assumed that nurses are actually practicing human care when they are nursing. Non-caring is not to be present with the patient, but to be there solely to get the job done (Watson, 1985). Upholding caring values in daily practice helps transcend the nurse from a state where nursing is perceived as “just a job,” to that of a gratifying profession. Upholding Watson’s caring theory not only allows the nurse to practice the art of caring, to provide compassion to ease patients’ and families’ suffering, and to promote their healing and dignity but it can also contribute to expand the nurse’s own actualization. In fact, Watson is one of the few nursing theorists who consider not only the cared-for but also the caregiver. Promoting and applying these caring values in our practice is not only essential to our own health, as nurses, but its significance is also fundamentally tributary to finding meaning in our work.

Emergency nursing is a unique role where we can make an immediate difference in people’s lives. An emergency nurse typically works with patients that have not yet diagnosed, is not yet accustomed to the institutional environment, is struggling to deal with a reality of illness or injury, and may have intoxicants or behavioral barriers to effective diagnosis or treatment (ENA, 2009). My emergency nursing experience not only incorporates the technical skills and clinical knowledge and but also the caring aspect of my patients which is one of the most meaningful features of my profession. The nature of nursing within an emergency department is often physically and technically demanding and nurses are also often faced with weighty demands to provide pity, sympathy and compassion.

The act of caring that may not necessarily advantage clinical condition is an important and memorable part of the acute patient journey, and often the basis of many letters of compliment and conversely the topic of many complaints within our ED. The inability for an ED to evaluate, treat and make a disposition for the patient within a reasonable timeframe is the most scrutinized aspect of ED care. However the small things like

the welcome smile, the cup of tea, the outward show that the nurse is not too busy or rushed to care is what the patient appreciates and is often the residual memory of their visit to the ED (Almeidia, 2004).

Everyone that enters the ED is seeking something and is scared. Whether the fear comes from the extensive trauma or symptoms that they face or the common concern that they will not receive “good” care colours every interaction. This care situation is one of emotional distress for the patient and their family. It is essential as emergency nurses we strive to create an environment of trust, respect and acceptance to express his or her anxieties or fears (Kelly, 2005). This communication and recognition of patient feelings is fundamental and essential to develop a positive caring nurse - patient relationship.

Emergency Department Overcrowding

ED overcrowding is an international and local problem, which has become a chronic state in many departments. Overcrowding has received considerable attention politically and by researchers investigating the phenomenon (Hoot & Aronsky, 2008). According to the American College for Emergency Medicine (2004), ED overcrowding occurs when the identified need for emergency services exceeds available resources of patient care in the emergency department, hospital or both. There are many factors responsible for overcrowding. Hoot and Aronsky categorized the causes in three areas; input, throughput and output factors. The main factors are as follows.

Increased waiting times for transfer to inpatient beds has become the most important cause for ED overcrowding (CAEP, 2000). A common problem within hospitals is the lack of inpatient beds and the hospital occupancy rate exceeding recommended levels. Hospitals most efficiently operate at 85% capacity. Throughout Australasia hospitals are operating at 90-95% +, and therefore this allows for nil surge capacity (ACEM, 2004). Consequently there is competition for beds between emergencies and electives, and prominently between medicine and surgery, and there is a need to effectively balance the demand from these two sources (Boaden, Gordon & Proudlove, 2002).

As the New Zealand population is growing older and as we live longer ED's experience the presentation of more chronic age related conditions and therefore an increased complexity of presenting patients (Richardson, 2004). These patients often require complex assessments and treatment during their presentation. Social changes are effecting the changes of the health system and for many people GP fees and the increase in waiting times for procedures and specialist opinions, contribute to patients choosing the ED to receive care (Richardson, 2004). CAEP (2000) states that non urgent patient presentations are a less major problem leading to ED overcrowding.

ED's are designed to deliver episodic acute care. This dictates their physical design, intended patient flow patterns and staffing structures and systems. While ED's have overcrowding, this produces many adverse effects. Medication errors and missed diagnostic tests have been shown to occur as a result of ED overcrowding. As nurses and medical staff feel rushed and overextended, the risk of error is increased, and errors could lead to adverse patient outcomes (Canadian Association of Emergency Physicians, 2000). Increased length of stay for the patient in the ED has a correlation with increased inpatient stays. Length of stay is also an important determinant of patient satisfaction in the ED, with longer stays associated with decreased satisfaction with emergency care (Gardner, Sarkar, Maseli & Gonzales, 2007).

The ACEM (2004) have concerns that there is less time for teaching and research in ED's that have overcrowding. This has occurred in our ED as doctors "protected education" has been cancelled for two months to cope with patient influx, and the ED nurse educator is frequently used as another set of hands to help clinically. Patient education may also be compromised as time and physical constraints make it difficult to deliver discharge and health education (CAEP, 2000).

Increased pain and suffering for the patient, compromised patient dignity, correlation between waiting times and patient outcomes and compromised job satisfaction, and nursing burnout are all results of ED overcrowding that will be discussed within the analysis of the narratives.

Studies within literature with relevance to this study

Kilcoyne and Dowling (2004) conducted a phenomenological study highlighting nursing issues associated with working in an overcrowded accident and emergency department. All participants described lack of space and resources within their interviews, which they considered to be a barrier to the nursing role within their department. They experienced anger, stress, fear and frustration, a lack of safety and security as the aspects that were influenced by the lack of resources. Some of these feelings are also displayed within my narratives.

A study undertaken by Hallin and Danielson (2007) concludes that most nurses experienced their profession as enriching and provided them with a sense of professional pride. The nurses appreciated their relationships with patients, their ability to act and manage the quality of care, the teamwork, the independent work and the profession's consequential challenges. However the occurrence of workplace stress and nursing burnout are negative areas that are well documented throughout nursing literature. Nursing burnout is commonly conceptualized as a multidimensional syndrome consisting of three components; emotional exhaustion, depersonalization and reduced personal accomplishment. A study conducted by Lavery and Patrick (2007) examined the causes for nursing burnout which highlighted the importance of working controllable hours and manageable workloads. Nursing is essentially a stressful job, and added workplace stress can adversely affect employee health and well-being as well as worker turnover (Letvak & Buck, 2008). A comparative study conducted by Gillespie and Melby (2003) studied the burnout of nursing staff working in accident and emergency and acute medicine. This study examines the physical and demanding nature of emergency nursing, but doesn't discuss ED overcrowding and its effect on the nursing staff. Despite the focus on job satisfaction and retention the work environment provides only limited resources for alleviating moral distress (Corely, 2002).

Gillespie and Melby (2003) conducted a comparative study examining burnout among nursing staff working in accident and emergency and acute medicine. The aim of this study was to establish factors that contribute to nursing burnout and stress, to determine the experiences of nurses affected by it and highlight the effects on patient

care. It established that stress and burnout have far reaching effects for nurses in their practice and their personal lives. It concluded that if nurses continue to work in their current environment without issues being tackled then burnout will result.

A census was conducted in 2008 by the Royal College of Nurses about their careers and their overall views regarding the state of nursing. Emergency nurses recommended their specialty to others due to the great camaraderie, the autonomy, the fast pace, and the difference emergency nurses can make to a patients life within a short time. Those within the survey who would not recommend emergency nursing cited lack of support, the feeling of being undervalued and the inability to provide the basics of nursing care. The study revealed that the greatest job pressures are departmental understaffing and unrealistic targets.

Summary

This chapter presents a background for the study that examines my own experiences of providing care while working within a demanding emergency department. I have discussed my personal interest as to why I have chosen to undertake this study and provided an overview on the key topics of the notion of caring, emergency nursing and emergency department overcrowding. I have also provided an overview of previous studies with a similar focus to demonstrate study significance.

The following chapter includes an overview of my chosen methodology, autoethnography. The rationale for choosing autoethnography, the methods of data collection and data analysis will be discussed. Ethical considerations will also be examined. The second chapter provides the reader with an understanding of the chosen methodology, and theory that underpins the study and the applicable ethical considerations in conducting this study. Within chapter three I present my experiences of providing care while working within a demanding emergency department through narratives and discuss the key themes that have emerged through this study, and the analysis of my experiences. In conclusion, chapter four provides a summary of the insights gained through this research project process and a reflection of the findings. I will conclude this chapter with the implications for emergency nurses working within busy emergency departments.

Chapter Two - Research Methodology and Method

This chapter examines the chosen methodology of autoethnography. I will give a rationale of my chosen method and the research process. I will also discuss ethical and cultural implications considered within this research.

Autoethnography

The aspiration to understand my unique world of emergency nursing needed a theoretical framework. Autoethnography uses personal experiences to explore the relationship between self and culture through a systematic investigative process of data collection, analysis and interpretation (White, 2003). I was drawn to autoethnography as it can help me see the connection between my self and culture, and it will help others understand my and my culture's experiences. This narrative based writing also allows me the author to bond with the reader by writing evocatively, engaging and passionately to enable the reader to connect with my experiences (Chang, 2008). From my position at the heart of the emergency department I can write directly from my own experience. By using the autoethnography method I focus on the use of self as a starting point for data collection and analysis, from which the broader sociocultural issues can be explored.

As an emergency nurse with ten years experience in this area I qualify as an insider of the group being studied, something which lends itself to an autoethnographic approach (White, 2003). Using this autoethnographic study I will be seen as looking to understand self in order to more fully understand others. As an autoethnographer I will be able to show rather than tell others about the experience of working within an overloaded emergency department (Foster, McAllister & O'Brien, 2006). My autoethnographic data is presented in the form of personal narratives. I will provide a report that is scholarly and valid using support from multiple sources of literature evidence. This means my account is not made up with solely my own researcher's opinion but is also supported by other data to confirm or oppose my opinions

I have selected this qualitative methodology to ensure that the already outlined research question, 'What are my experiences as a senior nurse providing care within a

overcrowded emergency department?’ is methodically answered. Autoethnographies are case studies that follow the aspects of ethnographic research. The work of anthropologists during the early 1900’s was the beginning of ethnography’s extensive history. Ethnographer’s early focus was exploring and describing the lives of the “primitive” people, keen to display what life was like from the point of view of the “native”. Many researchers traveled to remote areas of the world to work, and lived amongst their study participants. The Victorian interest of other cultures diminished and they began work on exploring the working cultures of local institutions such as hospitals and schools, and also began investigating specific areas of a situation, such as gender issues, power relationships or group structures which belonged in the researchers own cultural context. In all the above situations the researcher was an outsider seeking to understand the lifeworld of others by conducting the research (Duncan, 2004, Chang, 2008, Denzin & Lincoln, 2005).

Denzin and Lincoln (2005) described the fifth moment in the history of qualitative research where participatory and experimental writing featured more markedly. The fundamental difference between ethnography and autoethnography is that in autoethnography the researcher is not trying to become an insider in the research setting, as he or she is in fact an insider (Duncan, 2004). Even at the initial stage where an autoethnographer enters into research, they are already very familiar with the topic, compared to ethnography where the researcher begins researcher within a unfamiliar issue (Chang, 2008).

Chang (2008) discusses the concept of self and culture. The concept of self appears to vary at different time periods and in different cultures. When attempting to understand the concept of self and others social constructivism is a perspective that is useful. It is an approach that assumes that understanding the world can be subjective, and reality does not simply exist but it is constructed (Foster, McAllister & O’Brien, 2006). Social constructivism maintains that people develop their sense of what is real by having conversations with, and observing others (Polit & Beck, 2006). Through this interaction people’s perceptions and definitions of what is real is fluid and changes regularly. From this perspective the concept of self is troubled (Foster, Mc Allister & O’Brien, 2006). Chang (2008), states that it is central to think of “self” as an extension of the community rather than “self” being an independent, self sufficient

being. This is because the essence of autoethnography relies on the possibility of cultural self-analysis and the understanding of “self” being part of the cultural community being examined. Foster, McAllister and O’Brien, (2006) agree describing the existence of self as being interwoven with society, and that different selves may emerge in different relationships, and therefore “self is seen as belonging as much to the other as to oneself” (p. 45).

Essentially the concept of culture affects how a cultural study is conducted. It shapes the research questions, the sources of data, the analysis, and interpretation and of course the writing. The concept of culture is inherently group orientated, because culture results from human interactions with each other. Anthropologists have toiled with the concept of culture for decades and although the idea that culture and people are intertwined is indisputable, the question “where is culture located?” is not. This question has been divided into two groups: the first argues that culture is located outside of individuals, and the other that culture is located inside people’s minds. These two directions produce different implications for how we view the concept of culture (Chang, 2008, Denzin & Lincoln, 2005).

The idea that culture is outside of individuals considers culture as a bounded whole with which a group of people is defined and distinguished. Differences of the individual are lessened at the expense of a coherent picture for the whole, and should be observable and presentable as a public representation of a group (Chang, 2008, Duncan 2004). De Munck (cited in Chang, 2008) describes his perspective of culture being outside of an individual when a set group of people is identified with a culture, and that culture has a life on its own, dictating, regulating and controlling people to maintain similarity and consistency within the inner group. Alternatively Kaplan and Manners (cited in Chang, 2008) describe culture as being the continuing arrangement of persons in relationships or controlled by institutions. In contrast the second theory of culture locates culture in people’s minds, where people are thought of as not only bearers of culture but active instruments who create, share, or change certain cultural traits.

Chang (2008) has blended the two opposing views of culture to form the key points which I will use to define culture for the purpose of this study. She believes

individuals are cultural agents, but culture is not all about individuality. Individuals are not prisoners of culture, despite inner-group diversity a certain level of sharing, common understanding, and repeated interactions are needed to bind people together as a group. Individuals may become part of multiple social organizations and cultures concurrently, each member contributes to the cultural make up of individuals with varying degrees of influence. Emergency nursing is my culture, and by using these definitions and ideas I understand that that the culture of emergency nursing in my workplace may not be the same culture in other New Zealand or international emergency departments. The culture within my workplace has been defined by individual current and previous employees, management, physical and financial constraints and previous patient experiences. I believe this is a limitation to my study. However this research compares my experiences and current literature to investigate that my experiences within the emergency nursing are not only individual but experienced by the wider ED nursing culture. This allows my research to be more authentic for readers.

The use of self as the only data source in autoethnography has been questioned. Autoethnographies have been criticized for being too self indulgent and conceited (Holt, 2003). Holt (2003) believes that autoethnography is positioned on the boundaries of academic research because such accounts do not sit well with traditional criteria for judging qualitative research. The traditional criteria used to critique qualitative research may not be that appropriate for autoethnography and may involve rethinking of terms such as validity, reliability and objectivity (Chang, 2008, Holt, 2003).

Research Process

The data for an autoethnographic study can come from the present as well as from the past. The collection of self reflective data that has been incorporated within this study are events that have occurred during this research process. Chang (2008) describes self-reflective data as data from self analysis of whom and what you are currently. I used a journal that I kept separate from my academic writing, to capture that data. I found that situations to base my narratives were plentiful and enjoyed this writing process. Autoethnographic writing values ordinary language over scientific language,

and the use of metaphor, and irony to engage more fully with the descriptions of life (Foster, Mc Allister & O'Brien, 2006). Autoethnographic studies are normally written in the first person, but can take a variety of forms. These may include short stories, journals and poems (Bochner and Ellis, 1999). I will create texts for analysis that portray my own experiences and create understanding of the emergency nurse culture. According to White (2003) the use of narrative writing in the texts and stories produces the effect of reality. Nurses have many stories to tell and are not often given the opportunity or encouragement to do so. According to Hudacek (2006) there is a lack of practice narratives in nursing, which can be compelling credible stories that make a difference to the people nurses care for. I will illustrate many complexities and lived moments through my texts. Traditionally in autoethnographic studies bracketing of thoughts and beliefs does not occur.

Denzin and Lincoln (2005) describe the challenge of analyzing and interpreting data as “the process of analysis and interpretation as neither terminal nor mechanical. “They are always emergent, unpredictable and unfinished” (p. 479). The analysis and interpretation of data needs to be focused on the detail of what creates an autoethnography which is the intent of gaining cultural understanding. Therefore I need to consider myself as a carrier of culture connected to others in the emergency nursing society. My behaviours, thoughts and actions should be interpreted in the cultural context. Autoethnographic data analysis and its interpretation involves shifting my attention back and forth between self and others, the personal and social context (Chang, 2008)

Chang (2008) believes that despite the strategies used to analyze and interpret autoethnographic data the key point to remember is what makes autoethnography ethnographic is the objective of gaining a cultural understanding. As a senior emergency nurse I am the carrier of my culture, connected to others in my profession, and my behaviors needs to be interpreted into the social context. The data analysis and interpretation involves shifting my attention back and forth between self and culture. I have collected a substantial amount of data by compiling my practice narratives and conducting a comprehensive literature review. Now the challenge is to use these “bits” of information to transform them into a culturally meaningful

explanation. Chang (2008) explains that data is there to support and illustrate the argument not to stand independently to tell the story.

As mentioned the data for this study is the group of narratives that I have compiled. Chang (2008) suggests multiple steps to conduct the analysis and interpretation stage of a study. This includes the searching for recurring topics and themes, looking for cultural themes, identifying exceptional occurrences, analyze narrative inclusion or omission, connect the present with the past, analyze relationships between self and others, comparing yourself with other peoples cases, broadly contextualize, compare with social science, and frame with theories. She believes that her list is a helpful guide only rather than being considered as the complete tool. I have based my analysis process on this approach.

Collected data has been written as narratives and by utilizing Chang's (2008) strategies this information has been analyzed for themes. These themes have been explored within the context of social and cultural meanings. Identified themes have been discussed in relation to available literature. I have chosen to write my study by using two voices, the narrator's voice that represents the experience and the theoretical voice that conceptualizes what is presented. I will take also take the stance held by Ellis (1997) who affirms that theoretical and personal perspectives can both be presented separately or sometimes intertwined (Jones, 2002) in dialogue throughout the text.

Rigor

I established the quality of my autoethnographic work by addressing five key issues regarding the legitimacy and representation of my account. The framework for the critiquing was used in a study conducted by Duncan (2004). She used the issues related to study boundaries, instrumental utility, external validity, reliability and scholarship. Duncan (2004) outlines the importance to delineate these issues clearly due to the potential bias against the inner knowing within the research culture. Outlining the boundaries of a study is essential to defining and reporting the research. Following along with Duncan (2004) I will describe the study boundaries by using four aspects, including time, location, project type and point of view.

The instrumental utility or usefulness of this study can be shown in three ways as suggested by Eisner (1991). By effectively outlining these three points I will avoid criticism that the study was only self-serving. The term moral distress was an emerging theme and is a relatively unknown expression, and for those readers who may or may not be nurses this theme may be unfathomable or confusing. My study will provide an understanding and clarification around this subject. This study will also help the reader anticipate future possibilities and scenarios. Eisner (1991) suggests this is the second way of displaying the study's usefulness.

Though my study reports the particulars of a unique work setting it displays situations and emotions that the reader may come across in other health care settings. The third method of proving instrumental utility as this study may act as a guide, which highlights particular aspects of nursing that may otherwise go unnoticed. My autoethnographic account provided such as guide, highlighting my experiences while working within an overcrowded emergency department. As outlined previously there are a minimal amount of published studies examining this nursing issue.

Personal experiences result in autoethnographic writing that presents one reconstruction of an individual's narrative but not necessarily the only one. The task of meeting the criteria of external validity therefore does not lie in finding an emergency nurse to mirror my experience and point of view, but it does lie in the strength of the themes contained in the study findings and how they can be applied to others (Yin, 1980). The themes uncovered that I have reported provide three main ways in which the study can be externally validated.

Duncan (2004) suggests that research reliability can be met by establishing a protocol to allow the reader to follow the research procedure. This allows the reader to gain an understanding of the method and methodology that was employed in the research. The method and methodology of this study has been outlined throughout, and the research process should be obvious to the reader.

As discussed previously autoethnography has been accused of the over reliance on personal writing to evoke direct responses in readers, without providing deeper analysis and reflection. Duncan (2004) emphasizes that enduring a scholarly account

is a measure of the quality of the research. I chose narrative style writing because it provided the most appropriate means of investigating the subject. I have attempted to move beyond emotional expression by demonstrating deeper levels of reflection and analysis. I have systematically followed frameworks to analyze my narratives, to provide a scholarly representation of this research experience. The use of an academic supervisor has also provided me with guidance and mentorship whilst conducting this study.

The reader of this autoethnographic study plays a crucial part in establishing its research value. McIlveen (2008) describes some of the quality indicators including a faithful and comprehensive rendition of the author's experience. I believe that this study portrays a true reflection of my experience within a demanding emergency department. These accounts can inform readers who have never or are very unlikely to ever experience these situations. Non-nurses or people who don't work within the health system may read the narratives and their explanation and feel shocked, overwhelmed or empathetic toward our working situation. Others with similarities may find themselves also reading this study and may easily have the ability to relate it to previous experiences they have endured in the past, or likely to endure in the future. This research holds the ability to construct lessons for the reader's sphere of practice (McIlveen, 2008).

Ethical considerations

I believe that using autoethnography supports my own philosophical beliefs and values as a person and as an emergency nurse. I am a New Zealand born female with strong values and commitment to provide equality, safety, comfort, empathy, and justice to my patients and colleagues. One of my key goals as a researcher was to provide a voice and a platform for discussion for the emergency nurses who face similar experiences frequently within their own workplace. The challenge laid by autoethnography is to open ourselves to the type of self-criticism that promotes the examination of how we are all, at least on occasion (Hughes, 2008).

Although the gaining ethical consent was exempt from this study, confidentiality was considered throughout. The Privacy Act governs the concept of privacy and

confidentiality in nursing research (NZNO, 2010). My anonymity will be preserved by assigning pseudonyms at the publishing stage of this research. The identity of others within the narratives should not be recognizable in the research reports (RCN, n.d.). Disguising myself the participant and researcher adequately may be a difficult task, due to the relatively small number of emergency nurses involved in this level of education and the rich descriptive narratives used in the report. Every effort should be made to avoid breaching confidentiality (Polit & Beck, 2006). Place of work and detailed descriptions of others have been intentionally minimized to reduce disclosure. The ethical framework of research should be governed by the principles of beneficence and respect for person and justice. Beneficence is doing well for others and it requires the provision of benefits and where possible prevention and removal of harm (Wilkes, 2005). All research involves some risks but in this study the risk to the participant is minimal. Polit and Beck (2006) defines minimal risks and to be no greater than those encountered in daily life.

Other potential benefits for conducting this study include the opportunity to express and document my experiences and emotions regarding the role as a nurse in an demanding ED. Billeter-Koponen and Freden (2005) conducted a qualitative study examining stress, burnout and patient – nurse relationships. It revealed that it is important for nurses to be given the opportunity to talk to someone, to reflect their experiences and feeling and recognize that they are not alone in how they feel. This unfolds another ethical dilemma regarding my relationship with this study. Eide and Khan (2008) state the primary intent in engaging in the relationship is for qualitative research purposes, but would argue for recognition for an unsurprisingly therapeutic aspect of completing this form or research. Primarily the engagement in research is to investigate the experiences of ED nurses, and not to provide a therapeutic action for myself. However the reality is that often the relationship between the researcher and the study does have therapeutic privileges. However using self as data does bring a degree of risk (Dyson, 2007). This is described by Ellis and Bochner (2000) as vulnerability. “The vulnerability of revealing yourself, not being able to take back what you have written or having control over how readers interpret what you have written” (p.738). By revealing my experiences, thoughts and emotions through narratives I realize I am exposing myself to comment and criticisms. I have reflected this risk against my reasons for conducting this study and I believe this research will

not hold any negative impact for myself or others. I will remain as open as possible with my narratives and present my study as honestly as possible, and allow the readers their own interpretation of the reality.

Cultural Considerations

As a New Zealand (NZ) nurse displaying cultural respect and integrating the key principles of the Treaty of Waitangi into my practice underpins my daily practice. The concept of cultural safety is a substantial component of my core value of caring. Interactions incorporating recognition of the patient as an individual and showing acknowledgement and respect of difference are foundational to cultural safety. Within my narratives I have not distinguished patient ethnicity, and will be analyzing the narratives against my core values of nursing which I believe hold the key aspects of cultural safety in New Zealand.

In writing and analyzing my narratives I believe I have gained a greater understanding of my personal emergency nursing perspective. To improve cultural safety Richardson, Williams, Finlay and Farrell (2009) recommend that each nurse needs to undergo a process of self recognition to raise the individual practitioner's awareness of their own nursing perspectives that informs practice. This creates a context which cultural safety can develop. Therefore another potential benefit of this research may lead to a greater understanding of self, which will enable me to demonstrate a higher level of awareness and knowledge related to cultural safety and my commitment to utilize this in my everyday practice.

Summary

Within this chapter I have supplied an overview of the chosen methodology, reasons for its selection and outlined the research process. I have also discussed the theoretical framework, and the cultural and theoretical considerations.

The next chapter contains personal practice narratives which have been assembled together into arising themes. The overall emerging theme of these narratives, moral distress is discussed using personal experience and documented experiences of my nursing culture.

Chapter Three - Data Analysis

Caring began as an interest and an internal feeling I experienced. It grew through my educational process and knowledge learnt, into the need to assist my patients to exist, heal and grow. I experienced the satisfaction of caring relationships with my patients, and this became my philosophy and approach to life and my profession. As my knowledge expanded I applied it into my daily practice in the emergency department. I care for and about patients. That's why I nurse.

This chapter presents the analysis of my written narratives. Chang (2008) suggests searching for a cultural theme which is a declared or an implied position which appears throughout the narrative data. The study's cultural theme describes relationships among various elements of the data. The identified theme can therefore frame the final writing of the autoethnography study. The cultural theme that is identified through the data is that the notion of caring is at the route of my nursing practice and working within an overcrowded ED can compromise these values. The narratives reveal themes that overlap and impact reciprocally on each other. I discuss and analyze the narratives and experiences of how my work place affects my ability to provide satisfactory care, and simultaneously contextualize my experiences using examples from literature. I draw on Chang's (2008) ten step method of analysis and interpretation as discussed within chapter two of this project. My experiences will be further compared to the notion of caring hypothesis, as discussed in chapter one.

I swipe open the door to enter the department. Immediately I sense an atmosphere of stress, busyness and observe a feeling of discontent on the faces of my colleagues. I greet another senior colleague as I head to the staff room to drop my bag. "How's your shift been?" I ask. "Crazy!" she replies. "No inpatient beds, lots of presentations and 2 sick calls. I've had enough. No one cares about us." She was right. That's how it feels. ED will cope, they always do. How can we care for others if no one seems to care about us?

Chang (2008) recommends placing the narratives into themes or topics. I read and then re-read these stories where many themes emerged. Most of the narratives have

indicators within the text that draw me back to the notion of caring that I have explored in the background part of this study, and how this foundation of my career is threatened by outside restrictions and complications leaving me, the ED nurse feeling with a feeling an inconsistency between my beliefs and my practice as demonstrated by the first two narratives. These narratives are a comparison between my beliefs on caring compared to the reality of my workplace. I have organized the narratives into three themes, what's the harm in waiting times? too busy to care and feeling all used up.

What's the harm in waiting times?

Ok, here are the notes of the next person to be collected from the waiting room. It was definitely not a random selection. It was systematic with many factors having been considered such as acuity, waiting time, available space for disposition and availability of medical staff to see. As I enter the waiting room the patients quickly identify me as the nurse who calls people in. Many pairs of eyes watch me as I call out his name. I avoid eye contact with the man on the right, and the elderly lady on the left who have sat there for a long time, and ignore the aghh noise of frustration from the back as I call out Mr. Brown's name. It is his turn, we do have systems, this isn't a haphazard selection. "Hello Mr. Brown, sorry about the wait sir, please follow me".

I look over and see the very tired, frazzled mum sitting on the bed attempting to entertain and negotiate with her grizzly two year old girl. It was 0300 and I was exhausted regardless of my mammoth day long sleep, but I did feel extremely sorry for the mum and Sally who must be a lot more exhausted than me. Sally's mum Anna rushed her daughter in at midnight as she awoke with a loud seal like cough and difficulty breathing. I had triaged Sally on initial arrival. Sally looked well and mum had described her improvement during her journey into the hospital. It was a busy night, but I did have an empty cubicle which I placed Sally and her mum into and routinely explained the process of patient prioritization. Mum still looked anxious and worried about her daughter as I explained that my clinical examination showed nil obvious respiratory distress and that a Dr will see them when able. Although Anna had regular nursing assessments by my colleague over this three hour period I felt

apologetic for not facilitating a doctor to come examine Anna, but I knew that she was stable and I had to allocate my resources to other patients whom had potential to deteriorate, like the two patients with chest pain, and the young man with a head injury.

Hi Lynette, can you please come to reception to talk to a patient. He just won't listen to me." The poor receptionist looked a little weary. While on duty I was also responsible for this administration team who by default field the majority of patient inquiries regarding waiting times due to their physical position in the department. "Hi sir, how can I help you?" I maintained my professional demeanor as the gentleman spoke very derogatory terms about my workplace and the service my team was providing. "I should have known! Last time I was here it was the same. Do you guys not care about us?" I listened with respect and attempted to explain some of the underlying issues regarding his prolonged wait in the ED. Maybe he thought that if he vented his anger at me it would change things. Admittedly if I was in his shoes I would have the same concerns and frustration. He was sent here by his GP for a laceration which had potentially damaged a nerve and tendon. He was a builder and the lack of treatment may lead to further problems with hand function and in turn livelihood. He had been waiting for three hours for review by the orthopedic doctor on duty. I could not provide him with a definite time that the doctor could see him and urged him seriously about the risk of not staying to be seen. His anger clouded his logic and he stormed out of the department prior to examination.

The above narratives have been grouped together as I can observe my experiences deriving from a common theme of prolonged waiting times and the impact this has the provision of care. The question how long is almost certainly the most frequent question posed to me by patients and their families. Unfortunately due to the uncertainty of multiple factors within and outside of the ED that affect waiting times it is also possibly the hardest question to answer accurately. As displayed throughout the narratives I consistently attempt to communicate with patients the expectations of their acute patient journey. I consider this effective communication with patients and my nursing team an essential element of my repertoire of core values and a method I believe enables me to display my intent to provide care for my patient. My intention is to provide the patient with a feeling of trust and have confidence in my service by

gaining an understanding of the process and expectations for care of their injury or illness. However I often find myself in a situation where I am required to communicate with my patients our inability to provide the care that is required. This is mostly due to a multitude of issues that are beyond my control. This leaves me with a residual feeling of powerlessness. So therefore my attempt at using communication to create an efficient and safe acute patient journey as described now leaves me with a feeling of guilt, disappointment and sometimes embarrassment on how long the waiting times in our department can be. These feelings and emotions are also described in Dougherty's (2005) research. Emergency nurses often feel a burden as they regularly represent the whole institution for some patients. For many patients the only contact with a hospital may be a visit to the ED as a patient or support person. Patient level of satisfaction within the ED is influenced by many factors including longer ED waits, delays in discharge, departmental overcrowding and nursing shortage leading to a reduced amount nurse contact within their presentation (Dougherty, 2005). Often the patient begins their acute journey with memories of dissatisfaction from previous presentations. This is evident within my narratives. Just as Dougherty (2005) depicts how ED nurses represent more just their own service, I often feel patients unfairly believe I am accountable for many services within the hospital.

The above narratives describe my experiences and my observation of the patient's experience when lengthy waiting times occur. There are many reasons as discussed that affect waiting times, however regardless of the cause of the problem it affects my ability to care and most importantly affects the patient's ability to receive care. The patient's vulnerability and their dependency on health professionals imposes on me the ED nurse a moral obligation to take care of them. This obligation to care or compassion is a basic value of nursing care, and these descriptions of prolonged waiting times have resulted in guilt on my behalf that I was not able to provide the service that public expect and deserve. This intent to help is also held by the majority of health professionals within emergency nursing culture (Yongson, 2008). We are motivated by a desire to serve, and hold a passion to do the best for our patients and to relieve suffering. If organizations supported this core value by providing adequate resources this would further deepen the commitment of health professionals.

As I relive my experiences while reading the narratives I feel judged by our performance on the length of waits in the ED. I feel not only judged by the patients but also the Ministry of Health which is now also measuring our performance by monitoring departmental lengths of stay. This implementation of the six hour target in 2010 occurred as the Ministry of Health (2010) state that length of stay is an important measure of the quality of acute care. My narratives only include describe patient situations that breach ministry of health guidelines and recommendations. This multifaceted problem of waiting times have impacts on me (self), my culture (ED nursing) and others being the patient in these scenarios. A prolonged delay in treatment may lead to patients being in pain and suffering for longer.

With increased waiting times emergency nurses observe their patients being kept on stretchers when they should be on beds and in chairs when they should be on stretchers. The administration of pain relief and improvements in physical disposition are delayed beyond acceptable limits (CAEP, 2000). Increased waiting times and delays in diagnosis and treatment can be associated with increased morbidity and mortality in some cases. Stroke, acute cardiac ischemia and traumatic brain injury are conditions which clearly show a link between timeliness of treatment and quality of clinical outcome (Richardson, 2006). There is a proven increased mortality linked with ED overcrowding. A Perth based study found that of 3084 deaths among patients included in the study, an estimated 120 deaths (3.9 %) were exacerbated by overcrowding in the ED or inpatient setting (Spivulis, Silva, Jacobs, Frazer, & Jelinek, 2006). In New Zealand, Johnston (2008) claims that ED overcrowding results in about 400 deaths per year, which is a similar amount to the national road toll. Just like every ED nurse I am very aware of these proven statistics. Sometimes I feel like instead of protecting my patients from harm I am nursing them in an environment that statistically may in fact lead to a harmful outcome.

Although the theme of staffing levels has not been apparent through this set of narratives I believe it is an issue that needs to be discussed. Workforce issues of both ED nurses and medical staff contribute to the department overcrowding which also effects patient waiting times. Staffing an ED is always a challenge due to the fluctuating patient volumes and patient acuity. Due to the chronic nursing shortage and recruitment issues, there is a frequently a reduction of nursing personnel working

within the department. Additionally inpatient beds close due to lack of nursing staff within the hospital impacting further on the inability to transfer inpatients from the emergency department (ACEM, 2004). Pulling back and looking widely at the ED nurse culture I examined a literature review conducted by Hoot and Aronsky (2008), which revealed that the average nurse in an ED was caring for four patients simultaneously while the average physician was caring for ten. They discussed a study which showed that lowering the staffing levels of physicians and nurses predisposed patients to wait longer for care.

I have included a narrative describing a builder who left the ED due to his long wait to receive treatment. This is not an exceptional situation (Chang, 2008) so therefore it was included within this theme. I felt uncomfortable and guilty with this situation and although I wasn't impressed with the tone of language he used to express his discontentment, I felt responsible that our ED was unable to provide him with assessment and treatment within his perception of an acceptable time frame, and I also felt injured by his comment that we didn't care about him. Often patients have an unrealistic expectation of how quickly they should receive treatment but most frequently it is prolonged waiting times that lead to the patients leaving without being seen. This delay or absence in treatment may place patients at risk (ACEM, 2004). It leaves the patient unsatisfied with the quality of service and care provided, and may leave them at danger from conditions that have not been assessed or treated (Kennedy, MacBean, Brand, Sundararajan & David, 2008). Patients identify many reasons why they decide to leave prior to assessment and treatment; however the issue of waiting times clearly is a central theme. Not being able to provide any care to this patient group leaves me with a feeling of remorse that we have failed to provide a service that meets their needs. Often I hear ED nurses saying "they've gone, one less patient to see", but this is certainly not the view I have. Is my position different to the majority of ED nurses? I believe this is a breach of our endeavor to provide care, safety and a service to the community. Stepping back I searched unsuccessfully within literature for other ED nurse's experiences regarding patients leaving ED's prior to being seen. The intention to confirm my experiences were aligned with others within my ED nursing culture was unable to be displayed. I believe my narratives demonstrate examples of how I am individually left with a feeling of failing to provide quality care and empathy for patients whom leave prior to being seen and those who experience

extending waiting times within the ED. These experienced emotions blend with the next theme too busy to care.

Too busy to care

My experiences of being unable to provide the care due to the overcrowded ED are a common premise that emerges through all of the narratives within this project, and strongly shines through this collection. I experience emotional responses to nursing in an environment that is not conducive to providing quality care. Having the knowledge and skills but also the inability to provide the optimum care for my patients leaves me in a distressed state. Chang (2008) states that the analysis of narratives can be presented in multiple forms, therefore within this theme the narratives, my analysis and the comparison with ED nursing culture is written collectively within the text.

That man in the cubicle seems to be watching me work. He has been waiting for ages to get to the ward. No beds in the hospital again. It's so frustrating. I wonder what's on his mind. I bet he is thinking, "Why doesn't someone spend more time with me. I have been here for hours. Have they all forgotten about me?" But everything is just so rushed when we are busy. I'm trying so hard to get the patients through the system as fast as I can. When I first started nursing I had heaps of time to talk to my patients. That's what nursing is about isn't it? Yep he is definitely watching me. I have so much to do. I haven't got time to chat. My colleague was with him before. He looks safe. He doesn't look in pain. I can't look at him in the eyes. Off I go walking hurriedly past him to my next task.

"Can I get you a cup of tea Mrs. White?" The waiting times are really long tonight. She looks really tired. If I make her a cup of tea it will illustrate that I do care. I can't supply a doctor to see her daughter yet but I can do this for her. We do care the nurses and the doctors, "Sorry Mrs. White do you have sugar?"

I believe everyone who enters ED is seeking something and is scared. Often their fear comes from the symptoms that they face or from concerns that they will not receive care (Kelly, 2005). This can be a cause for emotional distress for patients and I clearly understand how by building relationships with patients to create an environment of

trust and open lines of communication is the most effective way to enhance nurse-patient relationships. I'm also aware strong nurse-patient relationships are therapeutic and according to Kelly (2005) are a critical foundation of quality care. However as I read this narrative I observe myself behaving contrary to my beliefs of providing quality care. I am an experienced nurse with a high level of clinical competence yet I find myself in a situation where I don't allow my patient to receive my time. Just as the patient can experience emotional distress within ED I also experience a similar sensation. My distress arises from when I am forced to act in a way that opposes personal beliefs and values. I ask myself was I really too busy to talk to him or was I displaying avoidance due to the inability to provide him the physical environment and care that literature has informed me is more effectual. I commented that he appeared safe and pain free. More than likely he was, however I somehow overlooked the holistic aspect of patient care that I supposedly hold as one of my core values that underpin my nursing practice. I was relieved but also simultaneously shocked that this coping mechanism is common within the ED nursing workforce. This frustration, anger and guilt can often actually lead to nurses avoiding patients or alternatively were over attentive to them because of the guilt about what is happening to them (Corley, 2002). This distancing and avoidance strategy I displayed in the first narrative was in complete contrast to the second narrative where I alternatively used techniques of paying special attention to a mother in attempt to alleviate her emotional distress during her ED experience. Or possibly this method was utilized to alleviate my own emotional distress in an attempt to lessen feelings of guilt that I hold due to our poor service.

Our ED trolleys are hard. I really need to find a minute to get Mrs. T onto a softer bed. Her acute patient journey has turned into a marathon, and I can see on her face that she is really uncomfortable. Ok, I have chance now to sort her out. Man, I had a chance, now it's gone. Another acute patient arrived that needs attention now. I have provided Mrs. T with a good sound assessment and instigated all the treatment that is required, but not making her feel comfortable is what she is going to remember about her stay in ED. I do want to give you more care Mrs. T. I will have a chance soon.

I do feel empathetic for that elderly gentleman on the trolley in the corridor; know he has been there for hours. He has no space, no dignity, no privacy, and no call bell. He

can tell by the hurrying, the crying children, and the staff rushing past them into a resuscitation room that we are busy. His visitors by his side are shuffled from one side of the corridor to the other, they keep apologizing to me for being in the way. I wouldn't like to visit my mum in this environment. I'm in control of this department there is nothing else I can do. I have allocated a nurse to look after him, I needed to use his cubicle for someone else, it the only way I can manage this. I know this isn't ideal, but it's not my fault.

Avoiding placing patients into corridors is often difficult within the overcrowded ED environment. We have been informed by the Ministry of Health (2008) it is not acceptable for patients to be treated and kept in ED corridors or other informal ED spaces due to overcrowding. As discussed the occurrence of ED overcrowding can lead to negative outcomes, but in addition patients nursed in corridors typically suffer discomfort, and experience a lack of privacy and dignity in the delivery of care (MOH, 2008). I regretfully observe my actions within the narrative of contradicting best practice and placing ED patients into corridors to attempt to facilitate patient flow within the department. I feel a huge sense of frustration in my inability to provide dignity and privacy for patients and clearly placing them in a situation that I know instinctively and from academic findings is not conducive to the best outcomes. Patient dignity and lack of privacy is an extreme deterrent to patients who are asked to provide confidential health information to their caregivers (Kihlgren, 2004). The reluctance for the patients to provide this information can lead to an inaccurate assessment, which in turn can have direct implications of the treatment, provided which will affect patient outcome. This occurs frequently as patients are placed into corridors and hallways with little privacy. The distress I feel when nursing patients in corridors is also experienced by ED nurses participating in Kilcoyne and Dowling's (2007) study. One nurse describes her department as being not physically designed or having the facilities to nurse patients for long periods of time, let alone in corridors. Like me she is aware of infection and health and safety issues and that are consequences of caring for patients in this manner and similarly she doesn't hold the ability to care for her patient in a way that she wishes. Another study participant articulates emotionally where she was caring for an elderly gentleman and the end stage of life. She describes how even though she believed the physical nursing care she was provided was good, the environment of an overcrowded ED compromised the

holistic care given to the patient and his family. Although a comfortable bed and a cubicle space were given the ability to provide a peaceful environment for the family to sit with him in a quiet area was not able to be afforded. She believed the noise of staff, public, alarms and children crying where her patient's last sounds. The inability for her patient's family to cry and grieve freely also troubled her. She described her feeling of helplessness that she was unable to do better in this situation, and how she perceived a failing to provide quality care and compassion for her patient and family. Collectively these anecdotes and my experiences display a failure to provide compassionate quality care. I do not stand alone in my feelings of frustration, helpless and powerlessness that leads to experiencing distress from nursing patients in corridors within emergency departments. Our emergency nurse workforce, my culture, is repeatedly required to care for patients in a manner that opposes core nursing values. It's not a good feeling to be too busy to care.

"Hi Mr. Brown I'm Lynette. I will be with you as soon as I can. Just shout if you need anything urgently" Off I go to get to the next task.

I have discussed in depth the notion of care, but according to Byrne and Heyman (1997) care is context dependant. They conducted a study which explored ED nurse's perceptions of their work. The nurses within the study saw their work as mainly concerned with providing urgent physical care. The holistic personalised care was perceived as being idealistic and nurses often felt very pressurized to complete tasks. As I compare my self with others as Chang (2008) suggests I can imagine being one of the nurses within this study that described working within a busy ED and the method of popping in and out signified to patients that they had not been forgotten. Examining my narrative I also use this strategy when looking after a weighty patient load, to ensure patient safety by conducting a quick "end of bed assessment". However, I believe this approach has negative and positive values. Although I am demonstrating that I haven't forgotten about the patient I can also see how my flurrying in and out can give the patient the perception that I was really too busy to stop and truly listen to their worries or problems. If the patient did get a chance to connect with me, I had already sent out a non verbal message that I was busy and they would probably have to wait. This is certainly not the way I wish to care for my patients but it's the necessity to maintain flow and patient turnover by completing a

task and quickly moving onto another. The study explains that overall emergency nurses utilize similar coping mechanisms to manage their workload. The nurses felt that the provision of psychological support was very important, however maintaining a smooth running department, and moving the patients through out weighed the provision of comforting and psychological care (Byrne & Heyman, 1997)

The above narratives reveal a sense of distress, as I have the inability to provide the most effective care for my patient due to many factors beyond my control and this distress is also common throughout my ED nursing culture (Kilcoyne & Dowling, 2004). This uneasiness I experience is about not practicing in a manner satisfies my moral and professional obligation of caring and protecting the patient form harm. Emergency nursing may be difficult, due to stresses caused by staff shortages, staff turnover, lack of stamina, increased business, and lack of space (Hallin and Danielson, 2007).

As I examine these two themes I once again apply Chang's (2008) strategies for analysis. The themes have an interwoven experience or cultural theme of the inability to provide quality care within the overcrowded ED which has I repetitively left me with a residual feeling of distress. However remembering to contextualize or place into context, these narratives are only written to describe clinical situations when the ED department is experiencing states of overcrowding. This experienced distress are the painful feelings and the disequilibrium that happens when I am conscious of the appropriate action required but is not able to carry it out due to boundaries. This distress is a major problem in the nursing profession that affects nurses internationally and is described as moral distress. Moral distress was firstly acknowledged in 1984 by Jameton (as cited in Corely, 2002). The inconsistency between a nurse's belief and actions, and the dissatisfaction experienced from the provision of care that is not optimum for the patient causes my profession moral distress (Zuzela, 2007). As displayed through my narratives just as patients can incur negative effects of overcrowding, emergency nurses can also experience suffering. ED nurses suffering can occur when their integrity and sense of self are threatened, and can affect a person's physical, emotional, behavioural and spiritual well-being. Emotional responses include anger, fear, guilt, resentment, anxiety, emotional outbursts and/or shutdown, cynicism and confusion (Danielson, 2007). Several but certainly not all of

these emotions were exhibited within my narratives. Moral distress can also affect individual behaviour however I see no evidence of this within my narratives. The effect of moral distress on nurse's behaviour may include, controlling, addiction, victimization of other, crying at work and taking aggression out on others. Moral distress can also lead to physical responses including but are not limited to, fatigue, exhaustion, headaches, impaired sleep, and gastrointestinal disturbances (Corely, 2002). My experiences of these emotional and physical responses to moral distress is evident within the next theme entitled, feeling all used up.

Feeling all used up.

We maintain that if nurses are liberated to give the care that they want to give and were able to use their knowledge in a fully efficacious way, while being adequately rewarded, the stresses inherent to nursing would be reduced to the manageable level imposed by the legitimate demands of caring. The stress of nursing becomes intolerable when the demands of the situation prevent the nurse from performing with a maximum level of skill and compassion. (Brenner & Wrubel, 1986)

I had been home for an hour but still I lay awake thinking over the events of the busy afternoon shift. I had managed the department well with the resources I had available. I doze on and off and wake up to the alarm feeling exhausted. That was such a broken sleep. So many work related dreams running through my mind. I think about my sleepless night and remember dreaming about my best school friend as the patient. She had an accident, can't remember what. She was so sore! Her leg was broken, and her arm. There was no more morphine in the department, but no fear we drove to McDonalds to get some. She was so sore and had to wait. Thankfully my dreams don't come true, but maybe there was some truth in it?

"I'm sorry Lynette but we don't have any beds for those patients". You are kidding me! I know it's not the duty manager's fault but that is a huge issue. We are having more than usual presentations to the department today and the inability to admit will be crippling. There are so many factors involved in hospital overload and I realize that the wards are also busy, but good old ED will once again have to absorb it and carry on. The congestion and "lack of efficiency" has filtered all the way down to

our department and directly affected our patient population. I get it, I know the problems, but it will be good old me who has to explain it to the patients in the waiting room. Good old ED, and good old me!

Through another shift, wow! There were multiple occasions of overload. I was really diligent and completed all the necessary overload reports. Not quite sure why I do them though. Nothing seems to improve. I wonder if the person that matters reads them. Actually who is that person? It always seems to be someone else that is responsible for these problems within our hospital. But it is definitely me who has to work in this environment.

I can see within my narratives the emotions of powerlessness and frustration with the organization which leaves me experiencing moral distress, feeling stressed and concerned about safety of the patients and staff within the department. When reading them I relive the experience of stress in occurrence including the uneasiness and sometimes even physical symptoms such as palpitations. Even sleepless nights are a regular event as displayed within the narrative. Sleeping is often difficult as I relive and analyze the care we provided the community throughout the shift. This strong association between moral distress, stress in the workplace, and burnout has been well documented as a substantial issue within my ED nursing culture (Patrick, 2007).

Within my narrative regarding the duty manager's inability to provide me with inpatient beds for admissions, I can observe a sense of frustration and not being supported to resolve the problem of ED overcrowding. Remembering this lack of support to assist with this chronic problem affects every faction within an autoethnography study. Me (self), emergency nurses (culture) and the patient and families (others). I displayed powerlessness, feelings of frustration, and anger being valued. These emotions lead to moral distress and also the experience of stress. I understand the solution to the overcrowding issue isn't easily solved, however in situations like this it feels like ED in absorbing the organization's downfalls and extra responsibility to care for boarded patients belongs to the ED nurse. Unfortunately many emergency nurses feel powerless in their role working within this busy work environment which they feel has become the accepted norm within their profession (Kilcoyne & Dowling's, 2004). A nurse that was interviewed described always

dealing with the same problems, with no solutions. She chose not to continue working within an environment that was unhealthy for staff and patients alike (Kilcoyne and Dowling's, 2004). This is an important issue for my ED nursing culture. If this issue isn't addressed nurses will become tired and the recurring environment of an overcrowded ED, and the frequent experience of moral distress may lead to burn out and resignation, and even nurses leaving the profession completely. The international workforce shortage is a major problem that unfortunately cultivates situations that create further moral distress for nurses (Corley, 2002). As emergency nurses experience the current and further anticipated workforce shortfall and the significant relationship between staffing matters and patient outcomes issues relating to the quality of the nurses workplace environment is increasingly of interest (Stone, Yunling & Gershon, 2007).

I am concerned with the increasing feelings of stress and fatigue that occur as I experience the increase in sheer nursing workload related to the multi faceted problem of ED overcrowding. Many interviewed ED nurses also describe similar situation and comment on how their workload as ridiculous, impossible and makes them want to leave nursing (Reineck & Fruino, 2005). Recurrent nursing shortages have resulted in numerous studies of the factors influencing nurse retention and intent to stay within the nursing profession, including a study by Buck and Letvak (2008). Nurse retention is directly associated with job satisfaction and workplace variables. The effect of job stress on the nurse is under appreciated, and little research has been conducted on the effects of workplace stress on nurse turnover. The profession of emergency nursing has evolved over the last 30 years and nurses have become more responsible and accountable for their practice. This specialty is considered one of the most challenging fields in healthcare today (Almeida, 2004).

Chang's (2008) method for analysis has enabled three main themes to be revealed which I have named, what's the harm in waiting, too busy to care, and all used up. However, the main cultural theme that remains apparent is how an overcrowded ED impacts on my concept of care that underpins my professional and personal life. I believe that none of the included narratives are exceptional for my workplace or exceptional in the wider emergency service. This is evident through the statistics displaying the national and international problem of overcrowding as discussed in

chapter one. As mentioned all the narratives included within this study have occurred during periods of ED overcrowding. The problem of overcrowding is certainly not a new issue but as revealed in chapter one this is having an increasing impact on my practice which was a reason for undertaking this research. Literature has been used to compare my experiences with my culture of ED nurses, which reveals I am not alone. Within the narratives I have written my perspective of how patients view their experience of being cared for in an overcrowded ED experience, which is again compared against literature. My documented narratives have repeatedly revealed feelings of distress within my workplace which aligns with the theory of moral distress. Within the next and final chapter of my study I begin my reflections on the benefits gained by undertaking this autoethnography study. Findings from the research are summarized and implications for ED nurses working within an overcrowded ED, the nursing profession and the organization are discussed.

Chapter four

Conclusions and Recommendations

Reflections

Within this chapter I will reflect upon the research process and findings of this research. I provide some insights that I have gained through completing this research process of autoethnography. I will conclude with recommendations on how to deal with the nursing issues revealed and implications for my ED nursing culture, the wider nursing profession and for hospital organizations.

The motive for conducting this research was to explore and understand my experiences of providing care while working within an overcrowded ED. The foundation of this research is based around the research question, what are my experiences as a senior nurse providing care within an overcrowded emergency department? I have utilized the concepts of the methodology autoethnography to complete this process. Autoethnography allowed me to use my personal experience as primary data and give it a voice (Ellis & Bochner, 2000), so therefore this became the ideal methodology to explore my experiences. Through autoethnography I have gained insights through the process of writing and analyzing my stories. By writing practice narratives and examining my self through a different point of view leads to viewing self from a different point of view (Chang, 2008). I have developed new insights into my practice through analysis of my text. I have revealed through my narrative writing the impact that ED overcrowding has on my ability to care for patients within my department.

The main theme that emerged through my writing was the notion of caring is at the route of my nursing practice and working within an overcrowded ED can compromise these values, and this is evident through all of my narratives. I believe caring is the core characteristic in nursing. In the ED lifesaving procedures of course take priority, but through my narratives I focus on the basic needs and comforts that meet the patient's physical and psychological needs. Dealing with obstacles caused by overcrowding inhibit the provision of good patient care, which results in a decrease of staff satisfaction as they become to busy to provide the care they know the patient

deserves (Curtis & Wiseman, 2007). The narratives which are positioned into three themes all have many similarities and are portraying comparable situations.

The first theme that revealed through my narrative writing was entitled 'what's the harm in waiting.' Within chapter one I have discussed the negative effects on patient outcomes, however within this theme I observed the personal emotional effects, and diverse coping mechanisms in dealing with this issue. The majority of the time I am ineffectual in facilitating shorter waiting times for my ED patients and this leaves me with a feeling of powerlessness in my practice. I reflect upon my attempt to use communication to inform and empower that patient and also myself. However this intention as revealed within the narrative has a differing effect of powerlessness and distress. However, I believe that communication remains an important skill within my workplace.

The second theme entitled 'too busy to care' looks at the physical constraints in attempt in providing care in an overcrowded ED. As I read my narratives I was stunned to witness my own personal behaviour of patient avoidance as a coping mechanism. This behaviour left me with a feeling of distress and somewhat failure in not fulfilling my moral obligation to provide physical and psychological care. Revealing that I along with other emergency nurses find the provision of basic care difficult or sometimes impossible is a frightening finding from this study. The physical effects for the patient and the psychological impacts on the ED nurse as evident through my analysis.

The frequent occurrence of feeling distressed within my workplace led me to the third theme 'all used up.' It revealed through my narratives that stress and burnout is appearing within me. Reflecting upon this it does concern me that I am heading down the path of many other documented emergency nurses of burnout which statistically leads to resignation or even exiting the nursing workforce. I was unaware that the distress I hold due to my workplace practice could possibly eventuate in this way.

Within all of the themes the message of how ED overcrowding is disabling my ability provide good patient care which leads to an inconsistency between my beliefs and actions. As I read literature I learnt that this phenomenon is experienced by nurses

worldwide and is called moral distress. This revelation that the emotions I experience have been intensely studied empowers me as this is not my own personal downfall but an issue that affects my nursing culture. Concurrently this concerns me that my culture is faced with similar emotions which have negative effects on our individual nurses and our workforce.

Autoethnography is an excellent vehicle to understand self and culture (Chang, 2008). I compared my experiences in narrative formation against published literature examining the issues that face ED nurses. I gained strength to uncover similar feelings of powerlessness and distress within my nursing culture. Like me many other emergency nurses care is impacted by issues due to ED overcrowding. Autoethnography also gave me the opportunity to reflect on the patient's perspective (others) that should be the foremost consideration for all nurses.

Through this process I have learnt a lot about my nursing practice, and how easily my ideals and values have been infringed upon by issues that impact my care, my position of a nurse. This does worry me that my professional and emotional self is affected by ED overcrowding. I believe that I am fortunate to have a strong robust personality that takes a considerable issue to dampen my spirit for nursing and the continuation to strive to provide the care that I know is most conducive to positive patient outcomes. Commencing this project I believed that the issues facing nursing within an overcrowded ED were all external to me (self) and my ED nursing culture. However as I examine and reexamined the narratives, analysis and literature I speculate as I as an individual and part of the emergency nurse culture too focused on the busyness of our jobs and the impact of ED overcrowding instead of focusing on the strengths of the nursing team. Possibly it is the nursing culture I am practicing within that is discouraging people to enter the emergency nursing profession. Perhaps the highly studied phenomenon of ED overcrowding tainting our position on how we view our workplaces and the care we provide. Additionally as I alluded to within a narrative which patients sometimes enter our department with fears of not receiving satisfactory care. Possibly the publications and media are provide further elements of distress for our patients. Bally (2007) state trends in today's acute care hospital settings such as low morale, a general apathy regarding professional collegial support, heavier workloads, reduced resources, and higher patient acuity can contribute to job

dissatisfaction, poor work performance, and may be putting positive patient health outcomes at risk. Shira (2004) also recognizes that many nurses feel powerless but by bemoaning our lack of power it is not likely to result in either change or improved professional status. There is concern regarding the negative impressions on students and those contemplating nursing as a career. In our current environment it is common to hear colleagues talking about the difficulties we face as emergency nurses, and the reluctance we have regarding encouraging others to join our workforce. The aim of this study was to highlight the issues for emergency nurses to provide a high standard of care in an overcrowded emergency department, not to discourage others to become emergency nurses. I believe emergency nurses are everyday heroes that affect lives on a daily basis, and I thoroughly enjoy my profession. The ability to recognize and communicate the excitement and the future of nursing is an essential step in developing a perspective of and using power in nursing. Expressing and believing in the positive aspects of nursing is not a denial of issues or concerns that require change, but is a professional perspective that the practice of nursing is important and worthy of influence within the health care system (Schira, 2004). I truly love my role nursing within the emergency department. I enjoy seeing the difference we make to patients, the camaraderie with colleagues, and the autonomy to make important decisions regarding patient care and departmental function, and variety of presenting complaints makes it a dynamic environment to work within. There are many educational opportunities within our department and with outside agencies to maintain evidence based practice knowledge that can improve patient care. However if workplace issues such as overcrowding continues our workforce will suffer and diminish leading to a further reduction in the provision of nursing care.

Implications for the emergency nurse workforce and the wider nursing profession

As identified nursing within an overcrowded emergency department often leads to circumstances where our moral obligation to provide optimum nursing care is difficult or even impossible which leaves the nurse with feelings of moral distress. I was able to conduct this auto ethnographical study as I am an individual I belong within with culture of ED nurses. As mentioned this study has left me with mixed feeling of disappointment and relief as I read the narratives and the analysis which has used

published research to confirm that these experiences are real for a lot of emergency nurses. Although coping mechanisms and methods of approaching these problems within the workplace were not explored within this research there are a large amount of studies examining methods to deal with the experience of moral distress within our nursing workforce. Increasing awareness through the ED nursing culture of the occurrence of moral distress will give ED nurses strength with the knowledge they do not stand alone with this issue.

I believe clinical supervision would benefit emergency nurses facing this issue in their workplace, and as a result of this study I will recommend a programme to be commenced within my workplace. Clinical supervision is a way of using reflective practice and shared experiences as part of continuing professional development (Corley, 2002). It has been demonstrated that clinical supervision sessions enabled nurses to share feelings about work scenarios and improve their moral decision making. They also reported an increase in self assurance and the ability to support patients and staff, and to take responsibility for decisions made within their practice. I was unable to locate evidence that directly examined the benefit of clinical supervision in emergency nurses, so therefore highlights an area for further potential research.

Although it is obvious that ED overcrowding is harmful for patients and nursing staff alike, emergency nurses adapt to their environment and develop methods to cope with the workload issues associated with overcrowding. It is important as a profession to remember that states of ED overcrowding is unacceptable, and to persevere with reporting these situations. Although within my narrative I describe the opinion that my reports were not actioned or listened to it is imperative that this formal process continues within our workplace.

Though this study directly examines the experiences of emergency nursing working within an overcrowded ED this study still has potential benefits for the wider nursing profession. As mentioned within chapter one I believe it is very important to protect and retain our workforce within the emergency nursing profession. By undertaking this study it allows me to share my experiences of providing care within a demanding

ED that emergency nursing colleagues may find relation with, and connect one nurse's experience with others in the ED nursing workforce.

Implications for hospital organizations

The purpose of this study was not to fix the existing problems of ED overcrowding. This would become a very celebrated research study if the worldwide dilemma was resolved. The obvious recommendation for hospital organizations would be to fix or minimize the issue of overcrowding within ED's. As mentioned ED length of stays are being examined by the MOH, with an aim to improve the effectiveness, efficiency and quality of acute services (MOH, 2009). As hospitals put in place strategies to reduce this problem this theoretically will improve ED overcrowding and therefore reduce the impacts restricting ED nurses to provide appropriate care for patients.

If the delivery of patient focused quality care within the ED is to be achieved it is imperative that nurses are listened to, their expertise acknowledged and they become involved in decision making processes regarding the acute patient journey. According to Perry (2008) employees who understand the sources of career satisfaction and conversely dissatisfaction can take deliberate steps to help nurses achieve it should retain staff easier. In an effort to create health care environments that retain qualified nurses the importance of professional satisfaction must be recognized.

Conclusion

Through the careful examination of the narratives I have established three emerging themes, 'are waiting times harmful,' 'too busy to care' and 'feeling all used up,' which all have many common overlapping characteristics. The overall theme as previously discussed is my notion of caring being compromised by external influences leading to the phenomenon moral distress. Through a literature search many forms of evidence were found to support these themes displaying the connection between self, me the ED nurse and the ED nursing culture, therefore this is a real contemporary issue facing our emergency nurse workforce. Writing and sharing my personal experiences using narratives and analysis have provided me with strength that I am not alone in this issue, and optimistically this will also educate and

empower the reader, whom may also face similar issues within their workplace. The issues and difficulties associated with overcrowding in the ED are complex and multifaceted, and it is important that ED nurses at constant risk of moral and emotional distress are not forgotten in strategic attempts to manage and improve this issue. These issues absolutely necessitate further examination and require addressing to improve the job fulfillment of ED nurses which will in turn improve patient care and satisfaction.

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