UNDERSTANDING EMERGENCY NURSES' EXPERIENCES OF MORAL DISTRESS

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By

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Declaration

I declare that this work is my own and has not been previously admitted for a degree at this or any other University.

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Abstract

This study sought to understand emergency nurses' experiences of moral distress. Classical Grounded Theory based on the works of Glaser & Strauss and Glaser informed the study design. Participants included Staff Nurses, Clinical Nurse Managers and Advanced Nurse Practitioners who were working in three Emergency Departments (EDs) in the Republic of Ireland at the time of the study. Unstructured conversational interviews were conducted with 36 nurses across the three sites. Twelve semi-structured observations lasting an average of 45 minutes were conducted to provide additional context for the interview findings. The substantive theory of *Adaptive Competence* emerged from the findings to explain how emergency nurses cope with their main concern of balancing the competing demands of overcrowding and maintaining patient flow to maintain standards of care. The study findings showed that emergency nurses engage in a sliding scale of practice ranging from *temporary solutioning* to *compromising caring* to *rationing care* in response to the competing demands placed upon them by heavy workloads and poor work environments. Temporary solutioning involved nurses going up a gear and stretching capabilities which helped reaffirm their moral integrity and resulted in moral resilience and a sense of role fulfilment. When nurses were unable to find temporary solutions or their efforts were constrained by institutional factors, they engaged in compromising caring which involves stepping back care and reduced surveillance of patients. Nurses used covering as an attempt to maintain minimal levels of surveillance. When nurses face overwhelming workloads due to overcrowding they used rationing care to prioritise the sickest patients. This resulted in reduced dignity and privacy for patients and nurses having to front for the system and apologise for the poor standards of care delivered. Compromising caring and rationing care are the most important causes of moral distress in this study and reflect the failure of participants to deliver basic levels of care in line with established professional standards. This perceived failure by nurses of their professional role damaged moral integrity and in some cases caused burnout among participants.

Chapter 1 Introduction and Background to the study

1.1 Introduction

Emergency care in Ireland is in a state of crisis at present (The Irish Times, 2006; Hughes, 2015). This crisis is predominantly due to patient overcrowding (Hoot & Aronsky, 2008; Pines, *et al.*, 2011) and is exacerbated by reductions in staffing levels (HSE, 2013). This chapter discusses the issues impacting on emergency care provision in Ireland and internationally. The different models of emergency care delivery which have been introduced to address these issues are examined. The chapter also explains how a typical Emergency Department (ED) operates, setting the context for the study.

1.2 Emergency Departments

Emergency Departments provide an important service to the general public by treating a range of acute illnesses and injury including major and minor trauma, minor illnesses and acute medical, surgical and paediatric emergencies. *Emergency Care* refers to emergency medical attention given to an individual who needs it. It includes those medical services required for the immediate diagnosis and treatment of medical conditions which, if not immediately diagnosed and treated, could lead to serious physical or mental disability or death. In the pre-hospital setting emergency care is provided by paramedics and pre-hospital specialist doctors. In the hospital setting emergency care is provided by doctors who practice emergency medicine and nurses who practice emergency nursing. *Emergency medicine* has been described as a medical speciality, a field of practice based on the knowledge and skills required for the prevention, diagnosis and management of acute and urgent aspects of illness and injury affecting patients of all age groups with a full spectrum of undifferentiated physical and behavioural disorders. It further encompasses the development of pre-hospital and in-hospital emergency medical systems and the skills necessary for this development (International Federation for Emergency Medicine, 2015). *Emergency Nursing* has been defined as the care of individuals of all ages with perceived or actual physical or emotional alterations of health that are

undiagnosed or that require further interventions (Newberry, 1998). Emergency Nursing requires a combination of generalised and specialised assessment, intervention and management skills and includes processes unique to this field of nursing including triage and emergency preparedness. Emergency Nursing roles include patient care, research, management, education, consultation and advocacy (Newberry, 1998; Patrick, 2009).

Previously called Accident and Emergency Departments, this title has now been shortened to Emergency Departments as it better describes the acute treatment of a wide variety of patient populations with undifferentiated medical problems. It is estimated that 25% of the population will attend an Emergency Department each year which amounts to 1.2 million attendances in Ireland annually (Health Service Executive, 2007) or 3,000 attendances nationally daily. Emergency Departments provide this service continuously 24 hours a day, 365 days a year. Emergency Departments are staffed by specialist doctors in Emergency Medicine, Emergency Nurses and a variety of paramedical and support staff. The provision of this service to the public has been estimated to cost the government €196 million in direct costs[1] and contributes to an estimated total cost of €1.696 billion in total costs for the initial treatment of patients in hospitals (Comptroller and Auditor General Report, 2010). The most recent figures available show a total reduction of health spending in 2013 to €1.295 billion (Comptroller and Auditor General Appropriation Account, 2013). The reduction in the cost of providing initial treatment of patients in hospitals was not been estimated in 2013 but in the context of these figures was presumably reduced significantly.

1.3 Structure of Emergency Departments

Emergency Departments were historically situated on a single site and co-located with a single acute general hospital. These Emergency Departments developed according to increasing patient demand for unscheduled care and

[1] Direct costs arise from the provision of the service and include staffing, utility and equipment costs. Indirect costs include items such as service development, capital investment and staff education and training.

initially consisted of informal casual attendance clinics, giving rise to the name 'Casualty Department'. These Casualty Departments have evolved into modern Emergency Departments in response to increasing numbers of patients accessing ever more complex acute hospital services.

A modern Emergency Department is situated on the campus of a large acute hospital with a variety of medical specialities provided on site. Emergency Departments accept walk-in or ambulatory patients, referrals from General Practitioner (GP) doctors in the community and ambulance transfers of acute emergencies and trauma cases. Emergency Departments aim to treat and either discharge home or admit patients to a ward in a timely manner. A full range of support services compliments the Emergency Department, providing diagnostic imaging (X-ray and scans), laboratory testing, operating theatres, intensive care and cardiac care units and wards for patient care and observation. The Emergency Department is structured into different areas to facilitate the streaming or moving of patients into different treatment areas according to the severity of their injury or illness. This process of streaming or moving of patients begins as soon as a patient walks in the door of the department. Patients are registered by an administrator who records demographic information such as name address, age and next of kin details. Then the patient is assessed by a specially trained nurse or doctor in the triage area. Triage is a system which refers to the systematic rapid assessment of patients and assignment of a clinical priority category according to the acuity or severity of their problem (Mackway Jones, *et al.*, 2014). In other words, the sickest patients are treated first while less sick patients are made to wait in turn for their care until more acute patients are finished treatment.

After triage, patients are assigned to a treatment area which best suits their treatment needs. Patients may be assigned to the Resuscitation Room, Major Treatment area, Minor Treatment or Ambulatory Care areas. Some patients may be directed to specialist treatment in a clinic in the main hospital or even to a different hospital or health care facility such as a Local Injury Unit (LIU) as appropriate. The Resuscitation Room, Majors and Minors

treatment areas are all specially designed and equipped to deal with the severity of patients seen in that area. For example, the Resuscitation Room contains complex monitoring and critical care equipment whereas the Minor Injury area is equipped with dressings, slings, braces and plaster cast equipment. The Nurse-patient ratio is much lower in the Resuscitation Room with one nurse for every one or two patients when compared to the ratios in the Majors and Minors areas where one nurse may be looking after 4, 6 or even 10 patients.

Emergency Departments typically have a separate entrance for ambulance arrivals which is situated close to the Resuscitation Room facilitating the rapid transfer of the most critical patients to this area for treatment. The Majors area usually has a doctor or nurse work station nearby to facilitate the observation of patients. A separate waiting area is provided at the entrance where patients wait for assessment in triage after arrival or where patients wait for results from tests and for further treatment.

In recent years, there has been a move away from single Emergency Departments working in isolation within a single hospital towards a system of Emergency Care Networks that consist of a number of hospitals and Emergency Departments working together to provide a seamless system of care covering a wider geographical area. These networks aim to consolidate services and pool resources to improve access and outcomes of care (Emergency Medicine Programme, 2011).

1.4 Organisation of emergency care

Emergency care has evolved internationally into two main models of organisation- the Anglo-American model and the Franco-German model (Smith, *in press*). In the Anglo-American model patients are transferred to hospital in the case of an emergency and are treated in an Emergency Department by specially trained emergency physicians and nurses. Emergency medicine and nursing are recognised as separate specialities (Smith, *in press)* from internal medicine and medical/surgical nursing in this system. In the Franco-German model of emergency care, specialist

emergency doctors provide care in the pre-hospital setting only and hospitals do not have a distinct Emergency Department or emergency trained physicians and nurses. Instead, in the Franco-German model, patients are transported from the pre-hospital setting after initial treatment directly to a hospital unit for further treatment by a specialist team (Smith, *in press).* In Ireland, emergency care has historically been organised according to the Anglo-American model of care.

In Ireland, health service planning has traditionally been reactive rather than proactive to demographic changes and service requirements, which has resulted in poorly planned services (Cusack, 2009). This historical lack of strategic planning of resources when coupled with increasing demands has led to a fragmented and disjointed emergency medicine service in Ireland (Cusack, 2009). Indeed, the provision of emergency services in Ireland and in the United Kingdom has been described in recent times as being in a state of 'crisis' (Emergency Medicine Programme, 2011). In response to prolonged waiting times and the problem of patient overcrowding in Emergency Departments, strategies to re-organise emergency care provision have been devised. In Ireland, the main strategy for improving emergency care is based on the Emergency Medicine Programme (2011). This programme seeks to organise emergency services into networks of hospitals affiliated to third level Colleges and Universities to improve training, staffing, access and care provision across the continuum of emergency services in Ireland. These Emergency Care Networks will form a national emergency care system under the direction of a steering group and will be facilitated through the organisation of all acute hospital services into networks of care. It is anticipated that emergency care networks will follow closely the templates and plans for reconfiguration of acute hospital services into hospital networks (Cusack, 2009). The introduction of networks of emergency care is based on research evidence and represents international best practice in the organisation of emergency care (Institute of Medicine, 2006; Comhairle na nOspideal, 2002). These networks have been shown to improve patient outcomes by centralising certain services such as trauma care (Mackenzie, *et al.,* 2006) and to deliver efficiencies in terms of

reducing the of duplication of services, the pooling of medical talent to develop centres of excellence and the facilitation of staff training (Comhairle na nOspideal, 2002; Institute of Medicine, 2006; Cusack, 2009; Emergency Medicine Programme, 2011).

The reorganisation of services into emergency care networks presents a significant challenge for healthcare managers and politicians alike because it is taking place against a backdrop of some of the worst patient overcrowding ever witnessed in Emergency Departments (Hughes, 2015).

1.5 Challenges in emergency care provision

Emergency Departments in many countries, particularly in the Western World have reported year on year increases in the number of patient attendances and complexity of cases attending Emergency Departments (Aiken, *et al.*, 2001; Sigma Theta Tau, 2001; Blunt, *et al*., 2015; Health Service Executive, 2015). Hospital closures, reconfiguration of services and fewer Emergency Departments have coincided with an international shortage of nurses (American Nurses Association, 1992; Aiken, *et al.*, 2001), particularly in specialist areas such as Emergency Department nursing. In Ireland, the increase in patient numbers attending Emergency Departments has coincided with dramatic cuts to the available infrastructure (Dunn, *et al.*, 2005; Nolan, *et al*., 2014; Health Service Executive, 2014).

1.5.1 Increased demand for emergency services

Nurses' work environments are characterised internationally by increasing consumer demand (American Nurses Association, 1992; American Association of Critical Care Nurses, 2005), cost containment measures and rationalisation and reorganisation of services (Dunn, *et al.*, 2005). Bed occupancy levels in acute hospitals in Western countries range from 82%-85% and frequently reach or even exceed 100% in Ireland (Deloitte&Touche, 2001; HSE, 2015). Hospitals have experienced dramatic reductions in the number of in-patient days spent by individual patients (Sigma Theta Tau, 2001) resulting in faster turnaround times. However, concurrent with this increased efficiency in patient length of stay, there has

been an increase in the acuity of patients presenting to Emergency Departments (Sigma Theta Tau, 2001; Nolan, *et al.*, 2014). The increases in case complexity and patient numbers have had a knock on negative effect on nursing workload and job satisfaction (Aiken, *et al.*, 2001; 2008; Sigma Theta Tau, 2001).

This increased demand in acute hospital services has been mirrored in Emergency Departments where attendance rates have increased by 23% from 89 million visits per year in 1992 to 110 million visits per year in 2002 in the United States (Pitts, *et al*., 2012). The rate of growth in ED presentations in the US is currently 60% greater than population growth (Pitts, *et al*., 2012). Similarly, emergency department waiting times and overcrowding have worsened in recent years in the United Kingdom due to increased demand and reduced resources (Blunt, et al., 2015). In Ireland, Emergency Department attendances have shown a similar trend in recent years with attendances increasing by 28% in the period 1994 to 2004 (Department of Health, 1994; 2004) during a concurrent rise in population of 14% in the same period (Central Statistics Office, 2007). Even though there were increased demands on services and staff reductions in recent times, the Irish public health system is providing more care to an ageing population with more chronic diseases requiring more care (Nolan, *et al.*, 2014).

In addition to increased patient attendance rates at Emergency Departments, there have been a series of financial cutbacks in healthcare funding in Ireland in recent years. These cutbacks in healthcare expenditure have been in response to the fiscal crisis that the Irish government faced following the collapse of the banking sector in 2008. The financial crisis led to a series of financial adjustments in healthcare spending that resulted in a drop in funding from 15.4 billion in 2008 to 13.6 billion in 2013 (Nolan, *et al.*, 2014). Such a dramatic drop in overall health expenditure is unparalleled in Ireland in recent times. These cutbacks in health expenditure led to a 10% reduction in staff levels with the loss of 11,000 posts since 2007 (Health Service Executive, 2013).

1.5.2 Nursing shortages

The increased demand for healthcare services has been exacerbated by an international nursing shortage and has resulted in what is now being described as a global crisis in nursing (American Nurses Association, 1992; Sigma Theta Tau, 2001). In particular, the nursing shortage has impacted severely on the availability of specialist nurses (Sigma Theta Tau, 2001) in areas such as emergency care. The shortage of nurses in Emergency Departments has resulted in attempts to quantify Emergency Department workloads (Ray, *et al*., 2003; Emergency Medicine Programme, 2011; Recio-Saucedo, et al., 2015) and publish minimum safe staffing levels (Ray, *et al*., 2003; Drennan, *et al*., 2014) in several countries. In Ireland, the analysis of ED workload has also informed a broader workforce planning strategy for the health services (HSE, 2009; HSE, 2014).

The present and evolving international nursing shortage has been recognised as being unparalleled (American Association of Colleges of Nursing, 2001) and more acute than previous shortages (Kimball, 2004), with a truly global impact on healthcare delivery (Sigma Theta Tau, 2001). The current nursing shortage has been worsened in many countries by an ageing nursing workforce, an ageing population with increasing healthcare needs and increased financial pressures to reduce the cost of healthcare delivery (Kimball, 2004; Aiken, *et al.*, 2014). The problem is not just one of a shortage of nurses *per se*, as even when there are adequate trained nurses; shortages may exist because nurses are unwilling to work in the current healthcare environment (Buchan & Aiken, 2008). In Ireland, the number of staff working in the public health system has been reduced by 10% of total numbers from 2007 to 2013 (HSE, 2013). The reduction of staff numbers in the Irish health service due to financial cutbacks in the last ten years has added to the nursing shortage in Ireland and resulted in recent initiatives to recruit nurses from other countries in an effort to maintain services.

The relationships between nursing shortages, job dissatisfaction and poor quality healthcare have been examined in detail in a series of international papers by Linda Aiken and colleagues over a number of years (Aiken, *et al.*,

2001; Aiken, *et al.*, 2001a; Aiken, *et al.*, 2002, Aiken, *et al.*, 2008; Aiken, *et al.*, 2014). In the first of these studies, over 43,000 nurses in 700 hospitals in North America and Europe reported workforce problems, poor nurse morale and job dissatisfaction. In addition, 30-40% of nurses in the countries surveyed reported higher than expected burnout scores on the Maslach Burnout Inventory (Maslach & Jackson, 1986). More than 30% of nurses in England and Scotland and more than 20% of nurses surveyed in the USA intended leaving their jobs within a year. In the context of increasing patient acuity, only 30-40% of nurses in Aiken's study reported adequate staffing levels to deliver safe levels of care (Aiken, *et al.*, 2001). In her most recent study, Aiken and colleagues have established a clear link between nurse education levels, nurse staffing levels and patient mortality rates across 300 hospitals in nine European countries (Aiken, *et al.*, 2014). Furthermore, nurses report more job satisfaction and fewer concerns about quality of care in hospitals with better care environments and better staff to patient ratios (Aiken, *et al.*, 2014).

The increased demand for services and limited supply of nurses is mirrored in many countries (Jayaprakash, et al., 2009) and has been described as a global problem in the provision of emergency care (Pines, et al., 2011). This has led to patient safety concerns and recognition that the problem is now global in nature and new approaches to addressing the shortage of nurses are needed if patient health and safety are not to be compromised (Joint Commission, 2001). The shortage of nurses has been most keenly felt in speciality areas (Jayaprakash, *et al.*, 2009) such as Emergency Department nursing (Robinson, *et al.*, 2004) and is one of the most critical issues facing these departments (Sawatzky & Enns, 2012). Nurse vacancy rates in the USA are currently 7.2% with Emergency Nursing having one of the highest speciality nurse turnover rates of 21.7% compared to the average of 16.4%, and one of the highest recruitment difficulty indices[2] at 95 days compared to an average recruitment difficulty index of 85 days (Nursing Solutions, 2015).

[2] The recruitment difficulty index is based on the number of days taken to recruit an experienced nurse with 10 or more years experience to fill a vacant position.

The shortage of nurses in Emergency Departments is a contributor to patient overcrowding (Jayaprakash, *et al.*, 2009) which results in poor patient outcomes such as increased morbidity and mortality levels (Richardson, 2006; Spirivulis, *et al.*, 2006; Carter, *et al*., 2014; George & Evridiki, 2015).

In addition to the significant impact of nursing shortages and increased patient acuity levels on the standards of patient care and patient safety, these changes in the healthcare environment have repercussions for nurses themselves. Poor quality and adverse healthcare work environments have been linked to overwork and stress among nurses and a contributory factor to burnout (Aiken, *et al.*, 2001; Shirey, 2006). Indeed, workplace issues are the leading cause of job dissatisfaction (Aiken, *et al.*, 2001; AACN, 2001) and turnover in the nursing profession (AACN, 2001). Conversely, when nurse work environments are improved, levels of burnout and turnover among staff drop while patient satisfaction levels improve (Vahey, *et al.*, 2010), demonstrating that happy content nurses lead to happy content patients (Aiken & Sloane, 1997, Aiken, *et al.*, 1997).

1.5.3 Overcrowding

In recent times, difficulties in the provision of acute services in Emergency Departments in Ireland have been the subject of much public debate. Patients attending Emergency Departments expect to receive a high quality service in a timely manner. However, prolonged waiting times and ED overcrowding have adversely impacted on quality of care and patient safety (Higginson, 2012; Carter, et al., 2014; George & Evridki, 2015).

Overcrowding in Emergency Departments has been described as the situation that exists when the identified need for emergency services exceeds available resources in the Emergency Department, hospital or both (American College of Emergency Physicians, 2006) or when inadequate resources to meet patient demands result in a reduction in the quality of care delivered (Pines, *et al.*, 2011). The terms overcrowding and crowding are often used interchangeably in the literature but a consensus on the use of the term 'crowding' as a preference has emerged (Hoot & Aronsky, 2008)

among Emergency Physicians. However, the term 'overcrowding' is more prevalent in the UK and Ireland and is the preferred term of the mainstream media. Overcrowding in Emergency Departments presents health service professionals with unique challenges on a daily basis. Patient overcrowding and extensive waiting times in Emergency Departments result in reduced quality of care and increases the clinical risk of adverse patient events.

Overcrowding in Emergency Departments has been described as a crisis in several countries in recent years (The Irish Times, 2006; Hodgins & Legere, 2011; IOM, 2011; McCarthy, 2011; Cooper, 2013; Whitnall, 2013), as a "national epidemic" in the USA (Institute of Medicine, 2011) and as a "national emergency" in Ireland (The Irish Times, 2006). In the United Kingdom the crisis in Emergency Care provision has been described as being at "breaking point" with physicians warning that they can no longer safely provide care (Cooper, 2013; Withnall, 2013) and that overcrowding is causing "serious harm" and even "potentially avoidable deaths" among emergency patients (Royal College of Emergency Medicine, 2015).

In the United Kingdom, the Royal College of Emergency Medicine has reported extreme pressures on emergency services with some Emergency Departments declaring major incidents due to overcrowding (Royal College of Emergency Medicine, 2015). In Ireland, the problem of patient overcrowding in Emergency Departments has consistently deteriorated since 2006. Figures published by the Irish Nurses and Midwives Organisation show that the total number of Emergency Department patients waiting for an in-patient bed in April of each year has increased from 4,555 in 2008 to 7, 860 in 2015. These figures signify an increase of 73% in patients waiting for a bed but housed on an emergency trolley in the last seven years. In fact, the figures are even more disturbing if compared from the lowest level of 3,326 patients waiting for a bed in April 2007 to the current level of 7,860 in April 2015. When those figures are used, the percentage increase is 136 % from 2007 to 2015 (INMO, 2015). These figures show that the overcrowding problem in Irish Emergency Departments has persisted

despite efforts to improve the situation by successive governments and ministers for health.

In addition to these changes within the Emergency Department, other changes within the larger hospital and healthcare system have had a profound effect on conditions in the Emergency Department. These include high bed occupancy rates and the deficiency in long term care beds in certain geographical areas, especially in Dublin. The Value for Money Audit of the Irish Health System (Deloitte&Touche, 2001) shows that the average occupancy rate in the acute hospitals sector remains extremely high with occupancy rates frequently exceeding 100%, which compromises service quality. This level of occupancy means that there are not enough beds for all the patients requiring treatment in the hospital and is high by international standards. These high bed occupancy levels are due, in part, to the low number of hospital beds in Ireland which has <4 beds per 1,000 population compared to the OECD average of 5.2 per 1,000 population (OECD, 2014). This high rate of occupancy reflects high utilisation of available capacity in the hospital system and contributes significantly to patient overcrowding in Emergency Departments.

1.5.3.1 Causes of Overcrowding

Emergency Department overcrowding has now been recognised as an international crisis affecting the quality of healthcare access (Hoot & Aronsky, 2008) and posing a significant public health issue (Pines, *et al.*, 2011). A systematic review of 4,271 research abstracts by Hoot and Aronsky (2008) concluded that ED overcrowding was a complex and multi-dimensional problem. A total of 93 relevant articles addressing the overcrowding issue met their inclusion criteria. Among these articles, Hoot and Aronsky (2008) identified the most commonly reported causes of patient overcrowding in Emergency Departments as non-urgent attendees, frequent flyer patients, surge in demand during influenza season, inadequate staffing levels, inpatient boarding of admitted patients in the Emergency Department and hospital wide bed shortages. The systematic review identified three categories related to the causes of Emergency Department

overcrowding; input factors, throughput factors and output factors. In their review, the major input factor affecting overcrowding was low acuity patients seeking treatment in Emergency Departments. These low acuity patients frequently attend Emergency Departments for their primary care needs. However, the attendance of these low acuity patients does not significantly impact on overall overcrowding levels (Forster, *et al.*, 2003; Spirivulis, *et al.*, 2005; Rathlev, *et al.*, 2007; Schull, *et al.*, 2007; Trzeciak & Rivers, 2009).

The most common throughput factor impacting on crowding levels was the provision of inadequate staffing levels and the most common output factor influencing overcrowding was the boarding of admitted patients in the Emergency Department while waiting for an inpatient bed in the context of the overall shortage of available hospital beds (Hoot & Aronsky, 2008). These findings are supported by the results of an Irish study by Gilligan and colleagues, which showed that the majority of Emergency Department patients felt that the main reason for Emergency Department overcrowding was a lack of inpatient hospital beds (Gilligan, *et al.*, 2007). In Ireland, there are <4 beds per 1,000 population compared to an OECD average of 5.2/1,000 population (OECD, 2014). This fact has been acknowledged by the Department of Health in Ireland, who identified the need for an additional 2840 patient beds in the acute hospital sector back in 2001 (Department of Health & Children, 2002).

The Institute of Medicine (2006) have identified that hospitals may have a financial incentive for keeping admitted patients boarded in the Emergency Department as the cost per night of keeping a patient on ED trolley is significantly less than the cost of admitting the patient to a ward bed (Institute of Medicine, 2006). This acts as a financial disincentive for hospital management to address the issue of overcrowding as it negatively impacts on the financial status of the organisation.

The Emergency Department overcrowding problem appears to be resistant to efforts to solve the problem and has persisted to the extent that it now

poses an international public health problem (Hoot & Aronsky, 2008; Moskop, *et al.*, 2009; Pines, *et al.*, 2011;) with significant consequences for patient safety and the quality of emergency care delivered (American Academy of Paediatrics, 2004; Eckstein, *et al.*, 2005; Coughlan & Corry, 2007; Kilcoyne & Dowling, 2007; Collis, 2010; Knapman & Bonner, 2010; Carter, *et al.*, 2014). In addition, Emergency Department overcrowding has been shown to effect nurse job satisfaction, stress levels and intention to leave (Keough, *et al.*, 2003; Sawatsky & Enns, 2012).

The international dimension of the Emergency Department crowding problem is also examined in an extensive review of emergency care systems in 15 countries conducted by Pines, *et al.* (2011). Pines and colleagues sought the perspectives of emergency physicians working in a diverse range of countries including the USA, Canada, Europe, India and Australia on ED overcrowding. Increased rates of Emergency Department attendance and increased crowding rates were reported in most countries except Scandinavian countries where better primary care services may mitigate against severe ED crowding (Pines, *et al.*, 2011). The review also found that patients attend the Emergency Department for their primary care needs where alternatives are more difficult to access or are in short supply (Pines, *et al.*, 2011). The main cause for patient crowding reported across the 15 countries was the boarding of admitted patients in the Emergency Department while awaiting an inpatient bed (Pines, *et al.*, 2011). The boarding of admitted patients has been identified as the main cause of Emergency Department overcrowding (Gilligan, et al., 2007). However, to address the problem of boarding in EDs through the provision of more inpatient beds would require significant investment in healthcare resources which are in short supply in Ireland in recent times (Nolan, *et al.*, 2014). In one Irish study, conducted in an Emergency Department with some of the most pervasive overcrowding problems, over 85% of patients indicated that the health authorities were not doing enough to solve the problem (Gilligan, *et al.*, 2007).

While it is now accepted that the causes of patient crowding in the Emergency Department are multi-factorial and complex (Hoot & Aronsky, 2008) and pose significant problems for healthcare delivery internationally (Pines, *et al.*, 2011), the consequences of Emergency Department crowding are likewise multi-faceted and far reaching (Bradley, 2005; Eckstein, *et al.*, 2005; Coughlan & Corry, 2007; Hoot & Aronsky, 2008; Moskop, *et al.*, 2009; Knapman & Bonner, 2010; Gilligan & Quin, 2011; Gilligan, *et al.*, 2013; Carter, *et al.*, 2014). When Emergency Departments become overcrowded they attempt to fulfil two roles-one as provider of emergency care and the other as provider of in-patient care to boarded patients. As a result, neither role is fulfilled adequately or safely (Jayaprakash, *et al.*, 2009).

1.5.3.2 Consequences of Overcrowding

The combined problems of patient crowding and diminished resources (Peterson, 2001; Kimball, 2004) have been reported in the emergency medicine and emergency nursing literature for a number of years now. This perfect storm of decreased resources coupled with increased demand has seen a dramatic rise in patient wait times and episodes of overcrowding in Emergency Departments internationally and in Ireland.

The evidence that links Emergency Department overcrowding to serious adverse patient outcomes has been growing steadily for the last ten years (American Academy of Paediatrics, 2004; Bradley, 2005; Hoot & Aronsky, 2008; Moskop, *et al.*, 2009; Carter, *et al.*, 2014; Richards, et al., 2014). Patient overcrowding has now been linked to diverse adverse patient outcomes such as impaired access to in-patient hospital care (American Academy of Paediatrics, 2004; Hoot & Aronsky, 2008), increased mortality (Bradley, 2005; Richardson, 2006; Hoot & Aronsky, 2008; Guttmann , *et al.*, 2011), prolonged pain (Derlet & Richards, 2000), delayed treatment (JCAHO, 2003) ambulance diversions (The Lewin Group, 2002; Eckstein , *et al.*, 2005; Hoot & Aronsky, 2008) and impaired patient safety (Canadian Association of Emergency Physicians, 2001).

The consequences of patient overcrowding have been further classified according to four categories in a systematic review conducted by Hoot and Aronsky (2008). These four categories summarise the different areas of patient care affected by overcrowding and are illustrated in Table 1.

Table 1.1 Consequences of overcrowding

(adapted from Hoot & Aronsky, 2008)

Adverse outcomes	Increased mortality rates Impaired safety
Reduced quality	Delays in treatment Delays in analgesia Impaired safety Patient perceptions of impaired care and loss of faith in system
Impaired access	Ambulance diversion Ambulance turnaround delays Patient left without being seen rates
Financial losses	Ambulance turnaround delays Increased length of hospital stay Increased morbidity and mortality (cost of litigation, increased cost of care resulting from sicker patients) Increased staff turnover

The most significant adverse outcome that results from patient overcrowding in Emergency Departments is an increase in mortality rates among patients when subjected to overcrowded conditions (Carter, Pouch & Larson, 2014; George & Evridiki, 2015). Increased mortality rates in overcrowded Emergency Departments have been documented in a number of studies (Miro, *et al.*, 1999; Bradley, 2005; Richardson, 2006; Spirivulis, *et al.*, 2006; Hoot & Aronsky, 2008; Guttmann, *et al.*, 2011). The measured increases in mortality rates were recorded among Emergency Department

patients directly subjected to overcrowding and among patients diverted during periods of overcrowding (Richardson, 2006; Pines, *et al.*, 2009). Across these studies, increased mortality rates were recorded over a period of time ranging from 2-30 days post admission. This shows that the effect of overcrowding on mortality rates has a pervasive effect long after the overcrowding event, presumably due to compromised care from arrival at the Emergency Department.

In addition to increased mortality rates, patient overcrowding adversely affects the safety of patients. Impaired safety related to patient overcrowding results from delays in care, pressure to maintain patient flow and impaired communication among healthcare workers (Bradley, 2005). Patient overcrowding has also been linked to a reduction in the quality of care received by Emergency Department patients including prolonged pain, prolonged wait for analgesia, no analgesia given, delays in treatment, poor documentation of care and prolonged waiting times for hospital beds (Bradley, 2005; Hoot and Aronsky, 2008; Carter, *et al.*, 2014). Prolonged pain and delays in analgesia administration have been reported in several studies to date (Derlet & Richards, 2000; JCAHO, 2003; Hwang, *et al.*, 2006; Bernstein, *et al.*, 2009; Johnson & Winkelman, 2011). In addition, time sensitive treatments such as those used to treat heart attack patients may be delayed by patient overcrowding (Schull, *et al.*, 2003; Schull, *et al.*, 2004). Furthermore, patient overcrowding has been shown to adversely affect patients' perceptions of the quality of care delivered (Pines, *et al.*, 2007; Pines, *et al.*, 2008) and result in patients who are less likely to recommend the Emergency Department service to another patient (Pines, *et al.*, 2008).

Many of the adverse effects on patient care related to overcrowding result from the inappropriate boarding of admitted patients in hallways and corridors while waiting for a hospital bed to become available. Caring for patients on hospital corridors has been linked with delays in care, increased disability, unrecognised patient deterioration and unrelieved pain (Richards, et al., 2014). In Ireland, up to 80% of admitted patients are cared for on ED

corridors (HIQA, 2012). Patients themselves appear to recognise the dangers of 'corridor care' in the ED, by expressing a preference to being cared for in a ward corridor instead of on an ED corridor (Garson, et al., 2008).

Impaired access to services due to patient overcrowding in Emergency Departments can be directly due to ambulance diversions (Derlet & Richards, 2000; Schneider, *et al.*, 2003; Eckstein, *et al.*, 2005; Burt, *et al.*, 2006), prolonged ambulance wait times and prolonged ED waits (Forero, *et al.*, 2010) but they can also result from reduced physician performance (Derlet & Richards, 2000) and patients leaving before being seen (Bindman, *et al.*, 1991; Weiss, *et al.*, 2005; Rowe, *et al.*, 2006; Gilligan, *et al.*, 2009; Kyrlacou, *et al.*, 2009). This is especially worrying given that patients who leave without being seen are at risk of ongoing health issues (Bindman, *et al.*, 1991; Gilligan, *et al.*, 2009).

Healthcare organisations face significant financial losses due to patient overcrowding. These losses stem from the direct costs of boarding patients in the Emergency Department (Bayley, *et al.*, 2005) and the indirect costs of reduced productivity (Derlet & Richards, 2000), delays in treatment, prolonged length of stay (Krochmal and Riley, 1994) and increased complexity of care due to delays in initiating treatment. Therefore, a financial as well as moral motivation exists to resolve the problem of Emergency Department patient overcrowding.

1.5.3.3 Impact of overcrowding on emergency nurses

Emergency nurses have previously reported that some of the main stressors in their work environment are related to low staff numbers, pressure of work and inadequate resources (Walsh, *et al.*, 1998; Keough *et.al.*, 2003). The pressure of work on emergency nurses is increased when they have to care for patients in overcrowded EDs because they have to care for both admitted and emergency patients (Gilligan & Quin, 2011). This additional workload impairs the ability of emergency nurses to provide quality care (Gilligan & Quin, 2011) and has been shown to cause frustration among nurses who are

unable to ensure the privacy and dignity of patients (Kilcoyne & Dowling, 2007).

Indeed, the requirement to care for both emergency and admitted patients may explain increased levels of secondary traumatic stress among emergency nurses (Duffy, et al., 2015). In the United States, emergency nurses report higher incidents of secondary traumatic stress (33%) compared to oncology nurses (16%) (Dominguez-Gomez & Rutledge, 2009). In addition, Irish emergency nurses have a higher incidence of self reported secondary stress (64%) when compared to US emergency nurses (33%) (Duffy, et al., 2015). It has been suggested that the high levels of secondary traumatic stress among Irish emergency nurses may be due to moral distress as a result of patient overcrowding (Kilcoyne & Dowling, 2007). Emergency Department overcrowding has also been linked to poor nurse job satisfaction, high stress levels and increased intention to leave a post (Keough, et al., 2003; Sawatsky & Enns, 2012).

1.5.3.4 Solutions to overcrowding

The solution to overcrowding is often suggested to be the diversion of inappropriate attenders[3] to other healthcare settings away from the Emergency Department. This simplistic view implies that a large number of people attending Emergency Departments do not need to be there and could easily be treated elsewhere. This proposed solution is deficient for two very important reasons; firstly, the numbers of people that could be diverted to other settings represents a small percentage of attenders in Emergency Departments (Spirivulis, et al., 2005) and secondly, the overcrowding problem in Emergency Departments is primarily due to *admitted patients* who are awaiting a bed (Bradley, 2005; Pines, *et al.*, 2011). These are patients who have been medically assessed to require admission. In other words, they were sick enough to need to be treated in the hospital and were not suitable for diversion to another healthcare setting in the first place. The

[3] Inappropriate attenders are patients who attend the Emergency Department with a non-emergent problem that would have been more appropriately treated in another healthcare setting such as GP practice or Local Injury Unit.

provision of alternative healthcare options to patients does not in fact, decrease the number of Emergency Department attendances (Cooke, *et al.*, 2004) or reduce overcrowding (Spirivulis, *et al.*, 2005). Therefore, solutions to ED overcrowding must address the bed capacity of hospitals as this is the primary cause of patient boarding and consequent patient overcrowding (Gilligan, *et al*., 2007; Hoot & Aronsky, 2008).

Unfortunately, the solutions to Emergency Department overcrowding are, like the problem, more complex (Hoot & Aronsky, 2008; Gilligan and Quin, 2011). The Irish Association for Emergency Medicine (2007) and the Health Service Executive Emergency Department Task Force Report (2007) both assert that Emergency Department overcrowding is a symptom of a systems failure and not an isolated Emergency Department problem. Emergency Department overcrowding is now recognised as being a complex multi-factorial problem (Hoot & Aronsky, 2008) whose main cause is access block due to high bed occupancy and reduced bed capacity (Higginson, 2012). Furthermore, it is now accepted that Emergency Department overcrowding requires a whole hospital approach (Arkun, *et al.*, 2010) or whole systems approach to resolution (Harris & Sharma, 2010; Gilligan and Quin, 2011) with changes to practice necessary beyond the four walls of the Emergency Department (Hodgins & Moore, 2010).

Resolutions to Emergency Department overcrowding can be divided into three broad categories of interventions that affect input, throughput or output of patients in Emergency Departments (Asplin, *et al.*, 2003; Bradley, 2005). The first category includes measures relating to diverting patients away from Emergency Departments which reduce numbers presenting for treatment, the second category includes measures which seek to improve patient flow within the Emergency Department by reducing delays and ensuring efficient use of resources and the third category describes measures to improve timely discharge of patients from the Emergency Department or rapid transfer to another hospital department or ward.

The difficulty with all of the solutions recommended in the literature is that they require significant additional investment and financial resources. The main cause of overcrowding is admitted patients being 'boarded' in the Emergency Department while awaiting a hospital bed (Kyrlacou, *et al.*, 2009; Kellermann, 2000; Derlet, *et al.*, 2001; McManus, 2001; Schull, *et al.*, 2001; Moroney, 2002; Richardson, *et al.*, 2002; Curry, *et al.*, 2003; Dunn, 2003; Estey, *et al.*, 2003; Forster, *et al.*, 2003; General Accounting Office, 2003; Proudlove, *et al.*, 2003; Schull, *et al.*, 2003). Therefore, solutions that focus on input or throughput measures only will not solve the overcrowding problem although they may improve patient flows through Emergency Departments. It is evident that any overcrowding solution will have to tackle the difficult issue of bed capacity within the acute hospital network and the significant investment required to remedy this by providing additional in hospital bed capacity and/or improving patient discharge processes.

1.6 Emergency care in Ireland

Emergency Medicine has been recognised as a specialist area of practice in Ireland since 2000 (Emergency Medicine Programme, 2011). The Irish Association for Emergency Medicine is the representative body for Consultants in Emergency Medicine and has been in existence for 25 years. Specialist postgraduate training in Emergency Medicine is now provided by the Advisory Committee for Emergency Medicine Training and is accredited by the Royal College of Surgeons in Ireland. A number of colleges and universities provide specialist training in emergency nursing at postgraduate diploma and masters degree level. Emergency nurses in Ireland are highly trained and competent in providing a wide range of specialist emergency nursing interventions (McCarthy, *et al.*, 2011).

Emergency care in Ireland has been undergoing a period of extensive change and modernisation under the direction of the Emergency Medicine Programme (2011). This programme of change sets out a roadmap for the future of emergency medicine and nursing in Ireland and will bring Irish emergency care in line with international best practice standards. This programme of care has been developed in response to a major change in the

organisation of healthcare sevrices undertaken by the Health Service Executive. The introduction of this programme of change has coincided with the worst levels of Emergency Department overcrowding ever experienced in Ireland (Hughes, 2015) which saw 601 patients boarded in Emergency Departments awaiting admission to a hospital bed during the worst day of the crisis in January, 2015. This unprecedented level of patient overcrowding has led to a renewed commitment to find solutions to this perennial problem (Irish Examiner, 2013) with the establishment of an Emergency Department Taskforce to oversee management of overcrowding. However, the problem of Emergency Department crowding has been getting steadily worse over the last ten years (Hughes, 2015) and has been described by successive Irish Ministers for Health as an 'emergency' (Department of Health and Children, 28th March 2006) as a 'national emergency' (Irish Times, 30th March 2006) and a crisis that 'will only get worse' (Irish Times, 7th January 2015) in the short term. Representative bodies for emergency medicine specialist trainee doctors and consultants in emergency medicine have described the Emergency Department overcrowding problem as 'unequivocally dangerous for patients' (IEMTA, 2014) with an 'increased risk of avoidable death, inferior medical outcomes and unnecessarily prolonged hospitalisation' (Irish Association for Emergency Medicine, 2014).

Patient overcrowding in Ireland compromises the ability of emergency staff to deliver emergency care (Gilligan and Quin, 2011) and has been associated with poor infection control, health and safety issues, lack of respect and dignity for patients and moral distress and burnout among nurses (Kilcoyne and Dowling, 2007). The boarding of patients has a direct impact on the delivery of emergency care with one study showing that 67% of patients in the Emergency Department were admitted and waiting for a bed (Gilligan, *et al.*, 2013). Overcrowding has been associated with prolonged waiting times and higher levels of patients leaving and not waiting for treatment (Gilligan, *et al.*, 2009) and adverse outcomes for elderly patients in particular (Gilligan, *et al.*, 2008). Overcrowding represents a failure of healthcare managers and politicians to proactively

manage a predictable situation (IAEM, 2014). The resolution of the complex issues causing patient overcrowding in Emergency Departments will require increases in acute hospital bed capacity in Ireland and a whole systems approach to finding solutions (Gilligan and Quin, 2011). The reconfiguration of hospital networks and the implementation of the emergency medicine programme will go a long way to achieving this end but are dependent on the proper financial resources being made available.

1.7 Motivation for this study

I have worked as an emergency nurse for the last 15 years and have witnessed the challenges facing emergency care in Ireland and in the wider international context. The issues are broadly the same with patient overcrowding being the predominant issue for the last 15 years. The issues of overcrowding, increased service demand and nursing shortages in Emergency Departments discussed in this chapter informed the topic of this thesis and helped me form *an area of interest* for this study in accordance with the principles of grounded theory (Glaser & Strauss, 1967) and the writings of Barney Glaser (Glaser 1978; 2001; 2011; 2013), one of the original authors of grounded theory.

The motivation for a study on moral distress came from focus group interviews conducted for my Master's thesis. In the course of the interviews, nurses described patient overcrowding due to boarded admitted patients as being the main concern in their practice. One of the nurses described the effect of overcrowding as:

> "I think there needs to be a clear definition in relation to that. We're taken away from doing A and E jobs because of the physical overcrowding of the department. We're doing what ward nurses would do. We're not being allowed to be A&E nurses because of the overcrowding in the department."
>
> (FocusG4:708-718, unpublished Master's thesis Gerard White 2007)

This nurse's description resonated with me and appeared to relate to a phenomenon that I had read about in a research article. The phenomenon in question was moral distress and fitted with the nurses' description of being constrained and not able to work effectively as an emergency nurse.

Furthermore, Kilcoyne & Dowling's (2007) study suggested that Irish emergency nurses may experience moral distress as a result of overcrowding. A brief review of the literature revealed that this phenomenon had been inadequately researched in the Emergency Department setting and warranted further investigation. This finding informed the area of interest investigated in this thesis.

1.8 Aims and Objectives of the study

The aim of the study was to investigate the phenomenon of moral distress among Emergency Nurses.

The objectives of the study were as follows:

- To investigate if moral distress is experienced by Emergency Nurses.
- To identify the main concern of Emergency Nurses experiencing moral distress.

1.9 Chapter Summary

This chapter has described the setting for the current study on moral distress among emergency nurses. The workings of a typical Emergency Department have been described along with the different clinical areas and functions they provide for patients and staff. The shift away from stand alone Emergency Departments towards emergency care networks and systems of care has been described along with some of the various challenges that face emergency doctors and nurses in providing emergency care. Furthermore, recent developments in emergency care in Ireland including the change agenda set by the emergency medicine programme and the serious challenges of patient overcrowding have been discussed. The background and motivation for the current study on moral distress have been described. The next chapter includes the initial literature review of the area of interest in this study, moral distress.

Chapter 2 Initial Literature Review

2.1 Introduction

This chapter examines the literature on the topic of interest - moral distress. How to use the literature in grounded theory studies is debated and this is explored in detail in Chapter 3. The preliminary literature review, reported here, explores the origins and properties of moral distress and critiques the development of moral distress as a concept. This focus adheres to the teachings of Glaser & Strauss (1967) and Glaser (1978; 1998), who recommend 'reading for ideas' to develop theoretical sensitivity and to avoid preconception (Glaser, 1978). The preliminary literature review was also used to develop an awareness of any potential conceptual pitfalls (Dunne, 2011; McGhee, *et al*., 2007) or dominant themes from the literature and to make sure that no important concepts were overlooked (Elliott & Higgins, 2012).

The approach adopted to reviewing the literature could be described as a phased approach, with an initial 'noncommittal' phase of examining the literature for dominant themes (Martin, 2006) which is presented here. A comprehensive critique of the literature was not conducted until later in the grounded theory process when the literature was compared to the emergent theory and when integrating the theory with the extant literature. These phases are described in more detail in Chapter 4.

The literature review was conducted by sourcing papers from a number of databases including CINAHL, Pubmed, Scopus, Web of Science and Psychinfo. Key words used as search terms included Moral Distress, Moral Distress & Emergency, Stress, Stress of Conscience, Stress & Emergency, Ethics & Emergency, Burnout & Emergency, Moral, and Morality.

2.2 The Literature Reviewed in this Chapter

Literature relating to moral distress and related topics was retrieved. The goal of the literature review was not to gain an exhaustive or conceptually complete review of the literature but rather to search for the most pertinent

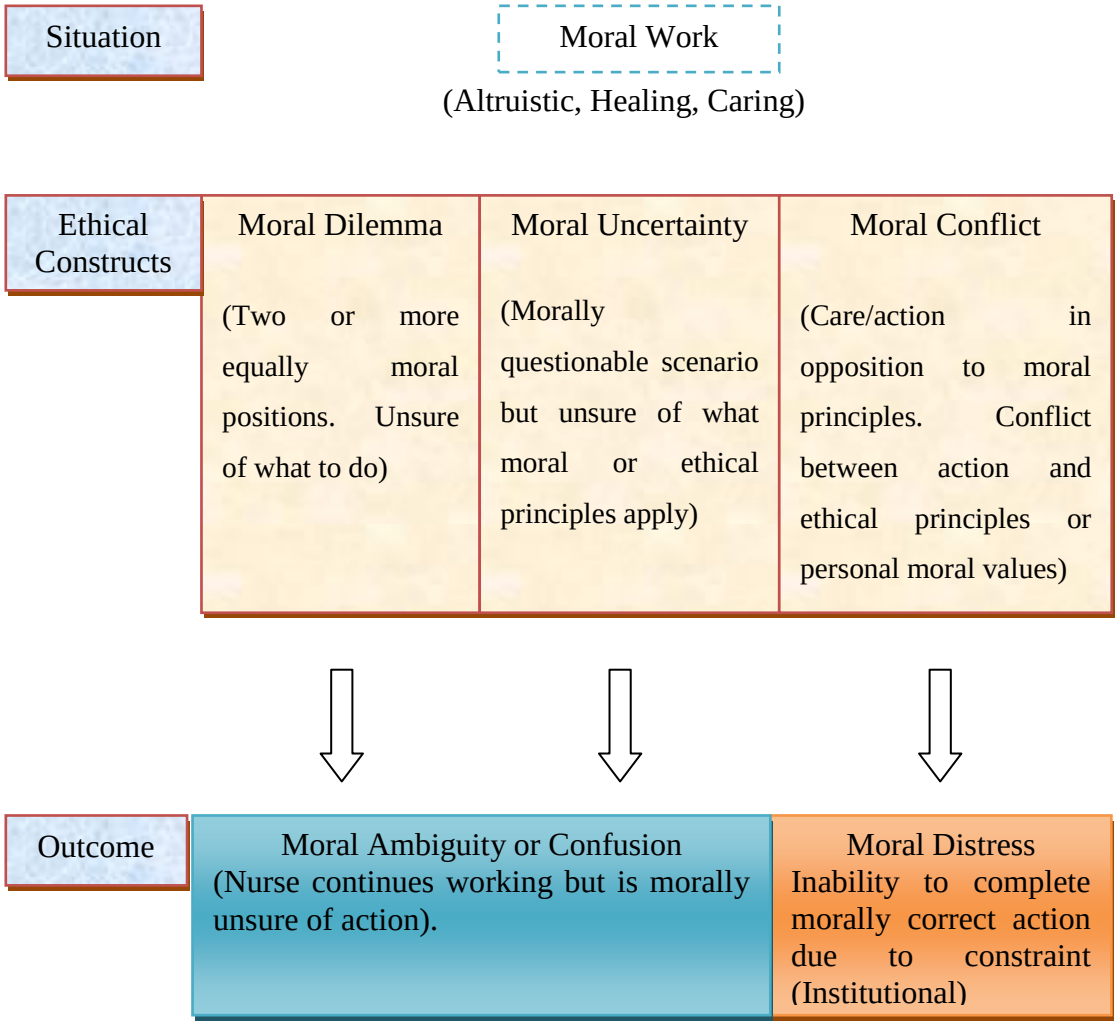
points from the published studies. Nonetheless, given the large amount of papers published on moral distress in recent years, a large volume of papers on the topic were generated. Papers were read for sensitising concepts and these concepts were recorded for later comparison with the study findings.

Furthermore, the initial literature was also supplemented by a much wider reading of grounded theory studies to develop theoretical sensitivity to potential theoretical codes (Ekstrom, 2006). These papers were examples of Grounded Theory studies but were not related to the substantive area. Studies were sourced from the same literature databases used in the literature review on moral distress and included CINAHL, Pubmed, Scopus, Web of Science and Psychinfo. Keywords included 'Grounded Theory' and 'Nursing'. In addition, grounded theory studies were sourced from the *Grounded Theory Review*, an open source peer reviewed journal of grounded theory studies; and from a series of grounded theory readers by Glaser (1993, 1994, 1995, 1995a, 2007, 2014). The purpose of reading a large number of unrelated grounded theory studies was to generate a series of sensitising concepts. The process of developing sensitising concepts from the initial literature review is described in detail in Chapter 5.

2.3 Key Concepts from the Initial Literature Review

This section describes the key concepts found in the initial literature review. The main concepts which emerged from the literature review were *Nursing as Moral Work, Moral Dilemmas, Moral Conflicts, What is Moral Distress*? and *Concepts related to Moral Distress*. Table 2.1 provides a summary of these concepts and provides a reference point for the discussion of these concepts in the next section.

Figure 2.1 Key Concepts from Literature Review



Based on (Jameton, 1984 and Phillips, 1992)

2.3.1 Nursing as Moral Work

Chapter 1 painted a picture of the complexity and competing demands of contemporary healthcare environments with patients who are more educated with higher expectations of the care they should receive being cared for by fewer nurses with fewer resources. In this dynamic environment nurses are frequently forced to confront moral and ethical issues (Wilkinson, 1987-1988). Morality is widely defined as an individual or societal sense of right and wrong (Davis & Oraskar, 1991) whereas ethics is defined as moral philosophy or the study of morality (Jameton, 1984). In other words, conscience reflects the individual nurses own moral values (Dahlqvist, *et al.*, 2007) whereas ethics are used as a collection of moral values to guide

wider ethical decision making by professional groups or society (Jameton, 1984).

As patients navigate the healthcare system, they rely on nurses to act ethically and according to widely held moral values. Nurses act as patient advocates and represent them when decisions are made for them by healthcare managers on behalf of the hospital or healthcare organisation (Wilkinson, 1987-1988). In other words, patients, and society in general, expect that nurses will behave in a morally responsible fashion.

The origins of modern nursing have been attributed largely to the works and writings of Florence Nightingale. In her 'Notes on Nursing', Nightingale (1969) emphasises that the sole purpose of nursing is the 'sake of saving life and increasing health and comfort'. This emphasis on caring for patients and the provision of a healthy environment persists to the present day with modern position statements on the purpose of nursing describing it as caring for patients, alleviation of suffering, preventing harm and providing an environment that is conducive to healing (American Nurses Association, 2015; International Council of Nursing, 2015). This emphasis on the caring dimension of nursing practice situates nursing as a moral endeavour (Glasberg, *et al.*, 2008) and consisting of moral work. Indeed, many nurses report that their only motivation for entering the profession was the provision of care to others (Boughn, 2001). Nursing and caring are terms that are often used interchangeably and many nursing theories have caring as a core component. Nursing involves the formation of a connection between the nurse and the patient (Lachman, 2012). Therefore, nursing involves an interaction that involves a degree of empathy or emotional connection between the carer and patient (Lachman, 2012). This connection also involves the nurse making a moral commitment to the welfare of the patient (Jameton, 1992; Lachman, 2012).

The professional goal of nursing has been described as the provision of high quality care to patients (Erith-Toth & Spencer, 1991). Indeed, the act of caring is an integral part of nursing practice and may be viewed as necessary

for meaningful nursing (Jameton, 1992). To this end, nurses are consistently at the forefront of efforts to establish best practice standards and the improvement of patient safety. Nursing it has also been argued, seeks to achieve ethical aims where nurses use their conscience and ethical standards to help them to make decisions in ethically challenging situations. Nurses achieve ethical aims when they advocate on behalf of their patients. This service of others involves a degree of selflessness to prioritise the patient's needs over that of the nurse and has been described as a 'moral endeavour' (Phillips, 1992). Moral endeavour reflects the morally worthy goals of caring for the sick, alleviating suffering and benefiting the larger public or society (Phillips, 1992).

2.3.2 Moral Dilemmas

A moral dilemma occurs when the nurse encounters morally equal but differing principles that relate to the moral situation (Jameton, 1984; Phillips, 1992) and is unsure of which choice to make or in some cases where there is no satisfactory solution (Davis & Oraskar, 1991). Nurses experience moral dilemmas in everyday practice due to the constraints of organisational resources (Jameton, 1984, 1992; Wilkinson, 1987-88; Phillips, 1992) and the limits that this imposes on the delivery of care (Corley, *et al*., 2001; Wilkinson 1987-88; Nathaniel, 2006; Helft, *et al*., 2009; Edmonson, 2010). Nursing by its very nature involves close and prolonged contact with patients (Jameton, 1992). This prolonged contact with patients means that nurses frequently encounter moral issues.

Nurses use a process of moral reasoning to make decisions (Wilkinson, 1987) in morally difficult situations. Moral reasoning involves a process of balancing the needs of the individual patient against that of the organisation (Davis & Oraskar, 1991; Phillips, 1992) or of society at large. In balancing these sometimes conflicting demands, nurses make a series of judgements (Wilkinson, 1987) about the moral virtue or otherwise of the conflicting decisions. Nurses' ability to make these judgements and decisions may be constrained by institutional requirements (Jameton, 1984, 1992; Wilkinson, 1987; Phillips, 1992) such as staffing levels, cost containment and priorities

of care. The innate conflict of competing moral arguments can give rise to a moral dilemma where the nurse is forced to choose between two or more paths of equal moral virtue. Indeed, it has been argued that nurses frequently lack the authority or means within the larger healthcare organisation to act upon their moral judgement (Jameton, 1984, 1992; Wilkinson, 1987; Phillips, 1992. This inability to enact their moral reasoning may give rise to moral distress (Jameton, 1984).

2.3.3 Moral Uncertainty and Moral Conflict

Moral uncertainty arises in nursing when morally ambiguous situations occur where the nurse is unsure of what the moral issue is or what moral principles apply to the situation (Phillips, 1992). Moral uncertainty usually arises out of a scenario where there is a feeling by the nurse that moral principles have been compromised or broken but the nurse is uncertain of what the moral problem is. When nurses encounter moral uncertainty they may act as a moral witness (Jameton, 1992) to the situation, for example, bearing witness to morally questionable care but not acting upon the substandard care because the moral conflict or dilemma is unclear.

Moral conflict occurs when care is in direct opposition to moral principles and the nurse recognises the conflict between their own moral values and the care provided. There is no moral uncertainty in cases of moral conflict. The nurse recognises the correct course of action but for some reason fails to commit to moral action. Therefore, the failure to act in a morally conflicted situation may give rise to moral distress.

2.3.4 What is Moral Distress?

All healthcare staff may encounter moral dilemmas in their practice but because of their close proximity to patients, nurses frequently encounter situations where their moral duty to the patient is placed in conflict with their professional duty to their employer or to the physician (Phillips, 1992). As a result, a nurse's moral integrity may become compromised as a result of the inability to carry out morally informed actions (Mitchell, 1982). Moral distress was originally defined as the situation which arises when one

knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action (Jameton, 1984). For example, prolonged attempts to sustain the lives of acutely ill patients near death or dissatisfaction with care delivered to patients at end of life or in the Emergency Department, can give rise to moral distress. Moral Distress has also been described as a state of psychological disequilibrium experienced when a person makes a moral decision but does not perform the moral behaviour indicated by the decision (Wilkinson, 1987-1988). Central to Wilkinson's (1987-88) and Jameton's (1984) definitions is the nurse's inability to act upon the moral decision made which results in distress of a moral nature. Both definitions are congruent therefore with each other describing the same phenomenon but in slightly different ways.

It is argued that nurses experience moral distress because they lack the authority to carry out morally justified decisions (Jameton, 1984) but are obligated to try to balance the needs of individual patients with the wider needs of the hospital, healthcare system or society (Phillips, 1992; Jameton, 1992). Moral distress is associated with the challenge of upholding professional values and responsibilities while practicing in complex clinical environments (Pauly, Varcoe & Storch, 2012). The issue of moral distress arises because the constraints on the moral agency of nurses are beyond the control of the individual nurses (Pauly, Varcoe & Storch, 2012). Moral distress has implications for nurses, patients and the wider issue of delivering safe and effective healthcare (Pauly, Varcoe & Storch, 2012). Jameton's (1984; 1992) writings on moral distress are limited to a few paragraphs and form part of his wider writings on ethics in nursing. While he explained the core tenets of moral distress (described above), Jameton failed to develop moral distress as a concept - a common criticism of the concept (Hamric, 2012; Lutzen & Ewalds Kulst, 2012; Pauly, Varcoe & Storch, 2012; Oh & Gastmans, 2013; McCarthy & Gastmans, 2014). Jameton's failure to develop the properties of Moral Distress and situate it within the wider ethical literature has resulted in poor conceptual clarity and impeded effective research on the topic.

Wilkinson (1987-88) explains that nurses experience moral distress whether they personally behaved immorally or witnessed a colleague behave in an immoral manner. Therefore, nurses can feel moral distress even if they are indirectly involved in morally conflicted acts. They feel guilt and moral distress by association with the act. In other words, when nurses fail to act to halt morally dubious or even immoral acts, they will experience moral distress, even though they did not commit the act themselves. In this case failure to act in a morally responsible manner constitutes an immoral act in itself. This phenomenon of moral distress by association with immoral action is illustrated very well in a study by Kalvemark, *et al.* (2004). Kalvemark and colleagues conducted a series of focus groups of multi-disciplinary healthcare staff working in a variety of clinical settings. Healthcare staff were found to experience moral distress even when their actions are morally justified if their actions were in opposition to professional or legal guidelines (Kalvemark, *et al.*, 2004). In other words, nurses can act in a morally correct way but they experience moral distress because their moral position is in conflict with ethical guidelines. It would seem to be the case that nurses are damned if they do and damned if they don't.

Incidents of moral distress were further described in Wilkinson's (1987-88) seminal study when she interviewed staff nurses working in acute care hospitals. Wilkinson's study was the first empirical study to use Jameton's (1984) definition of moral distress as a theoretical framework for the study. Wilkinson (1987-88) used a mixed methods approach to study moral distress among registered nurses working in direct patient care roles. A survey was used to gather data to generate conceptual categories and properties which were then used as a framework for 24 one-hour interviews with nurses. Wilkinson used a combination of the constant comparative method (Glaser, 1965), phenomenological enquiry and qualitative analysis to describe the lived experience of moral distress among the nurses interviewed. Moral distress occurred most frequently in cases of prolonging life, performing unnecessary tests and interventions, lying to patients and incompetent or inadequate treatment by a doctor (Wilkinson, 1987-88).

Moral distress, Wilkinson found, did not occur automatically when a particular type of case arose. Moral distress occurred as a result of a combination of the case and the nurses' beliefs i.e. it arose when the case caused conflict between the nurses' beliefs and the institutional constraints. Importantly, the nurses' perception of the constraint was more important than whether the threat was real or exaggerated. Nurses perceived an inability to act because of past experience or fear of repercussions. More experienced nurses were better able to manipulate the system to get what they wanted and were, therefore, less likely to suffer from moral distress.

The results of this study were used to develop a simple model of moral distress and to distinguish between moral distress and moral outrage (which is explained later). Moral distress (Figure 2.1) is described as part of an equation that has a cause (experience) and an effect or consequence. In this equation, the nurse experiences a morally difficult situation. The nurse then fulfils an action that they feel is immoral or acts immorally by withholding an action. The inability or perceived inability to act on the part of the nurse causes psychological disequilibrium as the inaction is at odds with the nurse's moral choice. This inability to act gives rise to the 'psychological disequilibrium' experienced by the nurse. The effect of this inability to act and resultant psychological disequilibrium causes the nurse to engage in coping behaviours to deal with the situation (Wilkinson, 1987-88). In turn, these coping behaviours then have an effect on the individual nurse and on the quality of patient care that they deliver.

Figure 2.2 The Moral Distress Equation (Wilkinson, 1987-88).

Experience

Moral Situation	+ Moral Decision About Right Action	+ Perceived Inability to Act	=	Painful Feelings and Psychological Disequilibrium

Effect

Coping Behaviours + Frequency of Cases	=	Effect on Wholeness	Effect on Patient Care

Moral outrage is also explained as an equation with cause and effect. Moral outrage (Figure 2.2) occurs when someone else behaves in an immoral manner but the nurse experiences moral distress because they did not intervene or were complicit in the immoral action (Wilkinson, 1987-1988). This is similar to Jameton's description of reactive moral distress (1993) where nurses experience moral distress after the initial event because they failed to act on the moral imperative in the initial situation and now harbour feelings of guilt and frustration because of their failure to act. In these cases the nurse may act as a moral witness (Jameton, 1992) to the action but not intervene.

Figure 2.3 The Moral Outrage Equation (Wilkinson, 1987-88).

Experience

Moral Situation	+	Moral Decision + Belief that Others are Acting Immorally		Perceived Inability to Stop Them	=	Painful Feelings and Psychological Disequilibrium

Effect

Coping Behaviours	+	Frequency of Cases	=	Effect on Wholeness	=	Effect on Patient Care.

In cases of moral distress and moral outrage the consequences are the same (Wilkinson, 1987-88) and result in painful feelings and psychological disequilibrium for the nurse and a detrimental effect on patient care.

Even when nurses' moral decisions are not in conflict with professional or ethical guidelines, they may still result in moral distress. In an interpretive phenomenological study of ten critical care nurses, Sundin-Huard & Fahy (1999) found that when nurses attempted to advocate for patients as a result of experiencing morally distressing situations, there were serious repercussions for the nurse. Unsuccessful advocacy resulted in an intensification of feelings of anger and frustration and resulted in nurses

being relocated within the hospital, being scapegoated or burning out (Sundin-Huard & Fahy, 1999). This is a further theoretical development to the understanding of moral distress based on Jameton's (1984; 1992; 1993) original description where moral distress was only experienced when nurses were prevented from fulfilling the morally correct action.

2.3.5 Moral Distress in Different Settings

Initial research on moral distress in nursing has concentrated on critical care settings (Wilkinson, 1987-88; Sundin-Huard & Fahy, 1999; Corley, *et al.*, 2001; McAndrew, *et al.*, 2011; Lawrence, 2011; Ganz, *et al.*, 2012; Papathanassoglou, *et al.*, 2012) which is understandable given the acuity of these care settings and the high volume of moral and ethical issues that arise from caring for critically ill patients and from the withdrawal of care, futile care (Mobley, *et al.*, 2007; Shorideh, *et al.*, 2012) and unnecessary prolongation of life (Hamric & Blackhall, 2007). Wilkinson (1987-1988) conducted 24 one-hour interviews where she discussed moral distress with staff nurses working in hospitals. Half of the interviewees had worked in intensive care settings with one quarter of interviewees (n=6) working in intensive care at the time of the interview. Wilkinson found that harm to patients and dehumanising of patients were the most common causes of moral distress among the nurses studied and that this resulted in feelings of anger, frustration and guilt among nurses (Wilkinson 1987-88). Importantly, this study found that nurses experienced moral distress regardless of whether they themselves acted in an immoral manner or others such as doctors acted in an immoral manner. Nurses may also use coping mechanisms such as avoidance to deal with the moral distress (Wilkinson, 1987-88; De Villers & DeVon; 2012). However, when coping mechanisms failed nurses felt overwhelmed with some nurses resigning (Wilkinson, 1987-88) or (including Wilkinson herself) even leaving the profession altogether (Phillips, 1992). Wilkinson's (1987-88) study described a total of 72 different cases which gave rise to moral distress. The moral issues identified most often by participants in Wilkinson's (1987-88) study were harm to the patient (in the form of pain and suffering) and the

dehumanisation of patients (where they are treated as objects). These moral issues arose from four types of situations:

1. Prolonging life (including overly aggressive or heroic treatments of dying patients)
2. Performing unnecessary tests and treatments (especially on dying patients)
3. Deception or lying to patients or family (about treatment prospects and/or prognosis)
4. Incompetent or inadequate treatment by a colleague.

A number of subsequent studies (Sundin-Huard & Fahy, 1999; Corley, *et al.*, 2001; McAndrew, *et al.*, 2011; Lawrence, 2011; Ganz, *et al.*, 2012; Papathanassoglou, *et al.*, 2012) have used Wilkinson's study as a benchmark for further developing the concept of moral distress. However, these studies focus on the four types of situations identified by Wilkinson (1987-88) and ignore the moral issues identified in her study (patient harm and dehumanisation). This is a major limiting factor in developing moral distress theory as it narrows the study of moral distress (Hamric, 2012) to critical care examples only and does not address the moral issues or root causes of moral distress i.e. where the patient suffers pain or distress or when patients are dehumanised (Wilkinson, 1987-1988). Furthermore, the focus on moral distress among critical care nurses alone is problematic (Hamric, 2012) because the impact of different practice contexts may have on moral distress has not been considered. Even though moral distress has now been studied in a wide variety of clinical settings among diverse populations (Tiedje, 2000; Cohen & Erickson, 2006; Ferrell, 2006; Kain, 2007; Austin, *et al.*, 2009; Klein, 2009; Brazil , *et al.*, 2010; Houghtaling, 2012; Lazzarin, *et al.*, 2012; Browning, 2013; Edwards, *et al.*, 2013; Fernandez-Parsons, *et al.*, 2013; Pye, 2013), the majority of these studies use Wilkinson's (1987-88) and Corley's (2001) examples of moral distress which are critical care context specific. Corley's scale (2001) in particular, is based on examples of moral distress which are specific to critical care practice contexts (Hamric, 2012) and its use across studies has resulted in a prevalent theory of moral distress (Corley, *et al.*, 2001) that lacks any recognition that moral distress

may be experienced differently by nurses working in other clinical specialities.

Corley, *et al.*'s (2001) scale (referred to above) was developed to measure levels of moral distress among 214 critical care nurses. A theoretical framework based upon Jameton's (1984) concept of moral distress, role conflict theory (House & Rizzo, 1972) and Rokeach's (1973) value systems theory formed the theoretical basis for the scale. Content analysis of previous research findings was combined with analysis of interviews with three nurses to develop the items for the moral distress scale. However, it is not clear if the content analysis of research findings included a range of practice contexts or from critical care contexts alone. Interviewing just three nurses also limits the scope for domain identification.

The resulting Moral Distress scale was submitted to critical care nurses and occupational health nurses for completion. Interestingly, while the critical care nurses (n=25, 88% response rate) reported experience with the items on the scale and moderately high levels of moral distress, the occupational health nurses reported no moral distress related to the scale items. The occupational health nurses did, however, report other causes of moral distress that were specific to their practice context. This finding was not incorporated into the moral distress scale (Corley, *et al.*, 2001) or conceptual framework (Corley, 2002). Failure to consider the practice setting remains a major weakness of this theoretical framework for moral distress and is the focus for criticism of the scale by others. The Moral Distress Scale has been criticised because it does not include external factors such as contextual constraints (McCarthy & Gastmans, 2014) and has exacerbated the conceptual confusion surrounding moral distress (Johnstone & Hutchinson, 2013; Lutzen & Ewalds Kulst, 2012; McCarthy & Gastmans, 2014; Oh & Gastmans, 2013; Pauly, Varcoe & Storch, 2012). The moral distress scale was developed for use with critical care nurses (Hamric, 2012) and was designed to measure moral distress in this setting alone. Appropriate interventions to moderate moral distress will not be found if instruments designed to measure moral distress do not capture the

root moral issues of the phenomenon (Hamric, 2012) or relevant contextual factors.

Content validity of Corley's (2001) scale was improved by submitting the scale to a panel of experts for review including Jameton (1984) and Wilkinson (1987-88). This study demonstrated moderately high levels of moral distress among nurses which factor analysis showed was related to three elements: individual responsibility for the patient, acting in a way that was not in the patient's best interest and the use of deception when caring for patients. Similar to Wilkinson's (1987-88) findings, Corley, *et al.* (2001) found that some nurses (15%, n=23) had resigned a position in the past due to moral distress.

These findings were replicated in a quantitative study by Elpern, *et al.* (2005) who also found moderate levels of moral distress among 28 intensive care nurses who completed Corley's (2001) moral distress scale. However, Elpern and colleagues (2005) also found that moral distress adversely affected job satisfaction employee retention, staff well being, self image and even spirituality. These findings show how moral distress can have a lasting effect on the individual due to the importance of professional identity to individual nurse.

Much of the original published research on moral distress has focused on intensive care and critical care nurses experiences of moral distress (Wilkinson, 1987-88; Sundin-Huard & Fahy, 1999; Corley, *et al.*, 2001; McAndrew, *et al.*, 2011; Lawrence, 2011; Ganz, *et al.*, 2012; Papathanassoglou, *et al.*, 2012). This is reflected in the causes of moral distress provided in the literature, with the majority of reported incidents occurring in cases of unnecessarily prolonged life, the performance of unnecessary test or procedures, situations where patients are lied to and in cases of incompetent care (Wilkinson, 1987-1988; Corley, *et al.*, 2001).

The main criticism of subsequent studies on moral distress which use Corley's (2001) scale is that they assume (because they are using this scale)

that the context of critical care environments apply in other practice environments. This has the effect of limiting the exemplars of moral distress to those found in critical care settings (Hamric, 2012) and represented in the scale. In this study, Corley's (2001) study was reviewed as part of the initial literature review. It was evident from examining the moral distress scale (Corley, *et al.*, 2001) that the elements of the scale failed to include some of the contextual factors related to emergency nursing, for example, patient throughput. This is not surprising given that the scale was designed for use with critical care nurses (Hamric, 2012). In Corley's original (2001) study, the three scale factors had Cronbach's α values of 0.82, 0.84 and 0.97. However, the content validity of the scale among different populations has not been well documented in subsequent studies. This gave rise to the motivation for the current study, which was to better understand moral distress among emergency nurses and to examine whether or not the different practice context influenced this understanding.

Moral distress has been described in settings as diverse as paediatric critical care settings (Tiedje, 2000; Kain, 2007; Austin, *et al.*, 2009), oncology and haematology units (Cohen & Erickson, 2006; Lazzarin, *et al.*, 2012; Pye, 2013), in long term care (Edwards, *et al.*, 2013), and end of life care (Ferrell, 2006; Klein, 2009; Brazil, *et al.*, 2010; Browning, 2013). Interestingly, the majority of studies outside of the critical care context tend not to use Corley's (2001) scale and instead tend to be to be qualitative studies designed to capture the broader context of Moral Distress. This would suggest that Corley's (2001) scale is unsuitable for these practice contexts.

Moral Distress has also been studied using other methods other than Corley's scale. In a descriptive study of twelve critical care nurses, Gutierrez (2005) found that nurses experienced moral distress as a result of an inability to identify meaning from patient's suffering combined with an inability to act on that suffering. Individual semi-structured interviews were thematically analysed by Gutierrez (2005) to describe how nurses' lack of inclusion in decision making contributes to moral distress and resultant

withdrawal behaviours. A lack of collaboration between physicians and nurses combined with ineffective communication contributed to feelings of powerlessness among nurses and resultant moral distress. When nurses are excluded from ethical decision making they may face conflict with surrogate decision makers (Schwenzer & Wang, 2006). Moreover, not alone were nurses found to be excluded from meaningful decision making but nursing management were unaware that nurses were experiencing moral distress at all (Gutierrez, 2005).

However, there remains very little research into the phenomenon of moral distress in emergency care with one study examining moral distress among emergency nurses (Fernandez-Parsons, *et al.*, 2013) and one study among trauma nurses by Houghtaling (2012) who describes futile care and how nurses endure moral distress as a coping mechanism. The only study examining moral distress among emergency nurses used a quantitative descriptive design examining moral distress levels among 51 emergency nurses who completed the Moral Distress Scale-Revised (Hamric, 2010). The Moral Distress Scale-Revised attempts to rectify my earlier criticisms of the scale's reliability when used in different populations by eliminating some items from the original scale. Fernandez-Parsons, *et al's.* (2013) study of moral distress among emergency nurses found that overall moral distress levels were low and was most often associated with incompetent care or futile care. The revised version of the moral distress scale developed by Hamric (2010) has high internal consistency measures (Cronbach's $\alpha = 0.88$) and purports to be applicable to a wider potential audience with the elimination of redundant items and enhanced clarity (Fernandez-Parsons, *et al.*, 2013). However, the revised scale was tested on intensive care unit nurses and the content validity has not been tested among emergency nurses. The absence of comparable data for a relatively newly developed scale is acknowledged by the authors as a limitation of the study and the absence of studies using the moral distress scale-revised among emergency nurses is discussed (Fernandez-Parsons, *et al.*, 2013). This raises the question as to whether this scale is suitable for use among emergency nurses and highlights the need to validate the scale among this population.

Moral distress has developed as a concept and has been used to describe the distress felt by individuals when unable to carry out a moral course of action in fields as diverse as healthcare education (Chiu, *et al.*, 2008; Lomis, *et al.*, 2009; Ganske, 2010; Range & Rotherham, 2010; Wiggleton, *et al.*, 2010; Berger, 2013; Pratt, *et al.*, 2013; Theobald, 2013), healthcare management (Mitton, *et al.*, 2010, 2011), allied health professionals (Carpenter, 2010; Mueller, *et al.*, 2011), psychiatrists (Austin, *et al.*, 2008; Lutzen, *et al.*, 2010) psychologists (Austin, *et al.*, 2005), pharmacists (Sporrong, *et al.*, 2006) and even podiatrists (Iglesias, *et al.*, 2010). Even among nurses the reported studies on moral distress now include moral distress among military nurses (Fry, *et al.*, 2002), nurse anaesthetists (Radzvin, 2011), nurse practitioners (Laabs, 2005) and nurses who assist in performing abortions (Hanna, 2005).

This explosion of research into moral distress in such diverse areas has resulted in the widening of the conceptual description of moral distress and in the development of associated concepts such as moral reckoning (Nathaniel, 2006) and stress of conscience (Glasberg, *et al.*, 2006). Indeed, Jameton himself has added to this discussion by describing the application of moral distress to environmental issues related to healthcare (Jameton, 2013). This muddying of the waters and loss of clarity around the original concept of moral distress has even resulted in some authors arguing in a complete re-examination and redefining of moral distress (McCarthy & Deady, 2008). Some of these theoretical issues such as the lack of conceptual clarity and quality of research pertaining to moral distress are discussed in the next section.

2.3.6 Clarifying Moral Distress as a concept

Moral distress research and discussion has been hampered by a lack of conceptual clarity (Oh & Gastmans, 2013) and much conceptual confusion (Hamric, 2012; Lutzen & Ewalds Kulst, 2012; Pauly, Varcoe & Storch, 2012). Conceptual fuzziness (McCarthy & Gastmans, 2014) and difficulties in defining the properties of a concept become more common as the level of abstraction of the concept grows (Oh & Gastmans, 2013). Part of the

conceptual difficulty of moral distress is that while it may be described in terms of its psychological, emotional and physiological effects, it is not reducible to them as they fail to incorporate the moral nature of the issue in question (Hanna, 2004; McCarthy & Deady, 2008). Models of moral distress need to address internal factors related to the nurses own moral constitution and external factors such as contextual constraints (McCarthy & Gastmans, 2014).

The lack of a contextual element in previous discussions and models of moral distress (Jameton, 1984; Wilkinson, 1987-88; Corley 2002) has resulted in a rigid concept which is unsuited for adaptation in different units, areas of practice and healthcare systems. Related concepts similar to moral distress such as stress of conscience (Dahlqvist, *et al.*, 2007; Glasberg, *et al.*, 2006) and moral reckoning (Nathaniel, 2006) may have emerged in an effort to address these contextual differences (Varcoe, *et al.*, 2012). Indeed, the conceptual weakness of moral distress is so great that it has been argued that it should be abandoned as an ethical concept altogether (Johnstone & Hutchinson, 2013). The published research on moral distress to date has also been criticised for being methodologically weak (Johnstone& Hutchinson, 2013) and is based mainly on a north American context and focused primarily on critical care practice settings (Wilkinson, 1987-88; Corley, 2002; Hamric, 2012; Pauly, Varcoe & Storch, 2012). Furthermore, the use of quantitative measures used in these studies accept as a given fact the presence of moral distress and preconceive the attributes of moral distress without due consideration of contextual or other relevant factors (Johnstone & Hutchinson, 2013).

Moral distress includes the assumption that nurses have the moral awareness to understand the right thing to do and that their moral judgements are correct and justified (Johnstone & Hutchinson, 2013). This assumption of nurses' moral understanding runs the risk of nurses imposing their moral values and judgements on patients without due regard to the patient's own feelings. Furthermore, by blaming external constraints, moral distress risks understating the moral responsibility of nurses to take corrective moral

action to address a moral wrong and may be used as an excuse for inaction (Johnstone & Hutchinson, 2013). This is a valid concern regarding the conceptual opaqueness of moral distress. However, this argument views moral distress as a concept affected by the individual's moral views and conscience only and disregards totally the collective moral values and professional standards of nurses.

This argument is polarised and totally disregards any respect for the professional standing of nurses on moral issues and the ability of nurses to act in a morally reflective manner. The main problem with this position is that it excuses the systemic failures and contextual constraints on moral action that undoubtedly exist for some nurses and in attempting to refute moral distress as a moral concept, it over simplifies the argument. In so doing, Johnstone & Hutchinson (2013) are guilty of the very fault that they warn nurses to avoid- that of imposing their moral argument on another without due consideration of the opposing view. Indeed, Johnstone & Hutchinson go one step further and dismiss moral distress as nothing more than the "ordinary psychological and emotional reactions to difficult ethical issues". In dismissing moral distress as nothing more than ordinary, the enduring and pervasive nature of moral distress is ignored, moral crescendo is not recognised and the personal consequences for nurses (frustration, burnout) and patients (depersonalisation, poor quality care) are dismissed (Wilkinson 1987-88; Schwenzer & Wang, 2006; Hamric & Blackhall, 2007; Pauly, Varcoe & Storch, 2012).

2.3.7 Concepts related to Moral Distress

This section describes moral reckoning and stress of conscience which are related to moral distress but have a distinct perspective. These concepts are part of the development of moral distress theory and share many of the same attributes of moral distress. The similarities between these related concepts are discussed and used as a basis for developing a comprehensive understanding of the properties of moral distress.

2.3.8 Moral Reckoning

The concept of moral distress was developed further into a three stage process by Nathaniel (2006) in a grounded theory study which proposed the theory of moral reckoning. In moral reckoning, there is an initial stage of ease which is interrupted by a situational bind or seminal event. This leads to a stage of resolution and finally a stage of reflection on one's beliefs and actions. Nathaniel's theory of moral reckoning views the phenomenon of moral distress as on ongoing process rather than an isolated event.

In moral reckoning, nurses experience an initial stage of ease where the work environment is comfortable and there is no moral conflict between the nurse and hospital or healthcare organisation (Nathaniel, 2003). A situational bind then occurs where the nurse's moral values are in conflict with those of the institution. This conflict between the nurse's moral view and that of the organisation leads to moral distress. The nurse next enters a stage of resolution where she either makes a stand for her moral views or she gives up and acquiesces. Finally the nurse enters a stage of reflection where she tries to make sense of the conflict by reappraising her feelings, beliefs and morals.

During the Stage of Ease there is comfort with the rules and expectations of the workplace. The nurse knows what is expected of her and has the ability to fulfil her role. The nurse's moral values and expectations are congruent. Unexpectedly, a moral issue arises in which her moral values are in conflict with those of the organisation, physician or colleagues. This constitutes a situational bind that forces the nurse into a Stage of Resolution where the nurse compromises her moral values and gives up or stands by her values and makes a stand. The nurse then moves into the final stage of Reflection in which feelings, actions and values are re-appraised in light of the situational bind and consequences (Nathaniel, 2003).

Nathaniel's (2006) model of moral reckoning develops on Jameton's (1993) description of moral distress which views moral distress as being initial or reactive. Initial distress is due to the inability to act at the time of the event

and reactive distress follows later due to one's inability to act to the initial problem. Nathaniel's reflective phase (2006) where nurses ponder their moral actions and feelings is similar to Jameton's original description of reactive distress (1993). Moral reckoning develops the original definition of moral distress into a 3 stage process and appears to clarify the concept and add to its understanding. Moral reckoning also describes moral distress as a situational bind or crisis point which is congruent with Jameton's (1984) definition. Finally, Nathaniel's (2006) process of moral reckoning show two possible outcomes from moral distress-namely taking a stand or giving up. These outcomes add to the density of moral distress as a concept and make more theoretical sense in that the outcome is not always a negative one. Therefore, moral reckoning meets Glaser's criteria for rigour in grounded theory research by achieving fit, work and modifiability (Glaser, 1978) with the previous existing explanations of moral distress.

2.3.9 Stress of Conscience

Further attempts have been made to develop the initial concept of moral distress (Jameton, 1984) by Dahlqvist, *et al.* (2007) and Glasberg, *et al.* (2006). These two related studies sought to address the theoretical brevity of Jameton's definition by defining stress of conscience as the stress caused by 'not following the voice of one's conscience'. However, this concept is theoretically very similar to Jameton's (1984, 1993) writings on reactive moral distress (Jameton, 1984) where nurses experience moral distress after the initial event due to one's inability to act to the initial problem. Therefore, the concept of stress of conscience does not clearly develop or improve upon the initial concept of moral distress. Dahlqvist, *et al.* (2007) and Glasberg, *et al.* (2006) attempted to develop a higher conceptual abstraction of moral distress termed stress of conscience which incorporated the idea of a situation in conflict with one's own conscience. McCarthy & Gastmans (2014) also differentiated between moral distress where nurses are forced to act against their professional values and moral discomfort where nurses' personal values are not satisfied. This distinction would place stress of conscience (Glasberg, *et al.*, 2006) back under the umbrella term of moral

distress (McCarthy & Deady, 2007) as the conscience element of the conflict with professional values is addressed.

Conscience has been described as a person's inner voice (Fromm, 1990) or the expression of moral responsibility towards others (Ramsay, 2001). Dahlqvist, *et al.* (2007) describe conscience as the integrated moral values of the individual, or as the individual's moral compass (Dahlqvist, *et al.*, 2007) which is consulted when dealing with morally difficult situations or when work circumstances are opposed to the nurse's own sense of morality (Juthberg, et al., 2010). Nurses' conscience may in part be informed by nursing practice as clinical practice acts as a touchstone for the values and principles that underscore the nursing profession. In other words, nurses use their everyday experiences of caring as the basis for their moral choices. However, nursing practice also generates moral issues as nurses frequently do not have the authority or means to fulfil their role (Jameton, 1984). Nurses must balance the demands of the organisation or hospital with those of the individual patient which can lead to competing moral demands on the nurse (Dahlqvist, 2007). Conscience may be troubled when the nurse confronts ethically or morally challenging situations and in particular, when they feel unable to fulfil the caring role (Glasberg, *et al.*, 2006). This troubled conscience may lead to morally induced stress (Wilkinson, 1987-1988; Corley, 2002) or long term moral distress (Dahlqvist, *et al.*, 2007). This definition of troubled conscience is indistinguishable from Jameton's (1984) definition of moral distress and the two concepts appear to be so theoretically similar that they are essentially describing the same concept.

Dahlqvist and colleagues (2007) sampled 444 nurses, nurses' aides, enrolled nurses and doctors to examine healthcare workers perceptions of conscience in their Swedish study to develop a questionnaire. This study sought the perceptions of conscience of staff as it was felt that the widely used moral distress scale (Corley, *et al.*, 2001) did not adequately explain how nurses react to compromising their moral values (Dahlqvist, 2007). Nurses' perceptions of conscience were explained by a six factor solution which included the perception of conscience as an authority to be considered when

making decisions, conscience as an asset, as a burden and conscience as being culturally dependant. Furthermore, nurses perceived their conscience as a moral guide or compass which they used to help them to decide whether or not to carry out actions that troubled their conscience (Dahlqvist, *et al.*, 2007). The study findings also showed that staff perceived conscience as having a vital role as an authority that cannot be ignored and as a warning signal against morally dubious or morally reprehensible care provision (Dahlqvist, 2007).

The perception of conscience study by Dahlqvist, *et al.* (2007) was part of a larger study to develop a stress of conscience questionnaire (Glasberg, *et al.*, 2006). After examining what nurses' perceptions of conscience (Dahlqvist, *et al.*, 2007) were, Glasberg, *et al.* (2006) examined stress of conscience in the same cohort of staff. Stress of conscience is referred to as the stress caused by a troubled conscience (Glasberg, *et al.*, 2006) which is very similar to Jameton's initial description of moral distress (1984) as the distress that arises 'when nurses know the right thing to do but institutional constraints make it almost impossible to do'. This similarity is acknowledged by Glasberg, *et al.* (2006) who attempt to differentiate the two phenomena by describing stress of conscience as the stress caused by 'not following the voice of one's conscience', thus placing the emphasis on the individual's conscience. This attempt to differentiate the two concepts is not elaborated any further and therefore not wholly successful as both concepts address the distress felt when confronted by a morally impossible task and the impact of the distress on the individual's moral self (Jameton, 1984, 1992; Glasberg, *et al.*, 2006, 2007). Therefore, it could be argued that both concepts essentially describe the same subject matter, albeit with a slight difference in emphasis. This congruence between stress of conscience and moral distress is further acknowledged by Juthberg, *et al.* (2007) with stress of conscience being described as the subjective stress experienced by nurses which arises from the conflict between their own morality and the reality of what they are forced to do. This description closely resembles Jameton's (1984) original definition of moral distress as knowing the

morally correct course of action but being prevented from carrying out the action due to institutional constraints.

Development of the stress of conscience questionnaire (Glasberg, *et al.* 2006) showed that stress of conscience was comprised of both internal and external factors. Internal demands related to the nurse's own feelings of failing to care and are related to one's own conscience or sense of morality. External demands included the ethics, rules and regulations which form part of the organisational context and which can impact on one's conscience. The presence of internal and external factors influencing conscience is congruent with the idea of stress of conscience being caused by incompatibility between these internal and external factors (Glasberg, *et al.*, 2006). Work overload, time pressure and competing demands also contributed to stress of conscience. The resultant stress caused by a troubled conscience has been shown to cause burnout among staff (Glasberg, *et al.*, 2007a). Stress of conscience contributed to staff burnout by causing an element of emotional exhaustion and forcing staff to deaden or harden their conscience (Glasberg, *et al.* 2007a). This stress of conscience may be exacerbated by increasing demands on workers who are forced to work with reduced resources and increased levels of responsibility (Glasberg, *et al.*, 2007b). Again, this description of stress of conscience being influenced by internal and external factors and resulting in distress and burnout is identical to the writings of Jameton (1984) and Wilkinson (1987-88).

The relationship between perceptions of conscience and stress of conscience was further studied among 146 nurses and nurses' aides looking after elderly patients in a nursing home setting (Juthberg, *et al.*, 2007). This study found a complex relationship between perceptions of conscience and stress of conscience which was explained through staff having to 'deaden their conscience' in order to survive in healthcare practice (Juthberg, *et al.*, 2007). Staff members described conscience as being a 'warning signal' (Juthberg, *et al.*, 2007; 2010) against causing harm to patients and that by deadening one's conscience, staff are not implementing what they have decided is the ethical or moral action (Juthberg, *et al.*, 2007). This is remarkably close to

Jameton's (1984) definition of moral distress as the stress experienced when nurses 'know the right thing to do institutional restraints make it nearly impossible to pursue the correct course of action'.

Deadening one's conscience and being exposed to contradictory demands in the clinical setting were identified as major sources of burnout among nurses and nurse's aides (Juthberg, *et al.*, 2008). These contradictory demands lead to the nurse not being able to follow their conscience and to feeling of moral burden (Glasberg 2008). Nurses experiencing stress of conscience have described feelings of inadequacy, incompetence and powerlessness (Glasberg, *et al.*, 2007b; Juthberg & Sundin, 2010). Stress of conscience occurs most often when nurses perceive that they don't have enough time to care for patients (Glasberg, *et al.*, 2007a; Juthberg, *et al.*, 2010). Indeed, nurses' stress of conscience may lead to avoidance behaviours and a sense of self betrayal of the core values of nursing (Juthberg, *et al.*, 2010). This incompatibility between the nurse's ideals of care and the reality of practice may even lead to an overwhelming sense of moral burden which is unsupported by management (Glasberg, *et al.*, 2008). Subsequently, the inability to express moral burden leads to stress of conscience and low resilience (Glasberg, *et al.*, 2008) among staff members.

The addition of stress of conscience to the theoretical development of moral distress on a conceptual level is problematic. The published studies described in this section demonstrate that stress of conscience has consequences for nurses and is a complex phenomenon but this does not delineate stress of conscience from moral distress. Therefore, moral distress, in its simplicity is open to criticism as an underdeveloped moral concept but is also open to contamination from other sometimes unrelated and sometimes indistinguishable theoretical concepts.

2.4 Consensus on Moral Distress

In addition to developments in the concept of moral distress, a large body of evidence has emerged relating to the causes and consequences of moral distress and proposed solutions to this phenomenon. Moral distress is now recognised as a complex phenomenon that has psychological, emotional and physiological consequences for individuals (McCarthy, 2014) and describes

a wider moral and ethical concept that involves an individual experiencing moral suffering as a result of acting in a way that contradicts the individual's ethical principles or personal moral values (McCarthy, 2014). Moral distress may now be described as the distress felt by individuals who are forced to act in a morally wrong manner or to engage in moral compromise (Varcoe, *et al.*, 2012) which adversely affects their moral integrity (McCarthy, 2014). Moral integrity is compromised by moral distress by threatening the personal moral values of the nurse (McCarthy & Deady, 2008). Therefore, the reconsideration and theoretical discussion around the conceptual development of moral distress championed by McCarthy and Deady (2008), Varcoe, *et al.* (2012) and McCarthy (2014) is to be welcomed as it clarifies moral distress as a concept and allows a deeper understanding of this subject matter.

2.5 Chapter Summary

This chapter has briefly described the rationale for and use of an initial literature review in this study. The literature relating to the area of interest of moral distress has been discussed in detail along with the multiple versions of moral distress which have emerged since Jameton's (1984) original definition. Subsequent developments of the concept and recent work on clarifying the concept of moral distress have been examined. Jameton's original concept of moral distress was grounded in nursing practice (Jameton, 1984; 1992) as this was where the practical application of the concept was demonstrated most clearly. Moral distress most often results from situations where patients are harmed (in the form of pain and suffering) or dehumanised (where they are treated as objects) (Wilkinson, 1987-1988). The similarities between the original causes of moral distress as described by Jameton (1984) and Wilkinson (1987-88) have parallels with the current issues of overcrowding and patient boarding in emergency departments. These similarities combined with the scarcity of research on moral distress among emergency nurses provided the basis for this thesis.

A post study literature review is described in Chapter 7 and formed the basis for the discussion chapter. The post study literature review was used to

inform, develop and enrich the study findings after the emergent grounded theory was developed. The next chapter describes the history of grounded theory methodology, the development of multiple versions of the method and the rationale for the approach taken in this study.

Chapter 3 Grounded Theory Methodology

3.1 Introduction

Classical Glaserian grounded theory (Glaser and Strauss, 1967; Glaser, 1978, 1998) was chosen as the methodology for this study. This chapter describes the grounded theory methodology and the rationale for its choice. The aims and origins of Grounded Theory, the philosophical basis for the method and the evolution of different approaches to the method are examined. Chapter 4 will discuss the implementation of the grounded theory method to this study.

A study's research design refers to how the researcher links the study's philosophical assumptions to specific methods to address the aim of a study (Creswell & Clarke, 2007). Research designs along with their associated philosophical beliefs and methodology are all heavily influenced by the prevailing paradigms of the time among the scientific and research communities, who direct, conduct and critique research studies. A paradigm can be described as a world view (Guba & Lincoln, 1994; Annells, 1996) or general perspective on reality (Kuhn, 1970; Polit & Beck, 2012) which is characterised by several assumptions or elements relating to that reality. It consists of a framework of assumptions that shape the way that researchers perceive and explain the world. These assumptions relate to ontology, epistemology and methodology as characterised by the paradigm. Ontology relates to the nature of reality and how reality is perceived. Epistemology relates to what we mean by knowledge and the different types of knowledge. Methodology is the theory of methods and relates to how knowledge is obtained and perceived. Methods are the techniques used to collect evidence in research (Porter, 2000) and describe the application of a particular methodology to a research study. There are numerous paradigms which may be employed to explain reality and applied as a framework for research studies. Regardless of the philosophical stance taken, it is evident that questions of paradigm and associated methodological assumptions have an important part to play in guiding how a research study is undertaken.

Researchers typically choose a research methodology and paradigm that reflect their own basic philosophical beliefs (Annells, 1996). Furthermore, the choice of paradigm may be more important than questions of method, as it is the underlying paradigm or philosophical beliefs of the researcher that will dictate the relevant ontology, epistemology and choice of method (Guba and Lincoln, 1994). In other words, each paradigm has its own criteria, assumptions and methodological practices (Denzin & Lincoln, 2005). Furthermore, the philosophical assumptions underlying a qualitative study can expect to be challenged by proponents of competing paradigms (Guba & Lincoln, 2005), so the researcher needs to clearly articulate the rationale for the choice of method and how the philosophical assumptions of the researcher are reflected in the chosen methodology. This chapter will explain the rationale for the choice of classical grounded theory methodology, how its philosophical basis is consistent with the researcher's own beliefs and how grounded theory methodology is most suited to addressing the research question.

3.2 Aims and origins of grounded theory

Grounded Theory was developed as a systematic method for obtaining and analysing data to generate theory to explain complex social phenomena (Glaser & Strauss, 1967). Glaser and Strauss (1967) believed that the prevailing logico-deductive and interpretive methods in sociological research stymied theory generation. Grounded Theory methodology arose out of a desire of the two authors, Barney Glaser and Anselm Strauss to move away from the dominant verificational paradigm concerned with testing the grand sociological theories of the time to allow a more inductive method (Charmaz, 2008) that generates substantive sociological theory from data. Grounded theory analyses data in a systematic way to generate conceptual categories and then to integrate these categories into a framework or substantive theory (Glaser & Strauss, 1967; Glaser, 1978). In this way the theory is *grounded* in the data obtained. The inductive nature of Grounded Theory lends itself to nursing research by contributing to the development of nursing knowledge and theory including areas of practice about which little is known (Benton, 2000, p.153).

Although Grounded Theory studies can use both quantitative and qualitative data sources (Glaser & Strauss, 1967; Glaser, 1978), qualitative data is more frequently used. Grounded Theory has been described as one of the most commonly used qualitative research methods (Bryant and Charmaz, 2007) that uses inductive processes (Glaser and Strauss, 1967) to develop theory to explain basic psychological and social processes (Bryant and Charmaz, 2007). Grounded Theory has evolved since its original inception by Glaser and Strauss (1967) to include three main variations of the method including Glaserian (Glaser, 1967), Straussian (Strauss & Corbin, 1990) and Constructivist approaches (Charmaz, 2006), although other theoretical perspectives have also been used including postmodernism (Clarke, 2005) and realism (Dey, 1993). Glaser (1992) argues that his version of Grounded Theory is the correct method and that subsequent changes to the method by other researchers do not constitute Grounded Theory. Thus, Grounded Theory has two predominant approaches to research-Glaser's method which is sometimes referred to as 'True',' Classic' or 'Glaserian' Grounded Theory and Corbin & Strauss's (2008) interpretive approach to Grounded Theory methods which Glaser labels 'Forced Conceptual Description' or 'Qualitative Data Analysis' (Glaser, 1992). The further emergence of Constructivist Grounded Theory as a contemporary approach to the method (Charmaz, 2008) emphasises how the method has been modified and evolved.

3.3 Paradigms associated with grounded theory

This section discusses the prevailing paradigms underpinning Grounded Theory including Post-positivism and Constructivism along with their associated ontological, epistemological and methodological assumptions. The philosophical beliefs underlying the different versions of grounded theory are examined and the rationale for the choice of Classical or Glaserian Grounded Theory for this study is discussed. When choosing and operationalising a grounded theory approach, the researcher is faced with the philosophical and methodological controversies and debates surrounding this methodology. The evolution of grounded theory has compounded this confusion by introducing multiple versions of grounded theory each with

their own paradigmatic assumptions and beliefs. This has been referred to as the 'methodological mire' surrounding grounded theory (Breckenridge, *et al.*, 2012). Glaser's position on the ontology and epistemology of the classical form of grounded theory is that it can be adapted to suit whatever paradigmatic assumptions the researcher has or needs to make (Glaser, 2005; Holton, 2008). This is in direct variance however, with Guba and Lincolns' (1994) assertion that the choice of paradigm is more important than questions of method, as it is the underlying paradigm or philosophical beliefs of the researcher that will dictate the relevant ontology, epistemology and choice of method. Glaser's views could be argued as being pragmatic in origin where issues relating to ontology, epistemology and methodology are secondary to the utility of the solution and multiple methods of achieving this aim are acceptable in the resolution of the problem (Creswell, 2009). However, Glaser has attracted much criticism for this stance as it is considered vague and uninformed of key concerns regarding knowledge and methodological rigour in research (Bryant, 2003).

Another area of controversy in grounded theory relates to the philosophical basis of grounded theory. It has been frequently asserted that the philosophical assumptions underpinning Grounded Theory are based on the constructivist paradigm and symbolic interactionism (Annells, 1996; Locke, 2001; Goulding, 2002; Holloway & Wheeler, 2004; Clarke, 2005). This may be true of the numerous contemporary forms of Grounded Theory (Strauss & Corbin, 1990; Clarke, 2005, Bryant & Charmaz, 2007; Corbin & Strauss, 2008; Charmaz, 2008) that have been developed in recent times. However, these paradigmatic assumptions do not fit with classical grounded theory and do not reflect the historical origins of the original method. Indeed, the roots of Classical or Glaserian grounded theory are more closely aligned with the philosophical assumptions of post-positivism and critical realism (Annells, 1996; Annells, 1997; Lincoln & Guba, 2005; Mills, *et al.*, 2007).

The positivist paradigm considers that reality does exist as a structured and ordered phenomenon that can be studied and observed. Reality exists

objectively and independently of human thought. This paradigm is often associated with modernism and the scientific method (Dash, 2005) and quantitative approaches to research (Polit & Beck, 2012) which seek to conduct research in an objective manner by acknowledging and controlling or removing the influence of the researcher on the subject. This approach employs logical deduction which seeks to test or verify theories by analysing data statistically and then generalising the results to the wider population. Post-positivism asserts that reality is imperfectly attainable due to the limitations of human understanding (Guba & Lincoln, 1994). Post positivist research acknowledges that it is impossible to remove the influence of the researcher on the subject phenomena completely to obtain a purely objective result and therefore seeks a more realistic approach by attempting to control this influence in so far as is possible.

Glaser's classical form of grounded theory has been described as having post positivist ontological roots based on pragmatism and which leans toward an ontology of critical realism[4] (Annells, 1996). In other words, Glaser's form of grounded theory is predicated on the belief that reality exists but cannot be fully realised. Critical realism attempts to take steps to ensure that reality is understood by humans as closely as possible to the true nature of reality by eliminating error (Guba & Lincoln, 1994). The epistemology of classical grounded theory has been described as a modified dualist objectivist view that objectivity is incompletely attained but is a goal to strive for. This modified objectivist epistemology uses canons of knowledge as a measure against which new findings are compared to ensure the replication of findings. Findings are also subject to the principle of falsification where they may be proven wrong by further research. The methodology of Glaserian grounded theory assumes discovery of findings (Guba & Lincoln, 1994) which is subsequently verified by sequential research (Annells, 1996).

[4] Critical Realism is the ontology associated with post-positivism. Critical realism holds that reality exists but is imperfectly apprehendable because of the limits of human intellect and the intractable nature of phenomena being studied. Reality is subjected to the widest possible critical examination to ensure that reality is understood as closely as possible (without being fully apprehendable) Guba & Lincoln, 2005)

Strauss and Corbin's (1990) version of grounded theory can be described as having a post positivist, critical realist ontology which states that reality exists but can only be partly apprehended (Annells, 1996a)due to the cognitive limitations of man. Glaser (1992) argues that the focus on verification of the data in Strauss and Corbin's version (Guba & Lincoln, 1989) is a post positivist trait (Annells, 1996a). Strauss and Corbin's (1990) version of grounded theory has also been influenced by a pragmatic ideology, in part due to Strauss's sociological training. This is evidenced in the modification of some of the purist ideas of the original work (Glaser & Strauss, 1967). There is also a move towards relativist ontology, especially in Corbin & Strauss's (2008) later iteration of the method. This version of grounded theory has a subjectivist epistemology with researcher influencing the data and using their experience to inform coding and theoretical sensitivity. There is a definite interpretive stance in Strauss and Corbin's (1990) version where the researcher's perspective colours the interpretation of the data (Annells, 1996a). It has been argued that this assertion that the researcher constructs a theory rather than discovering it is a tenet of the constructivist paradigm (Mills, *et al.*, 2006). Methodology in this version of grounded theory is heavily influenced by the symbolic interactionist[5] philosophy of Blumer (1998) and involves both inductive and deductive methods. Methods of verification of the grounded theory are built into the methodological framework.

Charmaz's (2006) version of grounded theory adheres to tenets of the constructivist paradigm which views reality as less reductionist and more socially complex. Constructivist researchers believe that reality exists in the individual's construction of reality (Dash, 2005) and that there is no objective reality removed from the reality which we perceive and construct in our own minds. Therefore, constructivism asserts that reality is socially constructed by the individual (Guba & Lincoln, 1994) and is relative (Mills,

[5] Symbolic Interactionism is a theory of human behaviour based upon the teachings of George Herbert Mead (1962) and Herbert Blumer (1969) which holds that human interaction is based upon the interpretation of actions by individuals and that the symbolic meaning of objects and behaviours for the individual will dictate how the individual interprets and reacts to others.

et al., 2007). Constructivism contends that reality is complex with multiple realities possible because events can be interpreted in multiple ways (Guba & Lincoln, 1994; Dash, 2005). Therefore, the constructivist approach considers reality in terms of the context of interaction between the researcher and subject and how we interpret these interactions and construct meanings from them. It is the individual interpretation of interaction and the meaning attached to such interaction that affects the social reality of subjects as described by the constructivist paradigm. This social interaction and its associated meaning are known as symbolic interactionism (Blumer, 1998). As there may be many interpretations of an incident or phenomenon, it follows that there are multiple realities or experiences of that phenomenon. Constructivist epistemology views research findings and knowledge as co-constructed by the interaction of the researcher and participant (Guba & Lincoln, 1994). Epistemology is transactional (Mills, *et al.*, 2007) and subjective and influenced by the researcher's experiences and thoughts. Constructivist methodology is dialectical with the researcher as a passionate participant who discusses and argues the findings with the participant to help construct a consensus of meaning (Lincoln & Guba, 2005). A comparison of the ontological, epistemological and methodological differences that exist between the multiple versions of grounded theory is demonstrated in Table 3.1 (adapted from Annells, 1996; Lincoln & Guba, 2005).

Table 3.1 Paradigmatic differences between grounded theory versions

	Ontology	Epistemology	Methodology
Glaserian	Critical Realism	Modified dualist/ objectivist	Exploratory/ Inductive/ Emergence
Strauss & Corbin	Relativism/ Critical Realism/Post Positivism	Subjectivist/ Interpretive	Symbolic interactionist/ Inductive/Deductive/ Verificational
Constructivist	Relativism	Transactional/ subjectivist	Dialectical

Attempts have been made to fit classical grounded theory into numerous different paradigms that are congruent with the philosophical origins of the method (Annells, 1996; Locke, 2001; Goulding, 2002; Holloway & Wheeler, 2004; Clarke, 2005; Nathaniel, 2011) and associated ontological and epistemological assumptions. However, there is no philosophical basis whatsoever for trying to force scientific methods into these paradigms (Paley and Lilford, 2011). So, the question arises, if grounded theory is associated with multiple research paradigms and attempts to arrive at a consensus on the philosophical basis have failed, how does the researcher address the questions of paradigm and research methodology? Kuhn (1970) asserts that the only logical way to view scientific research paradigms is from a historical perspective. This approach has utility when applied to the paradigmatic controversies surrounding grounded theory. Grounded theory started as a single method based upon the work of Glaser and Strauss in Discovery of Grounded Theory (1967). Since its initial development, Grounded Theory methodology has evolved and has been modified by researchers into several different research methods. Indeed, not alone have qualitative methods such as grounded theory arisen in a historical context, they have also been shaped by this historical context and have changed over time (Annells, 1996a). In the evolution of grounded theory, this historical context was primarily related to the paradigm wars of differing research perspectives (Denzin, 2010). The emergence of the grounded theory method occurred during the second moment of qualitative research (Annells, 1996a) and the emergence of the first paradigm war (1950-1970) which was comprised of the debunking of positivism and the ascendance of qualitative paradigms (Denzin, 2010). *The Discovery of Grounded Theory* (Glaser and Strauss, 1967) was part of this ascendance of qualitative research and went even further in that is sought to revolutionise the conduct of sociological research by moving it away from theory verification and towards theory generation. Glaser and Strauss's (1967) seminal work transformed qualitative research and showed that qualitative research methods could be systematic, rigorous and structured (Annells, 1996a; Charmaz, 2006).

In summary, the philosophical assumptions that underpin grounded theory have been described as existing in a methodological spiral from positivism to post modernism (Mills, *et al.*, 2007) reflecting the historical differences between versions of grounded theory based upon their historical contexts. This methodological spiral in grounded theory reflects a wide diversity of paradigmatic assumptions. There is no one paradigm or philosophy that explains grounded theory methodology. Therefore, the grounded theory version chosen for research should be dictated by the researcher's own philosophical beliefs relating to ontology, epistemology and methodology and by the nature of the research question. If the aim of a research study is to describe concepts in detail, then Strauss and Corbin's and Charmaz models may be used. If the aim of the study is to generate a substantive theory that explains the main concern of individuals, then any of the three main versions of grounded theory (Glaser, Strauss & Corbin, Charmaz) may be used. However, Glaser (1992) argues that his version of Grounded Theory is the correct method and that subsequent changes to the method by other researchers do not constitute Grounded Theory and are what he calls Qualitative Data Analysis or Forced Conceptual Description.

3.4. Rationale for choosing Grounded Theory

Grounded Theory is inductive in nature (Melia, 2011) and involves the 'discovery' of participants' main concern and how they resolve this main concern (Glaser, 1978). Grounded Theory also allows for the inductive generation of knowledge and theory (Melia, 2011) and suits the exploration of a topic (Hernandez, 2008) about which little is known. This method seemed to fit with the issue of moral distress among emergency nurses given the lack of conceptual clarity around moral distress described in Chapter 2.

In this study, grounded theory was the chosen methodology from the beginning as it allows a deeper understanding of the underlying problems of participants (Chenitz & Swanson, 1986; Hernandez, 2010) and their subsequent behaviour. Grounded theory appeared to be a natural choice given its suitability for explaining social issues and interaction between

individuals (Benoliel, 1996), the processes involved and the meaning attributed to these interactions. The inductive nature of Grounded Theory lends itself to nursing research by contributing to the development of nursing knowledge and theory including areas of practice about which little is known (Benton, 2000, p.153). It could be argued that the 'fit' between the researcher and the method occurred at the methodological level.

Initially, the author read Corbin & Strauss's (2008) third edition of *Basics of Qualitative Research*. Difficulties emerged almost immediately as the application of the conditional matrix to data analysis appeared to be forcing the data analysis. Furthermore, the multiple processes for data analysis were confusing and seemed arbitrary. This confusion prompted the author to seek the original seminal work of Glaser and Strauss (1967) on the Discovery of Grounded Theory and then to Glaser's further elaboration of the method in Theoretical Sensitivity (1978). These writings were clearer to the author and described a more open analysis of the data in the spirit of discovery described in the original grounded theory methodology (Glaser and Strauss, 1967). Glaser's dictum to remain open to the data and to avoid forcing also seemed to be a more open form of data analysis. Therefore, the decision was made that classical or Glaserian grounded theory would be the research methodology used.

Classical grounded theory adopts an inductive and radical (Moore, 2009) approach to research and seeks to inductively generate theory (Melia, 2011) whereas other grounded theory versions seek a more verificational (Melia, 2011) deductive (Heath & Cowley, 2004) and descriptive (Hernandez, 2008) approach. Classical grounded theory is concordant with the goal of discovery, with the focus on 'what's going on?' in the study aim and with the inductive generation of data which reflects the participants' main concern and its resolution. Furthermore, classical grounded theory (Glaser & Strauss, 1967; Glaser, 1978) has an associated epistemology which describes a modified objectivist view where objectivity is not fully apprehendable but as something to strive for. I further agree with Glaser's methodological dictum to allow findings emerge from the data (Glaser &

Strauss, 1967) without preconception or forcing (Glaser, 1998; 2001; 2005; 2011; 2013) which fits with this modified dualist/objectivist epistemology and fit with the methodological aim of the study which was to understand the concepts relating to moral distress and how it affected emergency nurses.

3.5 Implementation of the Grounded Theory Method

Grounded Theory is a systematic framework for the collection and analysis of quantitative or qualitative data to generate theory directly from the data (Glaser & Strauss, 1967). In addition, Grounded Theory involves the simultaneous collection and analysis of data (Glaser & Strauss, 1967; Glaser, 1978). This results in the research process progressing in a non-linear fashion with data collection and analysis taking place even at the very end of the study after the theory has developed in order to clarify or develop a point (Glaser & Strauss, 1967).

The main procedures of grounded theory are:

- Theoretical Sensitivity
- Theoretical Sampling
- Data collection
- Data analysis
- Constant Comparison method
- Theoretical Coding
- Memo writing
- Theoretical sorting and Theory generation
- Identification of a core category
- Theoretical saturation
- Theory integration

(Glaser & Strauss, 1967; Glaser, 1978; 1998)

The differences in implementation of the method according to the Classical, Strauss & Corbin and Constructivist versions of grounded theory will now be discussed along with a description of the implementation of the Classical or Glaserian version used in this study.

3.5.1 Theoretical Sensitivity

Theoretical sensitivity is developed in subtly different ways between the alternate versions of grounded theory. Theoretical sensitivity develops continually during a researcher's career and describes the process encountered when one thinks in theoretical terms and questions extant theories in terms of their type or structure (Glaser & Strauss, 1967). Theoretical sensitivity also involves insight into the area of interest and how these insights are used to inform research. Theoretical sensitivity should involve a wide reading of grounded theory studies to sensitise the researcher to as many potential theoretical codes (Glaser, 1978) as possible. Classical Grounded Theory methodology does not advocate a detailed initial literature review prior to data collection as this has the potential to stifle creativity, theory generation and reinforce preconceptions about the area of study (Glaser, 1992; Glaser & Strauss, 2009). Instead the researcher develops a conceptual overview of the main topics or issues relating to the area of study. This gives the researcher a starting point from which to begin data collection. A more detailed examination of the literature is conducted after the initial theory has been generated. This allows the researcher to focus the review to literature that will inform and clarify the evolving theory and reduce literature overload (Glaser, 2001). The literature then becomes data or as Glaser (2001) remarked 'All is data'. In other words the literature is then used as a rich and diverse source of data that allows the researcher to compare the emerging theory with existing theories in the substantive area of study.

The differences in approach to theoretical sensitivity have been misconstrued and misrepresented in the literature to form an overly simplistic and fractious view of the use of the literature by the alternate versions of grounded theory (Urquhart, 2001). A preliminary literature review to inform theoretical sensitivity is recommended by Strauss & Corbin (1990). It has been suggested that Glaser (1992) advocates that no literature review should take place prior to data collection (Stern, 1980; Stern, *et al.*, 1982; Stern & Allen, 1984; Lincoln & Guba, 1985; Stern, 1994; Strauss & Corbin, 1998; Hickey, 1997; McCann & Clark, 2003).

However, this is a misrepresentation of Glaser's position. Glaser has advocated avoiding a literature review of the substantive area of interest to avoid preconception (Glaser, 1978; 1992). He does advocate reading a wide body of literature including sociological and grounded theory works to develop theoretical sensitivity for potential theoretical codes (Glaser, 1978). Furthermore, it has been argued that familiarity with the substantive literature in an area of interest may be inevitable (McCallin, 2003) and that personal or professional experience of the area being studied could inform theoretical sensitivity (Strauss & Corbin, 1998). However, this is not necessarily a problem in Glaser's (1967; 1978; 1998) version either, once the researcher treats the preconceived literature as data for coding which must earn its relevance to the theory through constant comparison with concepts (McCallin, 2003; Holton, 2009; Glaser, 2013) and not as a source of concepts with preconceived relevance for automatic inclusion in the theory (Christiansen, 2008).

Both Glaser & Strauss's (1967) and Strauss & Corbin's (1990) versions of grounded theory aim to develop theoretical sensitivity through the use of the literature review. The difference between the versions in this regard is at the methodological level and how this goal of theoretical sensitivity is achieved (Urquhart, 2001). Glaser argues that the completion of a literature review would have the effect of narrowing the researcher’s viewpoint and focusing his attention on pre-conceived theories and ideas (Glaser & Strauss, 1967; Glaser, 1992). The abundance of literature on a subject may also suffocate the development of codes by the researcher by inundating him with vast quantities of irrelevant codes. However, once data collection has started and data is being codified, the method will dictate a detailed review of the literature arising *from the data* and determined by the data (Glaser, 1992). Theoretical sampling of the literature will result in a more focused literature review, with the literature becoming an additional source of data which informs and clarifies the emerging theory (Glaser, 1992). Glaser (1998) has further clarified his position on the use of the literature by stating that 'all is data' and that the literature becomes data to be coded and compared to the emerging theory to earn its relevance in the theory. However, in classical

grounded theory it is important to postpone the literature review until after the identification of a core category to avoid preconceiving theoretical codes (Holton, 2009).

Theoretical sensitivity also involves developing sufficient knowledge of general sociological theory to enable the researcher to identify potential theoretical codes from the data. Glaser (1978) argues that theoretical sensitivity is necessary in Grounded Theory as it trains the researcher to identify and codify important data from the study. Training in sociological research methods is the preferred method of achieving this theoretical sensitivity (Glaser, 1992). This is not possible or practical in the case of the researcher who is conducting this study in fulfilment of a PhD in Nursing. However, Glaser (1992) argues that theoretical sensitivity can also be achieved by studying the core Grounded Theory texts (The Discovery of Grounded Theory, Theoretical Sensitivity), and by becoming familiar with substantive and formal Grounded Theory studies in journals or in the numerous reader series of books. In addition, Glaser (1992) advocates the reading of *unrelated literature* at the beginning of the study to improve theoretical sensitivity to assist with conceptualisation of data and theoretical coding. Furthermore, theoretical sensitivity is derived from the researcher's own personal and professional experience as a nurse which facilitates familiarity with contemporary issues in the area of the substantive study (Glaser, 1992). Theoretical sensitivity is a gradual continuous process and continues throughout the researcher's career as theoretical insights are developed from the researcher's practice and professional experience (Glaser & Strauss, 1967).

3.5.2 Theoretical Sampling

In grounded theories, sampling has been described as being either theoretical (Glaser & Strauss, 1967; Glaser, 1978; Becker, 1993) or purposeful (Lincoln & Guba, 1985, Morse, 1991). Theoretical sampling indicates that the sampling is guided by a theoretical perspective (Glaser, 1978) or by the emerging theory (Sandelowski, *et al.*, 1992; Coyne, 1997; Cutcliffe, 2000). Purposeful sampling involves deciding to sample a

particular group based upon a preconceived set of ideas relating to the study group (Cutcliffe, 2000). However, when beginning a study, the researcher has no theoretical framework or emergent theory to guide sampling, therefore, the initial phase of sampling must be guided by a general perspective or by sampling from the same substantive group (Glaser & Strauss, 1967). Therefore, the initial sampling in grounded theory is purposive for this reason (Baker, *et al.*, 1992; Morse, 1991) as it involves seeking out individuals who are likely to have experienced the study phenomenon or one who has the knowledge, experience and time to participate (Morse, 1991). This is in keeping with Glaser's (1978) advice that initial sampling is based upon a general subject area. Therefore, initial sampling in a grounded theory study must be purposive (Cutcliffe, 2000) as it involves sampling individuals who have experienced the phenomenon (Hutchinson, 1993; Cutcliffe, 2000). However, the initial purposive sampling is replaced by theoretical sampling later in the study as the emergent theory acts as a guide for and delimits additional sampling (Sandelowski, *et al.*, 1992; Coyne, 1997; Cutcliffe, 2000). Again, this approach is supported by Glaser & Strauss (1967) who state that for a substantive theory the participants sampled should belong to that substantive group or type.

Furthermore, initial data collection is informed by the researcher's general area of study and by the existing literature and theoretical sensitivity of the researcher (Glaser, 1992; Glaser & Strauss, 2009). Once the researcher has started to collect and analyse data using open coding, categories and an initial theory will start to develop. Further, data collection is guided by the principle of theoretical sampling. Theoretical sampling in grounded theory methodology involves the use of emergent codes from the research data to dictate and guide further data collection (Cutcliffe, 2000; Glaser & Strauss, 2009). Theoretical sampling is the process of data collection for generating theory where the researcher concurrently collects, codes and analyses the data and then uses this analysis to decide what data to collect next and where to sample for that data (Glaser & Strauss, 1967 p.45). This process ensures that the grounded theory is constantly developed by each stage of

data collection and analysis (Glaser & Strauss, 1967 p.45). Therefore data collection is controlled by the emerging theory and the emerging theory is grounded in and developed by each stage of data collection and analysis (Glaser & Strauss, 1967). In effect, the researcher is asking of the emerging concepts and theoretical framework: What groups do I sample for next? What theoretical purpose does sampling this group serve? (Glaser & Strauss, 1967 p.47). In theoretical sampling, sampling of groups and participants is directed by the theoretical relevance that those groups may have to the emerging theory or conceptual framework (Glaser & Strauss, 1967 p.49). In this way, theoretical sampling constantly focuses and delimits the collection and analysis of data (Glaser, 1998). Groups and individuals are chosen according to their theoretical purpose and relevance (Glaser & Strauss, 2009) to provide comparison data (Benton, 2000) and not to fulfil pre-conceived methodological requirements (Glaser & Strauss, 2009). The details of data collection cannot be determined prior to commencement of the study as the process is dependent on the emerging theory to highlight areas that require further research and clarification (Benton, 2000; Glaser & Strauss, 2009).

The generation of substantive theory using the Grounded Theory method is facilitated by using theoretical sampling by choosing sample groups of the same substantive type initially (Cutcliffe, 2008) e. g. nurses experiencing moral distress and then by maximising differences between groups (Glaser & Strauss, 1967). As the substantive theory is completed, the researcher may develop middle range formal theories by using theoretical sampling to increase the differences between comparison groups by using sample groups with different substantive types (e.g. other professional groups experiencing moral distress) to highlight differences between the groups and incorporate these into the theory (Cutcliffe, 2008). This gives the formal theory more depth and adaptability (Glaser & Strauss, 2009). The purpose of this study was to generate a substantive theory of moral distress among emergency nurses.

3.5.3 Data Collection

Data collection is informed by the research study design and underlying philosophical paradigm. Qualitative research methods frequently use participant interviews, field observations and documentary evidence as data sources (Holloway & Wheeler, 2004). However, Grounded Theory methodology is unlike some other qualitative methodologies in that it can be based on one or several sources of data (Glaser, 1978). Indeed, Glaser (1978, 2001) argues that 'All is Data' and advocates the use of a diverse range of data including quantitative and qualitative sources, literature as data, informal interviews, correspondence, field notes and memos. However, the initial data collection method used is frequently participant interview combined with observation. Other data sources should only be used once the initial concepts have begun to emerge and serve to develop, guide and inform the emerging theory (Glaser, 1978).

3.5.4 Interview

While formal structured interviews and informal unstructured interviews have both been used to collect data for previous grounded theory studies (Chenitz & Swanson, 1986; Bowers, 1988), unstructured interviews are considered more appropriate as they allow participants to voice their main concern (Wimpenny & Gass, 2000) without being led with preconceived theoretical frameworks or pet theoretical codes (Glaser & Strauss, 1967; Glaser, 2001; 2005; 2011). These unstructured conversational interviews are more akin to guided conversation (Rubin & Rubin, 1995) or conversations with purpose (Burgess, 1984). In keeping with classical grounded theory, informal interviews and observation were the chosen data collection methods employed in this study. The implementation of unstructured interviews and the use of observation as a data source are described in detail in Chapter 4. Initial purposeful sampling was replaced by theoretical sampling which guided data collection as soon as a theoretical framework began to emerge.

Research interviews have been described as conversations involving the narrative of the participant and the questions of the researcher (Ryan, et al.,

2009). Several types of interview exist and the choice of interview type is based on the research question and methodology. Types of interview include the highly structured interview, semi-structured interviews and open-ended in-depth interviews (Holloway & Wheeler, 2002; Polit & Beck, 2012). Highly structured interviews employ an interview schedule where questions are asked in the same order and in the same way for each subject (Holloway & Wheeler, 2002). Semi-structured interviews employ a general interview guide which contains the key topics to be covered in the interview (Holloway & Wheeler, 2002). This allows a certain amount of freedom in the order in which questions are asked, how they are asked and the emphasis put on questions to allow the interviewer adapt the questions as the interview or study progresses (Holloway & Wheeler, 2002). Unstructured interviews are more conversational in nature and the interviewer allows the subject to guide the interview and discuss their main concern rather than seeking to direct the conversation towards a particular subject matter. In this study, unstructured interviews were used as there was very little is known about the phenomenon of moral distress among emergency nurses (Polit & Beck, 2012). Unstructured interviews were also used in keeping with Glaser's (1978; 1998) thinking and recommendation that the use of unstructured conversational-like interviews to allow the main concern of participants to emerge without preconception or forcing.

Preconception is a particular problem among the practice based professions such as nursing where researchers frequently have a broad knowledge of the many issues facing a particular practice area. Therefore, interviews in a Grounded Theory study should be unstructured to avoid the researcher forcing their own pre-conception on any emerging data and to allow the participant to talk about the basic social process that is their primary concern (Glaser, 1978). Interview schedules or guides may act to constrain theoretical sampling by not allowing the data to dictate the direction of the interview (Glaser, 1998). Indeed, Corbin and Strauss (2008) further argue that unstructured interviews tend to provide the densest data in qualitative research. Morse (2001) argues that individual, open-ended in-depth interviews are required to allow the participant the opportunity to explore

complex social processes in a meaningful way. Unstructured interviews are not structured around a preconceived list of questions and instead allow the participant to tell their story in a more relaxed, conversational manner. However, even in the unstructured interview there are identifiable structures and contexts that influence the process. These include a clearly identifiable interviewer, interviewee, setting, context and topic for discussion (Fontana & Frey, 2000). As this study is employing the discovery mode of grounded theory, a broad 'Grand Tour' question was used (Simmonds, 2010) to introduce the topic. This question was typically "What is it like for you to work as an Emergency Nurse?" In this study unstructured interviews were used to facilitate an informal conversational approach to encourage 'spill' from participants and to ensure that the main concern of participants was allowed to emerge. The only other question used was to ask the participants what was their main concern when working in the Emergency Department. This open interviewing technique minimised preconception and the forcing of theoretical codes and frameworks on to the data in keeping with Glaser's (2011; 2012) dictum of 'No Preconception'. This prevented the interviews from having a narrow biased agenda based on the researcher's own beliefs and preconceptions. In this way, the use of unstructured interviews allowed the salient aspects that constitute moral distress to be investigated among emergency nurses while also allowing the freedom to explore the main concern of the participant as advocated by Glaser (1967, 1978).

3.5.5 Observation

Observation of participants allows the researcher to observe behaviour in context to give meaning to the participant’s actions and to provide a social context for research data (Holloway & Wheeler, 2002) by providing insight into subject action and interaction. In addition to providing context for action, observation also provides information on the people involved in a given observed behaviour or action as well as information on the setting for the observed behaviour and the timing or frequency of behaviour (Jorgenson, 1989).

In addition, behavioural observation allows the researcher to formulate interview questions based on observed behaviour (McCann & Clark, 2003) to illicit further meaning and insight from the participant. Indeed, interview techniques also employ a certain amount of observational methods to read non-verbal behavioural cues from the participant which may better inform the interview process (Angrosino & Mays de Perez, 2000). In nursing research studies, observation allows behavioural phenomena to be observed in a natural setting and records the context of the setting including the physical environment (Mulhall, 2003). This method of natural observation was suited to this study as it facilitated the observation of nurses in the clinical setting where everyday issues were experienced and resolved.

Observation as a research method may be divided into two distinct forms- structured observation and unstructured observation (Mulhall, 2003). Structured observational methods seek to limit or eliminate the bias created by the researcher's presence in the field. However, even the most objective researcher cannot eliminate the potential bias introduced by his very presence in the field. Therefore, the question arises as to whether objective observational methods are desirable or even truly possible. Research participants may, of course behave in the way that they believe the researcher wants them to behave and may alter their behaviour based on the context of the interaction between the observer and participant, rather than on any situational or cultural context (Angrosino & Mays de Perez, 2000).

In determining the type of observational practice to be used in this study, the researcher used Casey's (2004) framework to decide what elements of observation were appropriate for this study. In describing the challenges of using observation as a research tool, Casey (2004) uses the following framework of questions to guide the use of observation as a data collection tool:

1. What type of observation practice (using Gold's (1958) framework) should the researcher employ?

Gold (1958) identifies four types of observation practice

- The complete participant.

In this role the researcher's identity is hidden from the research subjects as the researcher seeks to become part of the group under observation and to become accepted in to its culture.

- The participant as observer

  The researcher's identity is known to the research subjects and the researcher seeks to be accepted as part of the subject group to learn about the phenomenon under study.

- The observer as participant

  In this case the researcher has limited time with the subject group and does not seek to become part of the culture of the group but rather to observe or study it for a short period of time. The researcher may take a limited part in the group's activity by being in the same location but does not become integrated into the group (Holloway & Wheeler, 2002).

- The complete observer

  The researcher observes the phenomenon taking place without having any part in it.

In practice, observation is conducted as part of a continuum from complete participant to complete observer (Hammersley & Atkinson, 1995) and the amount of researcher/subject interaction will vary according to the research setting and research question (Mays & Pope, 1995). The non-participant observer role is most frequently used in nursing research studies (Casey, 2004) to yield a fuller picture of context specific behaviour. In this study the researcher chose the observer as participant as a guide for observation practice as the intended goal as the aim was to observe nurses' practice for indicators of relevant codes identified in early interviews and to stay open to other emergent codes. The researcher did not aim to become part of the subject group but rather sought to observe for participant behaviours and contextual codes.

2. Should the researcher use structured or unstructured observational tools?

Observational practice may also be classified according to whether the observation is structured or unstructured. Structured observational tools are

used when the subject matter is known and the researcher seeks to assess the extent to which the subject occurs in the field (Polit, et al., 2000). Unstructured observations are used when little is known about the subject area and does not use pre-defined categories but allow categories emerge from the data (Polit, et al., 2000). The unstructured method of observation fitted with the subject matter of this study where the researcher was investigating phenomena about which little was known in a previously unexamined setting. Unstructured observation also fits well with Glaser's assertions that Grounded Theory methodology and method are based on the premise that categories should emerge inductively from the data without being 'forced' in to pre-conceived frameworks. However, initial emergent concepts were used to develop theoretical sensitivity and to theoretically sample for emergent concepts while observing nurses in practice.

3. Should the observational tool be molar or molecular?

Molar observational tools are unstructured in nature and seek to capture the wider context of observed phenomena including non-verbal behaviour while molecular tools are highly structured observational tools and seek to observe in more detail the subject phenomena (Polit & Hungler, 1999). Molar tools are more likely to capture the social context of behaviour but also have an increased risk of observer error due to the lack of structure in the observation (Polit & Hungler, 1999). Molecular tools are less prone to observer error but may miss the wider context of behaviour. As this study sought to examine the underlying social processes involved in the area of study, a molar observational tool was used. Molecular tools were deemed unsuitable for this study as little was known of the area of interest in Emergency Departments and therefore detailed observational tools would be difficult to construct. Molar tools are more frequently used in the observation of human behaviour (Nolan, et al., 1995) and were used in this study to increase the likelihood that all elements of the basic social process being studied were captured.

4. What would be the best way of collecting the data?

In this study it was decided that the best way of collecting observational data was to use field notes followed by memo writing as soon as possible after the period of observation. This allowed the recording of important

events by using key words which were then elaborated upon at the end of the observation period. This addresses the tension that usually exists between trying to capture the data as it occurs without missing the actual event being observed while recording the data (Huxham and Vangen, 2003). It was decided not to employ the use of audio or video equipment for the purposes of recording observational data as the unit of observation was the behaviour of the nurse and not the individual. In addition, it was felt that the use of such recording equipment was likely to make nurses uncomfortable and less likely to consent to observation of clinical practice. Furthermore, the recording of nurses in clinical practice through the use of video or audio tapes would have raised serious ethical issues and necessitated the seeking of consent from all of the individuals present, including patients. This was deemed to be too intrusive to the workings of an Emergency Department and had the potential to cause distress or unnecessary worry for seriously ill patients who might not be in a position to give fully informed consent.

5. What observational position should be adopted?

There are three types of positioning in observational research; single positioning, multiple positioning, and mobile positioning (Polit, et al., 2001). Single positioning involves the researcher staying in one position and observing behaviour from a single vantage point only. Multiple positioning involves the researcher moving around the study site to observe multiple behaviours from multiple positions. Mobile positioning involves the researcher following an individual around the study site to observe the individuals behaviour over a period of time.

As the goal in this study is to observe the social and behavioural context involved when an individual nurse deals with difficult clinical situations, it made sense to employ mobile positioning as an observational strategy.

6. Should time or event sampling be used?

There are two sampling strategies employed by researchers to observe a phenomena time and event sampling (Polit, et al., 2001). Event sampling involves observation of a particular event or interaction whereas time sampling involves observation over a period of time to detect an interaction or event. Emergency Departments by their very nature are busy, unpredictable research sites. It would have been difficult to employ event

sampling as it would not be possible to predict when a nurse would encounter the phenomenon being studied. Therefore, time sampling was employed to increase the chance of the researcher observing the subject of interest over a period of time.

7. How long should the observational sessions in the field be?

Observational sessions need to be long enough to detect the phenomena being studied without causing undue researcher fatigue by allowing rest breaks (Hewison, 1995). There seems to be little consensus in the preferred length of time for an observational period with reported time spans ranging from as little as 10 minutes (Laitinen, et al., 2011) to 10 hours (Sorenson, et al., 2013).

3.5.6 Data Analysis

Data analysis in a grounded theory study is conducted using a variety of data analysis techniques and is performed concurrently with data collection. Data analysis begins as soon as the data from the first interview or observation is available and continues throughout the study until the grounded theory is developed (Hernandez, 2010). Data analysis begins with open coding which involves comparing incidents of behaviour to other incidents[6] of behaviour (Glaser & Strauss, 1967; Glaser, 1978). This allows for patterns of incidents to emerge from the data. Patterns of incidents then form concepts. A concept (sometimes referred to as a code) is the naming of an emergent social or psychological pattern generated by comparing many indicators of the pattern (Glaser, 2011). Constant comparison of concepts will help develop the relationship between concepts (Glaser, 1978). As coding develops and concepts emerge, coding moves from open to selective coding. Selective coding involves theoretically sampling for a concept. This allows further properties of the concept to emerge from the data and allows for tentative relationships between concepts to emerge. As a concept develops more properties and is related to other concepts, the concept may be elevated to the level of a category. A category then, is a well developed concept whose properties have emerged from the data through constant

[6] An incident is a discrete example of a particular type of behaviour or an example of a particular code.

comparison. A category is a concept that has been abstracted from the data to a higher conceptual level (Glaser & Strauss, 1967). Finally, data analysis involves comparing concepts to concepts to elaborate on the relationships between concepts and to develop a theoretical framework (Glaser, 1978) to provide a theoretical order to the concepts. Analysis continues until the categories are theoretically saturated, i.e. no new properties of the category emerge and until the framework explains the relationship between categories and is explained by a core category that resolves the main concern of participants.

3.5.7 Constant Comparative method

The constant comparative method of qualitative analysis was first published by Glaser in 1965 - two years before the publication of Discovery of Grounded theory (Glaser and Straus, 1967). Constant comparative method involves continuously comparing incident to incident, concept to concept, category to category to elicit further properties from the data. Multiple indices of a behaviour, concept or property allow it to earn its place in the theory. Any concept or property that does not 'pattern out' (i.e. multiple indices are not found) is omitted from the theory (Glaser and Straus, 1967).

Constant comparative analysis checks findings against further data (Elliott & Lazenbatt, 2005) ensuring 'emergent fit' (Glaser, 1978) between new data and the substantive theory. In other words, the constant comparative method is 'self checking' and ensures that the research findings are truly representative of the subject being researched (Hutchinson, 1993; Elliott & Lazenbatt, 2005).

The constant comparative method generates multiple properties of codes and can clarify the relationships between categories giving rise to tentative theoretical codes. An integral part of the constant comparative method is the coding procedure adopted. Key differences exist in the implementation of coding strategies between Glaser (1978, 1998) and Strauss & Corbin (1990). Glaser recommends the use of open coding, selective coding and theoretical coding. Strauss & Corbin (1990) advocate the use of open coding, axial

coding and theoretical coding. The key difference between the methods is Strauss & Corbin's (1990) use of a coding matrix which gives primacy to the 6 Cs coding family of context, covariance, causes, contexts, consequences and contingencies. Corbin & Strauss (2008) have subsequently described the coding matrix as one of many analytical tools available to researchers. However, the proposition of recommended procedures for data analysis that may not have earned relevance to the theory has the potential to limit analysis to these preferred analytical codes and limit discovery.

Glaser would disagree with the importance placed upon this family of theoretical codes by Strauss & Corbin (1990) and would argue that it is merely one of many potential theoretical codes or families of codes. Glaser would further argue that by placing such an undue importance on a particular coding paradigm, the researcher risks preconceiving the data and over emphasising 'pet' or favourite theoretical codes. Glaser would view the coding paradigm advocated by Strauss & Corbin (1990) as a single theoretical lens through which one may interpret the data and that there are many alternate ways of coding and interpreting the data. The particular theoretical lens used to interpret the data should arise from the data, earn its relevance in the theory and be grounded in participants' experiences. Furthermore, while grounded theory was originally described as a predominantly inductive method (Glaser & Strauss, 1967; Glaser, 1978) with some deductive and verificational elements built into the method, Glaser would argue that Strauss & Corbin's (1990) version has shifted the emphasis from induction to deduction and verification (Glaser, 1992). This argument is supported by Strauss & Corbin's (1990) own assertion that their version of grounded theory involves 'verifying inductively what we proposed deductively'.

3.5.8 Theoretical Coding

Theoretical codes conceptualise how the substantive codes relate to each other and form the framework for the emergent theory by reconstructing the individual codes and categories into a theory that explains the resolution of a main concern (Glaser, 1998). Theoretical codes must pattern out in the

data and 'fit' with how the categories relate to one another. Otherwise the theoretical code is not grounded in the data and has not earned its place in the emergent theory. Theoretical coding is the process of comparing theoretical codes and frameworks to the data to check for emergent fit. A wide variety of theoretical codes minimises the risk of applying pet or favourite codes informed by experience or professional issues. Researchers develop a large repertoire of theoretical codes to use in grounded theory through developing theoretical sensitivity by reading a wide variety of grounded theories from different fields to gain exposure to as many theoretical codes as possible.

3.5.9 Memo writing

Memos are the record of ideas that emerge when coding data, relationships between data that occur to the researcher and initial theoretical codes (Glaser, 1992, 2001). Field notes or field memos assist the researcher to clarify and inform data while coding whereas theoretical memos are used to illustrate the decision making process and to assist in writing the substantive theory for presentation as a paper or thesis (Glaser, 1992). Memo writing forms a crucial part of data collection as it reminds the researcher of context, ideas and connections that occur at the time of data collection and analysis that might otherwise be lost from the study. The process of memo writing is integral to establishing elements of qualitative rigour such as fit (Glaser & Strauss, 1967; Glaser, 1992), dependability and confirmability (Chiovitti & Piran, 2003). The process of memo writing ensures qualitative rigour (Glaser & Strauss, 1967; Glaser, 1992; Chiovitti & Piran, 2003) as it supports the use of an audit trail to show key decisions and how the emergent theory develops (Guba & Lincoln, 1981, 1989; Cutcliffe & McKenna, 1999).

Glaser (1965) originally advocated the use of memos as a simple tool to facilitate reflection and analysis of the data. More recently, Glaser (2014) has expanded his thoughts on memoing to describe how memoing can be used to track the growth of grounded theory and to facilitate theoretical sorting of data. Glaser's (2014) more recent work on memoing seems to be

in response to calls for more methodological rigor (Elliott & Lazenbatt, 2005) in particular for qualitative methods (Cutcliffe & McKenna, 1999; 2004) including grounded theory. However, to be fair, the more recent thoughts on memoing from Glaser (2014) seem to be elaborations of previously held perceptions on the subject (Glaser, 1965; 1978; 1998; 2011).

3.5.10 Theoretical Sorting and Theory generation

Theoretical sorting refers to the process by which theoretical memos are conceptually ordered or sorted to facilitate the write up of the grounded theory (Glaser, 1978). Theoretical memos are grouped according to the categories to which they refer. These memos are then sorted into a workable draft summary of theoretical memos for each category. When these summaries are completed for each category, a further summary is conducted where all of these summaries are conceptually ordered according to the theoretical framework used for the study. The write up of these conceptual summaries of theoretical memos forms the first draft of the grounded theory. The conceptual ordering of the memo summaries allows for an integrated, concise and parsimonious theory to emerge (Glaser, 1978). As theoretical sorting progresses, different potential core categories emerge and theoretical codes are checked for emergent fit with the theory. Memos are written on the decisions made and on possible further theoretical codes and ideas. The constant re-fitting of theoretical codes through constant comparison with categories and conceptual frameworks facilitates this theoretical sorting of memos.

3.5.11 Identification of a core category

The identification of a core category is a fundamental part of grounded theory (Annells, 1996a) as the core category explains how participants resolve their main concern (Glaser & Strauss, 1967; Glaser, 1978, 1998). Such is the importance of the core category in a grounded theory study that discovering the core category has been described as the first stage of a grounded theory study and the clarification and delimitation of concepts related to the core category as the second stage of the method (Christiansen,

2008). The identification of the core category is achieved by fracturing the data into slices or indices of behaviour and then constantly comparing these indices to one another. The constant comparison of data allows patterns to emerge from the data. These patterns are called concepts which when compared to each other allow properties (concepts of concepts) and theoretical codes (or relationships between concepts) to emerge (Glaser & Strauss, 1967; Glaser, 1978; Christiansen, 2008). The core concept or core category is the one that has the most explanatory power (it explains the most categories) (Christiansen, 2008) and that explains the main concern of participants (Glaser & Strauss, 1967; Glaser, 1978; Christiansen, 2008).

3.5.12 Theoretical saturation

Theoretical saturation of a category occurs when no additional data is found that develops additional properties of a category. Theoretical saturation of the grounded theory occurs when there are no more properties of categories emerging from the data and the researcher finds multiple indices of the same categories and properties over and over again (Glaser & Strauss, 1967). As the researcher finds multiple indices or multiple indicators of properties, he becomes empirically confident that the category is saturated. Saturation is recognised when no new data emerges from interviews and findings are repeated (Morse, et al., 2002).

3.5.13 Theory integration

Theory integration involves situating the emergent theory in the pre-existing published research literature. This is done by constantly comparing the emergent theory to the literature and checking for emergent fit while modifying the theory to include elements of the literature. It is important that this engagement with the substantive literature is postponed until the theory has been well developed or at least until after the core category has been discovered to avoid preconceiving data analysis with themes from the literature (Glaser, 1998; 2011; 2013). After comparison with the literature, the resultant grounded theory is more rounded and relates the theory to previous theories and papers.

3.6 Methodological Rigour

Reliability and validity are core concepts in determining rigour in quantitative research (Burns and Grove, 2003) and as such have been criticised as having little relevance to qualitative studies (Parahoo, 2006). Some researchers argue that qualitative studies should be subjected to the same validity and reliability criteria as quantitative studies even though these criteria may not be directly applied to qualitative studies (Hammersley and Atkinson, 1995, Silverman, 2001). Qualitative research methods have been the subject of much criticism for lacking the objectivity of quantitative methodologies (Burns and Grove, 2003) and for being incomplete, subjective and impossible to verify (Altheide & Johnson, 1994). However, much of this criticism is due to the fact that qualitative studies are subjected to the same assessment rules as quantitative studies. This method of assessing the validity and reliability of qualitative research findings may be inappropriate (Horsburgh, 2003) because the desired outcome is different (Morse, 1987, Burns & Grove, 2003). Qualitative research requires a different approach to ensuring quality that does not impose positivist assumptions on qualitative findings (Benner & Wrubel, 1989; Morse, 1991; Beck, 1993; Denzin & Lincoln, 1994). Indeed, the criteria used to judge qualitative research methods should also take into account the philosophical assumptions of the method (Beck, 1993) so that rigor is assessed appropriately for the chosen method (Evertz, 2001; Patton, 2002). Therefore, qualitative research should be tested for credibility using criteria that have been developed specifically for qualitative findings (Beck, 1993; Cutcliffe & McKenna, 1999).

Glaser (1967, 1992) advocates a number of criteria for ensuring methodological quality including fit, work, relevance and modifiability. The combination of methodological rigour with interpretive rigour described by Cooney (2011) is a more reasoned and pragmatic approach to ensuring the credibility of findings in a grounded theory study. This approach is similar to the framework posited by Chirovitti & Piran (2003) and is congruent with the original approach recommended by Glaser & Strauss (1967). Furthermore, these indicators of methodological rigour and interpretive

rigour are concurrent with Glaser & Strauss's (1967) and Glaser's (1978, 1998) iterations of the method which argue that the method has methodological quality control mechanisms built in to the method (Elliott & Lazenbatt, 2005) and require only that the method is followed faithfully to ensure quality (Glaser & Strauss, 1967, Glaser, 1978, 1992). These grounded theory specific criteria for ensuring methodological rigour as described by Glaser & Strauss (1967) and Glaser (1992) include:

1. Fit: The theory generated must relate directly to the data from which it originated and must relate to the area in which it will be used.

2. Work/understanding: The theory must be easily understandable by participants or people working in the subject area.

3. Relevance: The theory must be applicable to a variety of situations and adaptable to changing contexts.

4. Modifiability: The theory must be adaptable to a changing reality over a period of time.

The use of grounded theory specific quality assurance criteria is recommended by Glaser & Strauss (1967), Glaser (1978, 1998) and by Elliott & Lazenbatt (2005). Cooney's (2011) assertion that artistic measures of quality such as vividness, congruence and sensitivity should also be included is in keeping with recommendations by Beck (1993) and Corbin & Strauss (1998) but not with Glaser & Strauss (1967) or Glaser's version (1978; 1998; 2001). Therefore, these additional measures should not be included in classical grounded theory methods as the method is self correcting (Elliott & Lazenbatt, 2005) and participant validation is itself subject to quality assurance issues (Sandelowski, 1995; Murphy, *et al.*, 1998; Seale, 1999).

3.7 Ethical Considerations

Principles for the conduct of ethical research have arisen mainly as a result of historical scandals involving the exploitation of participants in the

conduct of research where participants were treated as research subjects without due cognisance or recognition of their rights or needs as people or individuals (Emanuel, *et al.*, 2000). The first international code for the conduct of ethical research was the Nuremberg Code (Nuremberg Military Trial, 1947) followed by the Declaration of Helsinki (World Medical Organisation, 1964) and the Belmont Report (US Department of Health, Education, and Welfare, 1979). These frameworks for ethical research arose from the conduct of biomedical research and the resultant frameworks reflect this by emphasising the principles of consent, a favourable risk-benefit ratio and independent research protocol review (Emanuel, *et al.*, 2000).

Biomedical research ethics guidelines are based on the principles of objective scientific research. This dominant research paradigm with its associated detachment of researcher and participant does not allow for the subjectivity of some social research methods with their associated field related real-life ethical dilemmas (Munhall, 2007). It is not clear whether the same biomedical research ethical guidelines are appropriate for the conduct of social science research where there is no significant immediate or obvious risk to participants (Lipscomb, 2010). Behavioural research is generally regarded as minimal risk (Labott and Johnson 2004). Minimal risk involves the probability of and magnitude of potential harm in research is not greater than those encountered during the performance of routine physical or psychological examinations or test (Resnik, 2005). Labott and Johnson (2004) further argue that the risks involved in participant observation are the psychological and social risks encountered in daily life while Oeye, *et al.* (2007) argue that adherence to medical research guidelines is incongruous with participant observation methods. This friction between a biomedical research ethics model and the conduct of social science research methods (Oeye, *et al.*, 2007) has given rise to a scenario where medical research ethical guidelines in particular are viewed as obstructive to social science research methods (Oeye, *et al.*, 2007) which are frequently used in Nursing research.

Ethical considerations in research relate to the protection of the rights of participants in research and include the principles of beneficence, respect and justice (International Council of Nurses, 1996; Polit and Beck, 2012). The principle of beneficence implies that the conduct of research involving human participants should do no harm to the individual involved. The risk/ benefit ratio of the research should also be considered. In the context of this study, beneficence may be maintained by ensuring that the purpose of the study and its potential applications is explained in detail to the staff involved.

The principle of respect includes full disclosure of all facts to participants including real or potential risks and benefits of the research. This includes the right of participants to self-determination. In practical terms this implies the right for staff to withdraw from the study at any time. The principle of respect is maintained by emphasising the voluntary nature of the study and the participants' right to withdraw both at the meetings and in the information sheet supplied with each consent form.

The principle of respect for patients described by Emanuel, et al.'s (2000) requirements for ethical research is linked closely to the principle of non-malificence in human research as described in the Nuremberg code (Katz, 1996), the Declaration of Helsinki (World Medical Organisation, 1964) and the Belmont Report (US Department of Health, Education, and Welfare, 1979). This respect for study participants includes the principal of ensuring the welfare of research participants. Behavioural research is generally regarded as having minimal risk (Labott and Johnson 2004) for patients and the potential harm from participating in research that employs sociological data collection techniques of interviewing and observation is no more than the psychological and social risks encountered in daily life (Labott and Johnson (2004). However, in this study participants were asked to discuss clinical practice involving ethical and moral issues. Therefore, the possibility was considered that in the course of the interview process or period of clinical observation that the participant could discuss a topic involving an ethical issue from clinical practice that could result in some

emotional or psychological distress (Labott & Johnson, 2004). The risk/benefit ratio involved (Emanuel, et al., 2000) in discussing these issues was still considered to be overwhelmingly positive, as the potential distress involved was relatively unlikely to occur and should last a short time. Therefore, the proportionality of potential risk involved for the participant nurse (Emanuel, et al., 2000) was relatively minor.

The principle of justice would include the rights of participants to anonymity, confidentiality and informed consent (Polit and Beck, 2012). Justice was achieved by ensuring that the confidentiality and anonymity of the study participants was maintained. Participants were free to withdraw from the study at any time without fear of censure. Participants had the rights to privacy, anonymity, confidentiality; fair treatment and protection from harm honoured (International Council of Nurses, 1996; Emanuel, *et al.*, 2000). This may be achieved by securing all data collected on a password protected computer which has access restricted to the author only. In addition, all results, memos, digital recordings, field notes and paperwork relating to the study should be anonymised with no individual identifiable factors such as names or workplace included. Additionally, at a very early stage in the Grounded Theory research process, the focus of the research shifts from individual to the behavioural indicator or social process involved. This helps protect the privacy and anonymity of individual participants as it is the social process which is observed and coded and not the individual or any personal trait of the individual (Glaser & Strauss, 1967; Glaser, 1978).

Research ethics considers the application of ethical or moral values on the conduct of research whereas research governance is a broader concept that includes research ethics, scientific rigour, and dissemination of research information, health and safety of participants and researchers and financial management (Haigh, 2008 p.125-127). The broader concept of research governance as described by Haigh (2008) mirrors the requirements for ethical research described by Emanuel, *et al.* (2000). In order to address any ethical concerns relating to this study, the researcher adhered to the

research governance model described by Emanuel, *et al.* (2000) and used an 'ethics as process model' (Ramcharan & Cutcliffe, 2001). Emanuel, *et al.* (2000) set out a list of seven ethical requirements that should be met by any research study to ensure that it meets the appropriate ethical standards. Ramcharan & Cutcliffe (2001) propose a process model to conducting ethical research in the field where ethical concerns are not forgotten upon ethical approval by a research ethics committee or institutional review board, but rather that ethics is seen as a continuous process of monitoring for ethical problems, dealing with problems as they arise and ensuring ongoing consent for the conduct of research throughout the duration of the study. Both of these methods envisage the ethical conduct of research as an ongoing process that does not end when ethical approval has been granted by a research ethics committee. Emanuel, *et al.*'s (2000) describes 7 ethical requirements for research including:

1. Social or scientific value. Research should have the potential to bring social or scientific value. Otherwise, there is no point in conducting the research. A study may have potential social and societal value in explaining how nurses deal with difficult issues in the clinical setting. Grounded Theory identifies the main concern of participants but also identifies the solution to that concern in the form of a grounded substantive theory. It is envisaged that the grounded theory generated in this study may assist nurses and managers alike in understanding the difficulties associated with working in Emergency Departments.
2. Scientific validity. This study will adhere to the classical grounded theory method described by Glaser and Strauss (1967) and further developed by Glaser (1978). This method has been used widely and is widely published with accepted qualitative rigour. In addition, the methods proposed by Chiovitti & Piran (2003) to improve rigour in grounded theory were used to ensure fit and understanding of the study findings.
3. Fair subject selection. Nurses were invited to participate and were free to withdraw at any time. This ensured fair selection without coercion.

4. Favourable risk-benefit ratio. A study should not proceed where there is undue risk to participants or where there is questionable or negligible benefit. The risk-benefit ratio must be favourable i.e. the potential benefit should outweigh the potential risk of harm. This study confers potential benefits for individual nurses in gaining insight on to their own ethical practice and for the wider profession by helping explain a complex clinical and ethical phenomenon while subjecting participants to minimal potential risk of any distress.
5. Independent review. This study was subject to assessment from the relevant Research Ethics Committee.
6. Informed consent. Informed consent was sought from all participants in the study at each phase of the study and adequate time was given for explanation of the study. The consent process must allow adequate time for reflection (An Bord Altranais, 2007; Elwyn, 2008; Royal College of Nursing, 2011) to ensure fully informed consent (Elwyn, 2008). There is however, a lack of consensus as to what is meant by 'adequate time' with some criticism of the inclusion of such vague terms in research protocols (Maltby & Eagle, 1993). Additionally, no internationally agreed published guidelines are available detailing a recommended time period for consideration of consent (Maltby & Eagle, 1993). Therefore, the exact period of time allowed for consideration of consent will depend on the individual nurse's requirements. Information posters for the study were displayed at each clinical site and the researcher was available to clarify and issues which potential participants wanted addressed. Potential study participants were then given 2-3 days to consider whether or not they want to participate until the next site visit by the researcher, which took place no sooner than 48 hours after the initial meeting. In addition, consent was considered an ongoing process (Ramcharan & Cutcliffe, 2001) with additional information given as required and ongoing consent obtained at each phase of the study.
7. Respect for potential and enrolled subjects. This criterion for ethical research was met by ensuring fully informed consent, fair

recruitment practices and the freedom for participants to withdraw at any time without censure.

In addition to the criteria described by Emanuel, *et al.* (2000) for ethical research, the researcher used the 'ethics as process' model described by Ramcharan & Cutcliffe (2001). This model envisages ethics as an ongoing process where consent has to be continually re-negotiated and the researcher continually re-assesses the potential ethical risks while ensuring that participant dignity and respect are maintained. As part of this process, Ramcharan & Cutcliffe (2001) also advocate the use of an audit trail to ensure that the research ethics process is open and available for external scrutiny by the Research Ethics Committee on an ongoing basis as required.

As part of the 'ethics as process' research model (Ramcharan & Cutcliffe, 2001), a detailed Research Proposal was submitted and approved by the relevant ethics committee (Appendix 1). The proposed study did not involve patients and was concerned with examining the phenomenon of moral distress among emergency nurses. In the first part of the study, nurses were asked to sign a consent form for interview. These initial interviews then informed the observation phase of the study.

In the second phase of the study, nurses were asked to consent if they were interested in participating in observation and subsequent final interview. Potential participants then had the proposed observation and interview phase explained to them and had an opportunity to ask questions relating to the study. Participants were able to opt out in this phase of the study if they so wished. If potential participants decided to continue with the observation and interview phase, they were again be asked to confirm consent verbally prior to enrolling in the second part of the study.

Procurement of consent from patients in this study was unnecessary as patients are not the focus of the study and are in fact, at most, transient participants in the research field. However, even if it was desirable to obtain patient consent, it would be practically impossible to obtain proper written

informed consent in a busy environment such as the Emergency Department (Griffiths, 2008). Previous researchers conducting observational studies in large healthcare organisations have encountered similar difficulties in obtaining consent from patients (Fitzpatrick, et al., 1996; Griffiths, 2008). Indeed, Punch (1994) argues that in large organisations where considerable numbers of people engage in constant interaction, it is a physical impossibility to get consent from everyone. Griffiths (2008) argued that in a busy clinical unit where there were large numbers of patients, visitors and healthcare staff that it was not feasible to seek informed consent from all who entered the field. The interests of participants who may enter the field are best served by continuing with the research, as to exclude their participation may discriminate against the individuals involved (Griffiths, 2008) or effect the provision of care.

Furthermore, consent should only be sought when the prospective subject has the opportunity to consider whether or not to participate to minimise the possibility of coercion or undue influence. Obtaining informed consent is especially difficult in the Emergency Department setting where time is limited, patients are under duress due to their injury or illness and no ongoing relationship has been established with the patient to build trust (Easton, et al., 2007). These factors mitigate against the possibility of obtaining informed consent from the patient without duress while suffering from pain, illness or anxiety. Subjecting patients to detailed explanations about research to gain consent would be unethical and uncaring given the conditions prevalent in Emergency Departments and could be considered inappropriate professionally and morally (Griffiths, 2008). Critically ill patients may lack the decision-making capability necessary for valid consent (Murphy & Nightingale, 2002; Thompson, 2003) and may be unable to communicate due to the severity of their injury or illness (Thompson, 2003). Furthermore, research involving individuals from whom is not possible to obtain consent may be ethically permissible if the condition that prevents the consent is a key characteristic of the research population (World Medical Association, 1964). This is certainly the case of acutely ill patients

who are unable to give consent due to the very nature of their presentation to the Emergency Department.

Likewise, consent from a surrogate or family member may equally be invalid due to the distress and emotional upset felt by the family when dealing with the serious illness of a family member (Cook, et al., 2010). Retrospective consent or proxy consent are also problematic given the short period of time that many patients spend in the Emergency Department combined with the acuity and severity of the illness or injury frequently involved with an attendance at an Emergency Department would make this approach impractical and untenable (Griffiths, 2008). Seeking retrospective consent could potentially cause the patient further duress or anxiety as it forces them to relive their illness at a time when they may still be convalescing and may violate the principle of avoiding undue intrusion (Association of Social Anthropologists of the UK and Commonwealth, 1999) which may arise from the researcher intruding into private or personal domains related to illness and treatment when the patient is not the subject of the study.

Indeed, Murphy and Dingwall (2001) argue that the seeking of consent in this type of situation offers the patient questionable benefit and is rather conducted for the benefit of the researcher as a box- ticking exercise. This flies in the face of contemporary ethical thinking which no longer views the ethical conduct of research as a static event (Creswell, 2009), involving the granting of ethical approval from a Research Ethics Committee. Rather, several authors argue for research governance which envisages the conduct of ethical research as an ongoing process (Macklin, 1999; Ramcharan & Cutcliffe, 2001) where ethical issues are dealt with as they arise, using ethical guidelines. Furthermore, the predominant biomedical model of research ethics views moral judgement as impartial and an essentially dispassionate force. Gilligan (1993) argues that this leads to a sense of alienation on the part of the researcher and may lead to moral blindness or indifference as it distances the ethical decision making process from the participant. Gilligan (1993) further argues that the contextual nature of

ethical dilemma should be considered and multiple perspectives considered when undertaking a decision in field.

The dual role of researcher and nurse involves the making of moral judgements in the context of clinical practice. This can enhance ethical decisions in the field. Rigid adherence to biomedical ethical guidance principles can lead to inappropriate ethical actions in the context of clinical research in the healthcare context. In this study, to seek informed consent would not be in the best interest of some patients due to their illness or the distress that attendance at a hospital may involve (Griffiths, 2008).

The nurse's ability to have a dual role both as a professional and as a researcher enables access that would otherwise be difficult to achieve Latimer (2000). The researcher must make individual judgements about the ethically correct approach when observing patients. Therefore, a balanced approach is required to address the conflict between ethical requirements for consent and the practicalities of obtaining truly informed consent without causing patient harm which may arise from the inappropriate application of medical research ethics requirements to social behavioural research (Johnson, 1992; Ramcharan & Cutcliffe, 2001; Labott & Johnson, 2004; Oeye, et al., 2007). The ethical framework used in this study addressed the potential ethical issues arising out of informed consent from participating nurses while also addressing any perceived potential for patient harm which could have arisen out of observing nurses' behaviour. In this study, patients were not the focus of the study and were not the unit of observation. They were however, recognised as peripheral participants in the research field and therefore must be considered in any ethical decision-making process. However, while it might not be feasible to seek express consent from all patients who enter the field (Griffiths, 2008) this does not mean that consent should not be sought from able patients, if it is appropriate to do so.

3.8 Chapter Summary

Classic Grounded Theory was used in this research study to facilitate the generation of substantive theory which is grounded in data to explain the

problem of moral distress among nurses and to examine the main concern of emergency nurses experiencing this phenomenon. Classic Grounded Theory was chosen as it is a method consistent with the generation of inductive theory to explain a phenomena of practice about which relatively little is known. Classical Grounded Theory was chosen (Glaser & Strauss, 1967; Glaser, 1978; 1998) due to the scarcity of evidence on this topic. Furthermore, the Classic Grounded Theory approach was used to minimise preconception and the forced application of logico-deductive and interpretive methods to force an explanation of data. This allowed the researcher the freedom to engage in a systematic method of data collection and analysis which did not restrict the inductive process of theory generation.

Chapter 4 Research Method

4.1 Introduction

A study's research method refers to the application of methodology to achieve the study's aims or objectives. In this study Classical or Glaserian Grounded Theory was used as the research method in line with the methodology described initially by Glaser and Strauss (1967) and further developed by Glaser (1978, 1998, 2012) and described in Chapter 3. This chapter describes the application of Glaser's methodology to a study examining emergency nurses' experience of Moral Distress.

4.2 Study Sample

Initial sampling in this grounded theory study was purposive (Baker, *et al.*, 1992; Morse, 1991) which involves seeking out individuals who are likely to have experienced the study phenomenon (Hutchinson, 1993; Cutcliffe, 2000). Purposeful sampling was chosen initially to ensure that participants had experience of working in an Emergency Department and who may have been exposed to the topic of interest, moral distress. Initial data collection was based on a general perspective or subject area (moral distress) (Glaser, 1978) by sampling from the same substantive group (emergency nurses who may have experienced moral distress (Glaser & Strauss, 1967). In addition, the decision on who and where to sample at the start of the study was informed by Glaser's (1978) advice that initial sampling decisions should be based upon theoretical sensitivity pertaining to where the problem area might likely be encountered. This ensured the theoretical relevance (Glaser & Strauss, 1967) of initial sampling. Sampling was carried out at three Emergency Departments to prevent sampling from becoming unit bound (Glaser, 2001) and to maximise the comparison of groups for the development of categories and properties (Glaser & Strauss, 1967, p.51). This ensured that a broad range of indicators for categories and properties was developed to ensure theoretical completeness and earned relevance of data in the theory.

Therefore, the initial sampling strategy used was purposeful (Cutcliffe, 2000) and was replaced by theoretical sampling (Glaser & Strauss, 1967;

Glaser, 1978; 1998) later in the study with the emergent theory acting as a guide for further sampling (Sandelowski, *et al.*, 1992; Coyne, 1997; Cutcliffe, 2000).

The hospital sites used in the study varied significantly in size and type of institution. Table 4.1 illustrates how the location of the sites varied from an urban town setting to an inner city setting and finally to a large urban city hospital. The number and level of services at each site also varied with Hospital A offering regional and supra-regional tertiary referral for medical and surgical specialities, while Hospital B and Hospital C provided some reduced specialist tertiary referral services. The bed capacity at two of the hospital sites was similar (Hospital B and Hospital C) whereas the bed capacity at Hospital A was more than double the capacity of the other two sites. Finally, the number of Emergency Department attendances at each of the sites varied in line with their bed capacity, with Hospital A reporting 64,000 attendances per annum and Hospital B and Hospital C reporting 34,000 and 24,000 patient presentations respectively.

Table 4.1 Comparison of study sites

	Location	Hospital Type	Bed Capacity	ED attendances
Hospital A	Urban Large City	Tertiary centre Supra- regional	800	64000
Hospital B	Urban Town	Acute General	354	34000
Hospital C	Urban City Centre	Acute General Some tertiary services	350	24000

4.3 Access to study sites

Ethical permission for the conduct of this study was obtained from the local Research Ethics Committee (Appendix 1). Following ethical approval, written permission to access the sites used in this study was obtained from

the Director of Nursing of each hospital. On receipt of this permission, site access was negotiated with the clinical nurse manager of each Emergency Department and a meeting arranged to explain the study. Following the meeting with the clinical nurse manager, a link person (usually the clinical nurse manager) was identified to facilitate meeting with staff, to explain the study and assist with the distribution of recruitment information posters. Access for individual interviews and observation was negotiated at a local level with the clinical nurse manager and individual nurses and was planned so as to minimise disruption to the functioning of the Emergency Department. The interviews took place before or at the end of a shift, or during the early morning period, to minimise the impact of the study on staffing levels in the clinical area. Interviews were conducted in the nurse managers' offices, relatives' rooms, teaching rooms or any quiet room which allowed privacy and was free from interruption.

Further access for observation of practice and follow up interviews was negotiated at a local level and was determined by the principle of theoretical sampling (Glaser & Strauss, 2009; Glaser, 1978; Glaser, 1998). Observational episodes were guided by the workflow of each department with the principle aim being to minimise disruption to the function of the department and patient care while allowing observation of nurses. Consent for additional interviews and observation was obtained from participating nurses in accordance with the 'ethics as process' model described by Ramcharan & Cutcliffe (2001). In practice, this meant that consent was dynamic, to allow nurses discuss freely what they felt was important without pressurising them to discuss difficult issues and to dictate the length of the interviews.

4.4 Inclusion and Exclusion criteria

Inclusion criteria:

1. Registered General Nurses working in an Emergency Department.
2. Nurses who consent to participate in the study.

Exclusion criteria:

1. Healthcare staff other than Registered General Nurses.

2. Student nurses.
3. Nurses who decline to participate in the study.

4.5 Selection and recruitment of participants

The first phase of participant selection involved the researcher going to each hospital site and providing a short 15-20 minute information session on what the aim of the study was and what participation involved. Questions from potential participants were answered and issues such as ethical concerns, issues of anonymity and confidentiality and time required for interview were all clarified. The area of interest (moral distress) was explained and nurses who thought they may have experienced the phenomenon were encouraged to take part in the study. Interested nurses then spoke to the nurse manager or other gatekeeper who released nurses from clinical duties for the duration of the interview. The researcher accessed the hospital sites on a day or date determined by the gatekeeper. This was usually arranged by the gatekeeper to coincide with a 'quiet' day or a day when staffing levels were higher to facilitate the interviews. Participants were asked at the end of the interview if they would consider participating in an additional interview as required and as determined by theoretical sampling.

4.6 Theoretical Sampling

As the study progressed purposeful sampling was replaced by theoretical sampling (Glaser & Strauss, 1967; Glaser, 1978; Glaser, 1998) to guide further data collection as the theory developed from the initial data obtained. Emerging categories from initial interviews were used to theoretically sample study sites, people and data. Theoretical sampling of study sites involved sampling nurses from three different Emergency Departments to compare local contexts and the effect (if any) of this conceptual grouping on the data. Examples of 'local concepts' or sensitising concepts in this study were 'overcrowding' and 'moral distress'. These sensitising concepts informed data collection and interviewing as the researcher was able to ask nurses to elaborate on elements of the interview to sample for these concepts. For example, when nurses spoke about the overcrowded physical

environment, the researcher asked how the overcrowding made them feel. This was an example of theoretically sampling for a concept e.g. moral distress.

These sensitising concepts accorded theoretical sensitivity to the researcher based on professional experience and exposure to the area of interest. The use of these sociological concepts ensured that the emerging theoretical framework reflected a broad range of nurses and nursing concerns. The use of three sites also ensured that emerging categories and concepts had a broad range of indicators to ensure theoretical completeness (Glaser & Strauss, 1967 p.49).

Theoretical sampling of people was conducted by selecting nurses of different grades working in the Emergency Departments. This involved ensuring that staff nurses, clinical nurse managers and advanced nurse practitioners were all sampled. Further theoretical sampling of nurses included nurses with different levels of experience, ranging from less than one year to over 20 years of Emergency Department experience. The theoretical purpose of this sampling was to identify if the main concern of participants varied according to nursing role and level of exposure to the area of interest (moral distress). In addition, nurses who had experience of a particular behaviour or concept were theoretically sampled to generate properties of that behaviour. One example of this type of sampling in the study was the interviewing of nurses who had left emergency nursing due to apparent burnout.

Another element of theoretical sampling was the theoretical sampling of data. This was achieved in a number of ways. The first method involved the use of codes from initial interviews to inform the questioning in subsequent interviews. This is what Glaser (1998) refers to as theoretical questioning or theoretical interviewing (Glaser, 2001). Theoretical questioning involves the adaptation of interview questions to sample for emerging categories and their properties (Glaser, 1978 p.39-40). Theoretical questioning is the opposite to an interview guide where interview schedules act to constrain

theoretical sampling by not allowing the data to dictate the direction of the interview (Glaser, 1998 p.157).

One example of theoretical questioning was the use of the code 'stretching' in subsequent interviews. Several nurses had described being 'stretched' in their ability to perform their duties when the Emergency Department was overcrowded. In a subsequent interview the nurse was asked;

"*Do you feel overstretched sometimes?"*

(Staff Nurse 6 interview, Hospital A).

The properties of the code of stretching were further elaborated by prompting the participant to give more detail on this code or category. A further example of theoretical sampling involved the code of the role of the shift leader. Previous interviewees had spoken about how important this role was for the workload of nurses. In subsequent interviews I asked the nurses about the shift leader role;

"*If it's a good shift leader on (duty), how does that work better*?"

(Staff Nurse 15 interview, Hospital B).

Elaboration of this topic resulted in nurses talking about the importance of the shift leader role and how the shift leader 'sets the tone' for the day. Interviewees were theoretically sampled for this code and multiple indices of this code were found in interviews using the constant comparison technique. This meant that this code had 'earned' its relevancy in the emerging theory. A final example of theoretical sampling in interviews or theoretical interviewing (Glaser, 2001) involved the code of advocating. In the interview example below, a nurse talks about doing the best for her patients and 'speaking for them'. This substantive code was given the tenuous conceptual label of advocating.

"It depends on the family. If they have no family to speak for them, you're fighting for them. It's very hard like."

(Clinical Nurse Manager 4, Hospital A).

In a subsequent interview, the nurse was asked:

"How do you advocate for patients?

(Staff Nurse 12 interview, Hospital A).

This allowed for elaboration of the topic and for some of the properties of the category to be developed. It is important to note that the same question was not always asked in subsequent interviews or asked in the same way. Rather, the topic was theoretically sampled for if it arose during the course of the interview. It was important for the flow of interviews that theoretical sampling was not forced or those interviews did not become restricted by a set of theoretical questions. The interviews were kept informal and conversational like in manner while still working theoretical questioning into the content.

Another form of theoretical sampling of data in the study was achieved by using emergent codes to inform the observation of practice in clinical settings. The initial emergent codes and concepts formed a set of conceptual cues to theoretically sensitise the researcher to emergent data patterns and inform observation to generate further categories and properties. Examples of these conceptual cues include the early codes of 'overcrowding' 'covering patients' and 'stretching'. Observation of practice was conducted to sample for these concepts and to elaborate on potential properties of these categories. While sampling for 'covering patients' and 'stretching' the researcher noted the constant interruption of tasks:

"The current task was interrupted and left unfinished for the moment."

(Observational memo 1, Hospital B).

"A nurse was observed drawing up IV medication and being interrupted several times while doing so."

(Observational memo 3, Hospital B).

> "Doctors are constantly being interrupted and pulled away from one patient to deal with a sicker patient or deteriorating patient."
>
> *(Observational memo 9, Hospital C).*

These observations generated the code of 'interruption'. In this way, the data directed the development of the theory and further data collection (Glaser, 1978 p.39). Theoretical sampling was used to check and correct the emerging conceptual framework (Glaser, 1978 p. 39) by allowing the follow up of cues from the data for further elaboration. Theoretical sampling forced the researcher to constantly engage in the checking of data for fit, relevancy and workability. The researcher achieved this by deducing what areas should be sampled next from the initial data cues. This allowed data collection and conceptual development to be responsive and adaptable to the emerging data and ensured that data collection and conceptualisation was guided by the emerging data (Glaser, 1978 p.39). In practice this was achieved through theoretically sampling for initial concepts during observation and using initial concepts to theoretically question participants (Glaser, 1978 p. 40).

Theoretical sampling was applied in line with the 'all is data' dictum by recognising that the interview and how it is conducted directly affect what data were collected and how it was used (Glaser, 1998 p.159). Furthermore, theoretical sampling involved the sampling of many forms of data including interviews, observation, casual conversation etc. (Glaser, 1998 p. 159). In theoretical sampling, the codes direct further data collection. Theoretical sampling of a code ceased when the code was saturated and integrated into the emerging theoretical framework (Glaser, 1978 p.36). This directed or targeted data collection in turn informed theory development by developing categories, properties of categories and theoretical codes until the categories (and eventually the theory) were saturated (Glaser, 1978 p. 36).

4.7 Profile of study participants

The population comprised all nurses working in the three participating Emergency Departments. Nurses working in three Emergency Departments

were purposefully sampled and a total of 36 nurses from the three departments participated in the study. Some participants were interviewed more than once in keeping with the principle of theoretical sampling. In addition, pilot interviews with three emergency nurses were used in the data analysis but were not included in the demographic details as they were not working in the Emergency Departments used in the study. Seventeen nurses participated from the Emergency Department at Hospital A, ten nurses from Hospital B and nine nurses from Hospital C. The numbers and grades of nurses who participated from each site are shown in Table 4.2.

Table 4.2 Study participants by hospital site and grade

	Participants	CNM	Staff Nurse	ANP
Hospital A	17	4	12	1
Hospital B	10	2	6	2
Hospital C	9	3	5	1
Total	36	9	23	4

A total of 23 staff nurses were interviewed, 9 clinical nurse managers and 4 advanced nurse practitioners. Nurses who participated in the study had a variety of roles and experiences, ensuring different perspectives and allowing for differences or similarities between participants to be explored.

4.8 Data Collection

Data collection consisted of informal individual interviews and observation of nurses working in emergency departments. Initial interviews were coded and the emergent categories used as sensitising codes for observation of clinical practice and as a guide for the conduct of further interviews according to the principle of theoretical sampling to ensure a data richness and identification of key subjects (Glaser, 1978, 1998)

4.8.1 Interviews

Pilot interviews were conducted with four emergency nurses to trial a semi-structured interview approach which gave participants a definition of moral distress and then asked them if they had ever experienced such a phenomenon in the course of their work. This provided a very narrow scope for the interviews to develop and felt forced and preconceived. Participants were unsure of what was being asked and how to proceed with the interview. In each of the pilot interviews, the schedule was abandoned early on and nurses asked instead a 'spill' question to generate conversation. This spill question was typically 'What is it like working in Emergency?' or 'What is your main concern when you go to work each day?' The use of a broad opening question was much more successful in subsequent interviews as it allowed nurses to discuss freely what mattered most to them in an informal conversational interview and the interview schedule (Appendix 2) was modified in favour of the informal approach. The number of pilot interviews and participant interviews by site are shown in Table 4.3.

Table 4.3 Participants and interviews by hospital site

	Hospital A	Hospital B	Hospital C	Total
Participants	17	10	9	36
Participant Interviews	18	10	9	37
Self Interview				1
Other interview				1
Pilot Interviews				4
Total Interviews				43

Early interviews were conducted with willing nurses who were working in the three participating Emergency Departments. As initial concepts emerged and theoretical sampling replaced purposeful sampling, interview participants were chosen based on their relevance to the emerging theory. Informal interviews were also used when observing participants in the clinical setting as it was not feasible to remove staff members from the clinical area to discuss observed behaviours. Data collected through informal interviews and conversations were used to supplement the unstructured interview data. This is congruent with Glaser's dictum that 'All is data' and that diverse data sources may be used once the initial concepts begin to emerge (Glaser, 1978). Both types of interview contributed valuable data to the study and the type of interview used was decided according to the clinical picture at the time and availability of staff members. Where informal interviews were used, field notes were taken and memos recorded as soon as possible after the interview. The majority of interview findings arose from the unstructured interviews. However, the informal conversational interviews also generated important findings. One example of this use was in the development of the balancing competing demands to maintain standards of care category. After the initial interviews balancing had emerged as a strong category. However, after discussing this code with participants after an information session, several nurses commented that a balance was never achieved in trying to balance the competing demands of the job. This led to two important theoretical codes- balancing competing demands to maintain standards of care and compromising as a consequence of striving for balance but being unable to achieve balance. These codes were subjected to constant comparison with the developing framework of other codes and categories and helped develop the main concern category of balancing competing demands to maintain standards of care and the resolution of this main concern which includes compromising caring.

Unstructured interviews were held in a quiet room away from the main Emergency Department wherever possible, to avoid the noise of the clinical area and to avoid interruption of the interview. Before the interview started,

the researcher introduced himself and a brief explanation of the study topic was given to the participant. The audio equipment was prepared while the participant was asked to sign a written consent form. As one to one qualitative interviews require the researcher to develop a rapport with participants quickly (DiCicco-Bloom & Crabtree, 2006), the researcher tried to put the interviewee at ease by emphasising that the interviews were anonymous and confidential and that the participant had the right to withdraw from the study at any time. It was explained to participants that they did not have to discuss any topic that might prove distressing for them and that the staff support mechanisms including staff counselling were available to them if required.

At the beginning of the interview, the author introduced himself and explained the method and purpose of this part of the study. The importance of confidentiality regarding everything that was to be discussed at the meeting was emphasised to encourage an atmosphere of trust between the subject and the interviewer (Ruff, *et al.*, 2005). The participant was also encouraged to discuss the subject matter freely and was assured that the validity of all viewpoints would be respected. The rationale for audio taping and note taking by the facilitator was explained and permission obtained from each participant prior to the commencement of the interview.

The goal in a qualitative interview is to get the participant talking and to get them to share as much information as possible in their own words (DiCicco-Bloom & Crabtree, 2006). To achieve this, the first step in the interview was to use a grand tour question (Simmonds, 2010) which was broad and open, without preconceived issues inserted. This question was typically "What is it like for you to work as an Emergency Nurse?" The participant was allowed the freedom to answer the questions without direction from the researcher. If the participant deviated completely from the topic, then they were asked the additional question of "What is your main concern/issue when working each day?" Further questions were used to clarify what the participant has said and not to answer a particular 'pet' question. In other words, open questioning led to 'spill' from the participants and open coding (Glaser,

2011). Conversation was encouraged throughout the interview by using non- verbal cues to interpret the participant's level of comfort (Ryan, *et al.*, 2009) with particular elements of the discussion and by allowing the participant responses to direct the interview (Moyle, 2002). The researcher also used subtle prompts and probing questions to illicit further information as the interview progressed (Ryan, *et al.*, 2009). In addition, active listening methods such as maintaining an open posture, leaning slightly forwards and maintaining eye contact were used to encourage conversation, allowing the participant to talk freely without interruption. Brief episodes of silence were allowed during the interviews and the participant was allowed to break the silence first. Additional interview aids such as repeating what the participant has said, paraphrasing the participant's responses and the use of prompts and probing questions (Ryan, *et al.*, 2009) assisted in maintaining the flow of conversation during the interview. Furthermore, a laddered questioning technique was used to gradually increase the level of probity of questions asked based on the participant's responses and comfort level (Price, 2002). This allowed the participants to discuss sensitive issues in a way that was most comfortable for them.

At the conclusion of the discussion, the researcher summarised the main topics that had been discussed without trying to form any consensus or conclusion. A further opportunity was given to participants to include any additional comments at this stage. The combination of this summary of main topics and invitation for comments served to improve the reliability of the data collected (Ruff, et al., 2005) by allowing the participants the opportunity to comment on findings and correct them as necessary.

A self interview was also conducted to identify and limit the effect of preconceived codes on the interview process. The self interview was coded and memos were written to identify preconceived codes. These codes were then constantly compared to the emergent theory and categories. This method is similar to treating the preconceived codes as an existing theory and switching to emergent fit mode (Glaser, 1978; 1998) to see if they pattern out. It is important to emphasise that the researcher identified the

preconceived codes and then put them aside until categories begin to emerge from the substantive data. If the preconceived codes were applied to early to the data, there was a danger that they would be unwittingly forced upon the data rather than earning their way in to the theory by demonstrating indicators of the preconceived codes in the data. For this reason, self interview and coding took place after the theory began to emerge and a potential core category had been identified.

So, for example, the preconceived codes of 'burnout' and 'moral distress' were subjected to constant comparison and patterned out i.e. multiple interchangeable indices for these codes were discovered in the data. When the preconceived codes were not supported in the data collected, they were deemed to be not relevant to the theory and were omitted. Examples of codes that did not pattern out when subjected to constant comparison included Salary levels and inter-professional relationships. This process facilitated transparency in the research process and an understanding of how the researcher came to the conclusions reached. This part of the process was guided by theoretical sampling where existing data or literature was sampled and coded before being compared to the substantive data. This allowed the salient aspects that constitute moral distress to be compared to the study findings while also allowing the freedom to explore the main concern of the participant as advocated by Glaser (1967, 1978).

This use of self interview is similar to the process of 'bracketing' which originated from Husserlian Phenomenology (Peters & Halcomb, 2015) and is widely used in descriptive phenomenology (Hamill & Sinclair, 2010). Bracketing has been described as the 'scientific process in which a researcher suspends his or her presuppositions, biases, assumptions, theories or previous experiences to see and describe the phenomenon' (Gearing, 2004) and is used to mitigate the effects of preconceptions that may taint the research process (Tufford & Newman, 2013). Bracketing may involve periods of reflection and memo writing to identify preconceptions (Cohen, *et al.*, 2000; Tufford & Newman, 2013). Importantly, bracketing

necessitates the fixing of assumptions and preconceptions in written form and the testing of these preconceptions in some way (Cohen, *et al.*, 2000).
The goal of bracketing is the suspension of preconception and the initiation of a process of reflection and critical analysis of assumptions when compared to research findings (Gearing, 2004; Cohen, *et al.*, 2000; Tufford & Newman, 2013). This goal is in keeping with Glaser's (2013) dictum of 'no preconceptions' where he advocates the suspension of experiential biases and pet theories to facilitate 'staying open' to the data provided by study participants.

4.8.2 Observation

In addition to participant interviews, data was collected from twelve episodes of observation which were conducted between the three study sites. Three episodes of observation were carried out in Hospital A, four episodes in Hospital B and five episodes of observation in Hospital C (Table 4.3). Periods of observation lasted from 45 minutes to 90 minutes. All periods of observation were conducted during daytime but during different periods of the day including early morning, afternoon and evening. A variety of clinical areas were sampled at each site including, triage, resuscitation and major treatment areas.

The method of data collection and observational analysis is discussed in detail in Chapter 4. Initial codes from participant interviews were used as a semi-structured guide for the observation phase of the study. This use of initial codes as a structure for observation allowed for theoretical sampling for behaviours and issues reported in the interviews whilst also allowing for new observational codes and concepts to be developed (Glaser, 1978; 1998; 2001). These observational episodes generated additional contextual factors and codes which were used to guide further data collection using the method of theoretical sampling.

Table 4.3 Observation Schedule

Hospital Site	Observation Episode no.	Duration (min)
Hospital B	Observational episode 1	60
Hospital B	Observational episode 2	45
Hospital B	Observational episode 3	45
Hospital B	Observational episode 4	60
Hospital A	Observational episode 5	45
Hospital A	Observational episode 6	45
Hospital A	Observational episode 7	45
Hospital C	Observational episode 8	90
Hospital C	Observational episode 9	90
Hospital C	Observational episode 10	45
Hospital C	Observational episode 11	45
Hospital C	Observational episode 12	45
Total		660

Observation of nurses working in emergency departments was undertaken at each of the three participating hospital sites and consisted of a number of elements including gaining access to the sites, communicating with relevant gatekeepers, meeting potential participants, establishing a rapport and the process of observation itself.

Access for observation

Firstly, permission to access the sites was sought from the Directors of Nursing at each hospital. Once permission was received, contact was made with the gatekeepers nominated by the Directors of Nursing. Gatekeepers were contacted initially by email and then this was followed up with telephone calls and a site visit. The aim of the study and how the observation was proposed to be completed was discussed. Once a consensus on access and how to proceed was agreed at each hospital, an information session was conducted to explain the study to staff and to seek their support.

Building rapport

The purpose of the information session was to explain the study and to give potential participants the chance to voice any concerns, seek clarification of points made in the information session and to allow the answering of questions. Tea, coffee and cakes were provided by the researcher at each departmental visit as a means of breaking the ice and allowing access to staff at break times without unduly imposing on the function of the emergency department. Staff were given the opportunity to opt out of observation at these meetings or to opt out privately by stating this preference to their clinical nurse manager in confidence. The researcher then worked with the clinical nurse manager to choose shifts for observation that coincided with these staff members being on duty.

Observer stance

The observational stance adopted for the study was that of observer as participant (Gold, 1958). This stance was adopted to avoid adversely impacting on the function of the emergency departments in the study. The observer as participant role involved being situated in plain sight and not being hidden from participants. The researcher wore a non clinical uniform so as not to be confused with staff nurses. A large identification badge was worn indicating that the researcher was an observer. Any staff members of patients who asked who I was or what I was doing were given a brief explanation and their permission to proceed was obtained verbally as appropriate. The researcher did not engage in direct patient care. Interaction with patients was confined to maintaining patient safety only and was conducted by the researcher in accordance with the ethical protocol (Appendix 5).

Two types of observation were conducted during this phase of the study. Descriptive observation was conducted where all observations were recorded in an attempt to stay open to as many potential codes as possible. In addition, focused observation was conducted using codes from interviews as a framework to develop theoretical sensitivity by observing for particular behaviours or issues arising from earlier interviews (Werner & Schoepfle,

1987). The researcher engaged in mobile positioning, moving from one clinical area to another. Each clinical area (e.g. Triage, Majors, Resuscitation Room) was observed for a period of 20-40 minutes. Positioning to a new clinical area was undertaken when no new observations were being recorded or when activity levels in an area dropped. Positioning was then changed to a busier more active area. A maximum total period of observation was no longer than four hours and no more than two of these periods of observation were conducted in any one day to prevent fatigue and inattention (Casey, 2004). This also allowed time for memo-writing and note taking. Short phrases and cues were recorded as field notes during observation and these field notes were then re-written as memos between observational periods or at the end of the day.

Observational analysis

A formal observational framework or guide was not used in this study. Instead, observation was conducted for behaviours or patterns of behaviour. Participant interviews were used to form broad concepts or potential codes for observation. Field notes were analysed and rewritten in more detail as observational memos with potential codes identified for further analysis by constant comparison and/or theoretical sampling. Further theoretical memos were written on the basis of the observational data where potential relationships between codes and concepts were proposed for further analysis.

4.9 Data Analysis

In depth interviews produce large amounts of rich and diverse data (Polit and Beck, 2012). In the conduct of the interviews, audio recordings were transcribed verbatim directly to text. Transcripts were then reviewed while listening to the recordings to check for any errors or omissions. Corrections in text and spelling were made to clean the data (Ruff, *et al.*, 2005) and to correct transcription errors. When informal interviews were used, the researcher took detailed field notes and then later transcribed these field notes into memos to identify important codes and categories within the data. This aspect of data collection is congruent with the Grounded Theory

method (Glaser, 1998) and facilitates the rapid accumulation of relevant data and the development of theory by eliminating the unnecessary transcription of vast amounts of irrelevant data (Glaser & Strauss, 1967, Glaser, 1978).

The constant comparative method of analysis was used to continuously compare incident to incident, concept to concept and category to category (Glaser & Strauss, 1967). This ensured that data was continuously verified by other data slices to ensure theoretical completeness of categories and properties (Glaser & Strauss, 1967, Glaser 1978). Emergent categories were deemed to be saturated when multiple indices of the category or property of the category were discovered in the data (Glaser & Strauss, 1967). This ensured 'emergent fit' (Glaser, 1978) between data and emergent theory. Constant comparative analysis ensured verification of data (Glaser & Strauss, 1967) for theory generation without preoccupation with worrisome verification and detailed description of data. This is congruent with Glaser's view that grounded theory is a framework of theoretically related concepts that explain the data and not a complete and descriptive theory *per se* (Glaser, 1978; 1998).

In addition to the constant comparative analysis method of data analysis (Glaser, 1965), memoing was used to record ideas, possible theoretical codes, areas for theoretical sampling and emergent categories. In keeping with classical grounded theory, free style memoing was employed. (Glaser & Strauss, 1967; Glaser, 2014). This type of memoing is not delineated or excessively structured. Rather, Glaser (2014) advocates that researchers memo in any way that works for them as long as they do not neglect the process of memoing and reflection. In this study, memos included expanded field notes, theoretical memos, potential ideas for theoretical codes, observations from interviews and clinical practice, mind maps and theoretical diagrams. An example of a memo on the concept of overcrowding is given below:

> "*Overcrowding describes the situation in Emergency Departments when there is not enough room to treat patients due to the volume of patients currently in the department. Both admitted and emergency patients can contribute to overcrowding. Overcrowding results in a physical care environment that is noisy, disruptive to patient care and frustrating for both staff and patients. Therefore, overcrowding causes frustration and influences the environment. Overcrowding is one of the main negative factors that gives rise to compromised care and moral distress. The crowded environment is not appropriate for the treatment of patients and results in rationing care.*"

Field notes were used to record important themes that arose during interviews and to record observational codes while in the clinical setting. Field notes were then transcribed as soon as possible (usually that evening) into memos to record not just the initial field observation but also to elaborate and reflect on potential emergent codes from the field notes. Theoretical memos were used to record the decision making process and to assist in the theoretical development of a framework for the emergent concepts (Glaser, 1992). Memo writing was a crucial part of data collection as it prevented the loss of data or potential codes that the researcher may otherwise have forgotten.

The core category in a grounded theory study explains how participants resolve their main concern (Glaser & Strauss, 1967; Glaser, 1978, 1998) and has the most explanatory power in the theory (Christiansen, 2008) insofar that it relates most to or explains the majority of other categories. A number of potential core categories arose from the data analysis in this study. The constant comparison of these categories ensured that the relationships between the categories and the conceptual hierarchy between them emerged from the data. In this way, an early potential core category of compromising care was subsumed into the process of adaptive competence (a higher conceptual level category and the final core category) which had sub categories of role fulfilment, compromising caring and rationing care. The

emergence of a conceptual hierarchy during the identification of the core category is shown in Table 4.4.

Table 4.4 Core Category Emergence

Core Category	Adaptive Competence		
Potential Core categories	Rationing Care	Compromising Caring	Role Fulfilment
Initial categories	Fronting for the system Rationing Care Unable to care Overcrowding	Covering, Keeping an eye on Managing patients	Focusing on present Improvisation Making a difference Strategising

Theoretical saturation of each category was deemed to have been achieved when no new properties of that category were found and multiple indices for existing properties of the category were found in the data (Glaser & Strauss, 1967). Furthermore, theoretical saturation of the grounded theory was achieved when a core category was found that related theoretically to all of the other categories and which resolved the main concern of participants. Full conceptual description was not achieved or desired, as the goal of the emergent theory was to provide a theoretical framework of conceptually related categories that offered a possible explanation for the observed data (Glaser & Strauss, 1967; Glaser, 1978; 1998; 2011). The process outlined above was facilitated greatly by using the QSR N-Vivo N10 software package to organise and code data, record field notes and theoretical memos and provide an audit trail in research practice.

4.10 Literature as a data source

In this study a broad initial literature review was conducted to generate theoretical sensitivity in the area of interest for potential theoretical codes (McCallin, 2006). These codes were then 'suspended' until after the theory

and core category began to emerge (Glaser, 2012). The initial literature review is discussed in Chapter 2. This is in keeping with Glaser's teachings on the use of the classical grounded theory method (Glaser, 1998).

A secondary literature review was postponed until after the theory was substantially developed with a core category and related sub categories and properties. A subsequent more detailed review of relevant literature was used to situate the theory within the existing body of nursing knowledge (Burstrom, *et al.*, 2013). The theory was clarified, developed and modified as appropriate through the use of the existing literature as an additional data source (Glaser & Strauss, 1967; Glaser, 1978) for comparison and coding against the emergent theory. The literature was sampled theoretically, coded, analysed and integrated in to the theory in the same way as primary research data using the constant comparative method.

The grounded theory method of allowing the emergent theory dictate the literature review and delimit the discussion (Glaser, 1978; 1998) was followed, allowing a focused review of the literature (Glaser, 1998). In addition, detailed engagement with the substantive literature began in earnest only after the emergent theory was well developed (Glaser, 1992; Burstrom, *et al.*, 2013) to avoid preconception of the theory or blocking of the emergent codes. This phasing of the literature review (Martin, 2006) is more pragmatic and avoids methodological confusion and unnecessary methodological constraints on the researcher (Martin, 2006; McCallin, 2006). This approach to the literature is in keeping with the teachings of Glaser (2013) who has never argued for a blanket ban on an initial literature review (Dunne, 2011), but rather has always cautioned against preconception and that preconceived concepts must be suspended to allow for emergence (Glaser, 2012).

4.11 Modelling and Theory Integration

Theory integration frequently emerges during data analysis as the interrelations between categories emerge along with the categories themselves and are readily apparent (Glaser & Strauss, 2009). The constant

comparison of categories and the recording of theoretical memos in this study informed the emergent theory and illuminated different properties of categories. The constant comparative technique (Glaser, 1965) was used to develop the properties of categories and to generate potential theoretical codes to relate categories to one another as illustrated in Table 4.4.

Table 4.5 Category Emergence

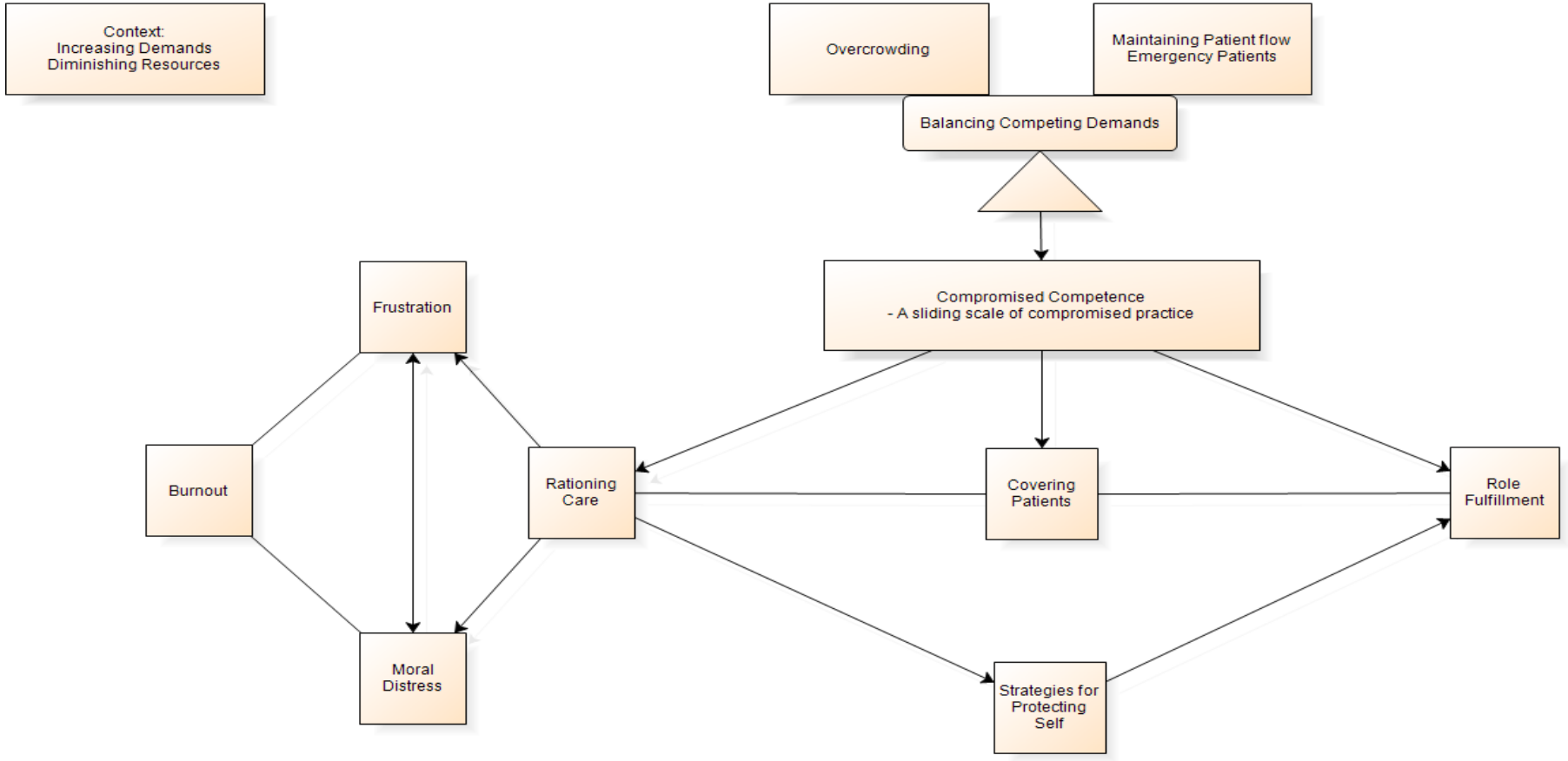
Category	Balancing competing demands to maintain standards of care	
Properties of category or sub-categories	Maintaining Flow	Overcrowding
Properties	Moving patients Clearing Patients Making Space	Physical environment Inappropriate treatment spaces Lack of dignity and privacy

Memoing was used to reflect upon the coding process and to describe the conceptual development of the theoretical framework. Memoing acted as a guide for theoretical sampling of properties of categories and potential links between categories. In the example provided below, a memo on the theoretical code of balancing was used to inform the development of compromising as a theoretical code for the consequence of balancing:

> "This model was used to visualise compromised care as a balancing code. Participants balance the positive elements of practice with the negative elements. Positive elements of practice include attending, supervisor support, peer support and strategising (solutioning). Negative elements of practice include overcrowding, poor support, poor staffing levels and poor skill mix. In reality, participants do not balance the positives with the negatives. They are always seeking balance but compromise as they never reach balance. Compromise is the best that can be achieved. The positive elements of practice mitigate against the negative elements but balancing may not be the correct theoretical code in this case."

The final stage in this process was the use of mind mapping and theoretical diagramming to relate the categories to each other and to trial different theoretical codes and frameworks to develop a set of inter-related categories with theoretical fit, conceptual parsimony and theoretical grab[i] (Glaser & Strauss, 1967, Glaser, 1978; 1998). The author used numerous models, diagrams and mind maps to illustrate the relationships between categories and to facilitate theory development by integrating categories into models and applying theoretical codes within these models. One example of an early mind map or model is shown in Figure 4.1 below.

Figure 4.1 Early theoretical model showing emergent relationships between categories



4.12 Ethical Issues in the field

Consent in medical research requires the consent of the person directly affected by the research (Andanda, 2005). However, Lipscomb (2010) argues that it is not clear whether the same ethical requirement for consent is appropriate for the conduct of social science research where there is no significant immediate are obvious risk to individuals. The research process in this study highlighted two potential ethical issues. The first relates to the question of consent and the second issue relates to maintaining the respect and dignity of participants.

4.12.1 Issues of Data Protection and anonymity

It is acknowledged that the small sample size and thick description characteristic of qualitative research can make maintaining anonymity challenging (Holloway and Wheeler, 2004; Orb, *et al.*, 2001). Therefore, the researcher ensured that where interview excerpts were used when writing up the findings that any potential detail that might reveal the identity of participants and information not critical to the meaning of the findings was changed to preserve anonymity (Polit and Beck, 2004). All data was collected, processed and stored in accordance with the Data Protection (Amendment) Act (Government of Ireland, 2003). Interviews and transcripts were codified to protect the individual's confidentiality and anonymity. All identifying material was removed from field notes and transcripts. In this study, the anonymity and confidentiality of the participants was maintained as there were no overriding ethical concerns encountered during the study (for example, the health or safety of patients) that required the release of such information.

4.12.2 Issues of consent

In this study written informed consent was sought from the nurses being interviewed and verbal consent sought for subsequent interviews and/or observation of their clinical practice. However, while consent had been received from the nurse being observed, the ethical issue arose as to whether or not consent should be sought from patients that the nurse interacted with. These patients were not the direct focus of the study but were recognised as

being peripheral participants in the study. In this study, the unit of observation was initially the nurse (Fitzpatrick, et al., 1996) and then very quickly became the behaviour of the nurse. At no time is the patient the unit of observation. Therefore, the potential risk to patients was minimal[7], as it was temporary and involved no more discomfort than what the patient would encounter in daily life (Burns & Grove, 2003) and ended with the termination of the period of observation.

In this study, to seek informed consent would not have been in the best interest of some patients due to their illness or the distress that attendance at a hospital may involve (Griffiths, 2008). Therefore, verbal consent was obtained from patients in the research field where the patient was not critically ill, sedated or otherwise impaired from giving consent by any distracting factor such as impaired consciousness, opiate drug administration, severe distracting pain or distress. Patients were informed of the nature of the observational study and the role of the researcher/observer. If the patient gave verbal consent, the researcher continued to observe the nurse and her practice. If the patient declined consent, the researcher withdrew and ceased observation until the nurse had finished interaction with the non consenting patient.

4.12.3 Participant safety and comfort

The likelihood of participant distress was kept to a minimum by informing all potential participants of the nature of the study and by obtaining informed consent for each stage of the study. In addition, the researcher tailored the level of questioning to the participants willingness to discuss the topic and minimised the likelihood of causing the participant discomfort or upset by allowing the participant space to discuss the topic without the questions becoming too intrusive (Price, 2002). Indeed, many nurses found the interview process cathartic and therapeutic (Lowes & Gill, 2006) as it

[7] Minimal risk involves a situation where the probability and magnitude of harm or discomfort anticipated in research are not greater than those ordinarily encountered in daily life or during the performance of routine physical examination or tests to the patient (Labott & Johnson, 2004; Resnik, 2005; U.S. Department of Health and Human Services, 2009).

enabled them to voice concerns about issues that were important to their practice and professional identity.

However, there were two occasions where participants became upset during the course of their interview. One occasion involved the participant becoming upset due to a lack of support from colleagues when dealing with patient overcrowding. The other example involved a participant who became upset when describing the sentinel event that gave rise to her leaving emergency nursing as a result of witnessing a lack of compassion and respect for an elderly patient. On both occasions the interview was stopped and the participant was allowed time to compose herself/himself. The participants did not wish to terminate the interview and insisted on continuing as they wanted their experience of moral distress to be recorded. At the end of these interviews, the participants were given time to discuss the reasons for their upset with the researcher and offered the opportunity to discuss the issues further with their line manager or to seek staff counselling/occupational health support as appropriate. This ensured that the researcher met the moral obligation of ensuring the participants well-being after discussing a potentially distressing topic (Orb, *et al.*, 2001).

In addition to the potential for emotional upset among participants from discussing sensitive ethical issues, the possibility that participants might disclose ethically sensitive information was considered. For example, a nurse might disclose an episode of poor practice or having witnessed unprofessional conduct or poor standards of clinical practice. The nurse researcher's obligation here was clear as any circumstance which could place patients/clients in jeopardy or which militate against safe standards of practice would have to be made known to the appropriate persons or authorities (An Bord Altranais, 2000). Participants were told at the start of the interview that the researcher would be obliged to report any disclosure of illegal or dangerous conduct in accordance with professional conduct guidelines (An Bord Altranais, 2000). However, no incidents of such concern arose during the course of this study.

In order to maintain the respect and dignity of patients encountered in the research field during periods of observation, the researcher used his professional discretion to judge when observation of a particular nursing action or period of care was inappropriate (Davies, *et al.*, 2000) such as when intimate care was being delivered (Lundgren and Segesten, 2001). In addition, the researcher planned to only intervene in patient care in an emergency situation (Elliott and Wright, 1999) when the patient was at immediate risk of harm (Davies, *et al.*, 2000) and another member of staff was not present. Again, no such incidents arose during the study.

An ethical protocol (Appendix 6) was followed to guide this decision making process based upon previously used ethical protocols used in observational studies (Elliott and Wright, 1999; Davies, *et al.*, 2000; Casey, 2004; Houghton, et al., 2010). This ethical protocol was in concordance with the ethical principles of non-malificence and respect for research subjects described in the Nuremberg code (Katz, 1996), the Declaration of Helsinki (World Medical Organisation, 1964) and the Belmont Report (US Department of Health, Education, and Welfare, 1979), the criteria described by Emanuel, *et al.* (2000) for ethical research and the 'ethics as process' model described by Ramcharan & Cutcliffe (2001).

4.13 Ensuring Rigour

Methodological rigour was maintained during the conduct of this study through the use of a number of procedures to ensure concordance with Glaser's (1998) canons of fit, workability, relevance and modifiability:

1. Fit:

   This study generated a substantive theory of moral distress which explains the main concern of emergency nurses experiencing moral distress and is intended for use in Emergency Departments. The theory was generated from one to one interviews and observation of participants, grounding the theory in the substantive area. Participants' own language was used to generate substantive codes and participants are quoted to illustrate the theory.

The patterns which emerged from data analysis were adequately explained through the main concern and the core category which explains the main concern. The emergent theory integrates the categories discovered and explains the findings without omitting large portions of findings.

2. Workability:

Workability was achieved by letting participants guide the research process and by using participants' actual words in the theory (Chiovitti & Piran, 2003). Workability was demonstrated when the initial theory were presented to participants who had experienced moral distress and they recognised their own experience in the researcher's account (Beck, 1993). Nurses provided feedback that the theory resonated with their experience and commented on how well the theory explained what they had experienced. Some nurses clarified elements of the findings and suggested changes to some findings. For example, nurses commented that the main concern was more like trying to balance or striving to balance as the competing demands rarely, if ever were balanced. The grounded theory explains the main concern and the resolution of the main concern in keeping with a workable theory.

3. Relevance/grab:

The relevance and grab of the findings have been demonstrated by the enthusiastic response from participants when presented with the findings. Furthermore, nurses from a wide variety of Emergency Departments throughout Ireland and internationally have described how the theory explains exactly what they have been experiencing in a clear and easily understood manner when presented with the findings at emergency nursing research conferences.

4. Modifiability:

The modifiability and adaptability of the grounded theory presented was demonstrated by integrating it with the existing research literature in Chapter 6. In addition, the study findings have been presented at

international conferences and demonstrated immediate grab for nurses working in emergency nursing in different countries which suggests the theory has transferability and is modifiable to other settings and contexts (Glaser & Strauss, 1967; Glaser, 1992).

Strict adherence to the grounded theory method in this study ensured methodological rigour as the grounded theory method is self-correcting by the process of theoretical sampling which ensures that the main concern of participants will always emerge (Glaser, 1978, 1991). Interview and observational findings were subjected to correction by the constant comparative technique to ensure the authenticity of and verification of findings. The researcher's personal views on the research area of interest were clarified (Chirovitti & Piran, 2003) through the process of self interview and by memoing these preconceived ideas as codes. The constant comparison of these codes to the emergent data prevented the predominance of pet codes and ensured that all codes had to earn their relevance in the emerging theory.

4.14 Chapter Summary

This chapter described how the grounded theory method was employed in this study in accordance with the original classical method described by Glaser & Strauss (1967) and further developed by Glaser (1978; 1998; 2011; 2014). The practical issues encountered in implementing these methods have been discussed and the decision making process described. Ethical problems which arose during the study have been described and the steps taken to resolve these issues explained along with the rationale for the approach taken. The next chapter describes the study context and settings.

Chapter 5 Findings 1: Description of study setting and context.

5.1 Introduction

Findings were collected across three large acute Hospitals in Ireland. Each of the Hospitals has an Emergency Department that is open 24 hours a day, 365 days a year. This chapter combines previously published descriptive data of each site with observational findings from this study with the aim of "painting a picture" of the physical environment, typical workload and ethos of the study settings. Some of the observational findings in this chapter are discussed in more detail in Chapter 6. This chapter also provides a context for the study findings presented in Chapter 6.

5.2 Hospital A

Hospital A is a large acute general hospital and has over 40 different medical and surgical specialties on the campus. Hospital A is a tertiary referral centre for a catchment population of 550,000 and a supra-regional referral centre for a total population of 1.1 million (HSE, 2014).

In 2013, Hospital A had 33,407 inpatient admissions, 80,244 day cases, and 64,830 Emergency Department attendances, making it one of the busiest Hospitals in the country. Hospital A has 800 beds and this may increase further to 1,000 beds on completion of the transfer of additional services to the Hospital A campus in the near future. Hospital A currently employs 3,269 staff of multiple professions and is a university teaching Hospital (HSE, 2014).

5.2.1 Emergency Department at Hospital A

The Emergency Department in Hospital A was rebuilt in 2005 to cater for 60,000 attendances per annum. However, the department now treats over 64,000 emergency patients each year and is operating over its intended capacity. In Hospital A, 58% of attendances to the Emergency Department

are male and aged 10-30 years (Cusack, 2009). A total of 37% of patients present with limb trauma. Sixty three per cent of Emergency Department patients in Hospital A are allocated to the urgent, very urgent or life threatening triage categories when assessed on arrival. In 2006, 67% of patients spent less than 6 hours in the department before discharge or admission to the hospital and a total of 27% of patients assessed in the Emergency Department were admitted to the hospital for further treatment (Cusack, 2009). The Emergency Department in Hospital A is staffed by 67 (WTE[8]) nurses including a nurse services manager, CNM 3, two advanced nurse practitioners, a GP liaison nurse and a clinical facilitator. The biggest issues facing the Emergency Department in Hospital A have been identified as patient overcrowding and maintaining adequate staffing numbers and skill mix (Cusack, 2009).

A total of 17 nurses from the Emergency Department in Hospital A participated in this study from a total of 73 nurses (67 wte). One advanced nurse practitioner, four clinical nurse managers and twelve staff nurses took part. The level and type of activity typical in the Emergency Department of Hospital A is described in detail in some of the observational memos recorded during the study. These memos provide a unique insight into the workings of the Emergency Department and the background level of activity typical of the department. The observational memos described below set the context for the Emergency Department at Hospital A.

5.3 Hospital B

Hospital B is a 354 bed acute general hospital located in a rural setting. The hospital manages 66,613 outpatient clinic appointments each year and 6,918 day cases per annum. A total of 70% of all inpatient admissions in hospital B were through the Emergency Department in 2008 (Cusack, 2009). The Emergency Department deals with approximately 34,000 Emergency Department attendances per annum (Cusack, 2009) and is staffed by two consultants in emergency medicine, three advanced nurse practitioners in

[8] WTE is the number of Whole Time Equivalent posts

emergency nursing and 32 nurses (29wte). Over ten thousand of these attendances (23%) resulted in hospital admission in 2008 (Cusack, 2009).

5.3.1 Emergency Department at Hospital B

This is a new purpose built Emergency Department with significant improvements in space and facilities for both staff and patients compared to the old department. In previous years, staffing was a significant concern (Cusack, 2009) along with inadequately sized and unfit for purpose facilities that have been replaced with the recent rebuild.

Ten nurses from the Emergency Department took part in this study out of a total nursing compliment of 32 nurses. Participants included two advanced nurse practitioners, two clinical nurse managers and six staff nurses.

5.4 Hospital C

Hospital C is a 350 bed acute general hospital situated in an urban location. The hospital has a number of in house specialities on site and some are shared with another hospital. Major trauma cases are usually bypassed from Hospital C according to a dedicated protocol but the Emergency Department is busy with medical and surgical emergencies, paediatric cases and ambulatory care patients on a 24/7 basis.

5.4.1 Emergency Department at Hospital C

The Emergency Department at Hospital C is a new unit purpose built in 2008 and currently sees approximately 24,000 patient attendances per annum (Cusack, 2009). Over three-quarters (78% of attendees) are discharged home with the remaining 22% are admitted to an in-patient hospital bed. A total of 9,582 patients were admitted to the hospital in 2008 and 5.457 of those admission originated from the Emergency Department.

The Emergency Department in hospital C is supervised by one consultant in emergency medicine with some sessional support from other consultants. There are 40 nurses employed in the Emergency Department (27wte) and a total of nine nurses participated directly in this study. This included one

advanced nurse practitioner, three clinical nurse managers and five staff nurses.

5.5 Summary of observational themes

This section describes the main themes which emerged from the observation of nurses working in Emergency Departments. Each of the themes is described with some related properties. These themes are also discussed as categories in more detail as part of the findings in Chapter 6.

5.5.1 Overcrowding

Each of the Emergency Departments observed have a significant overcrowding problem. During the periods of observation extra trolley places were allocated along the corridor to accommodate admitted patients while they waited for a bed to become available.

The porters had a difficult time moving patients around on trolleys as a result of the overcrowding. Patient trolleys and catering trolleys were constantly knocking and crashing off of each other as the porters and radiographers tried to move patients and trolleys along the crowded corridors. When patients needed to go to the toilet they had to walk along the length of the corridor to reach the bathroom. If the patient was unable to walk, they had to wait until a nurse answered their call and moved them into a cubicle for some bit of privacy.

> *Crowding was evident in the Majors area. All available trolley cubicles were filled, then the corridor area, extra trolley spaces, available chairs, and Paediatric and Psychiatric assessment rooms. The Minors and Resuscitation rooms were used as assessment areas when not full of patients receiving treatment. The waiting room then filled up with patients who had started treatment but were not yet admitted or discharged.*
>
> (Observational Memo 12)

Nurses were constantly moving patients around to make space for incoming patients. The physical environment was cluttered with too many trolleys and too many people causing difficulty in moving trolleys or moving between patients.

> *The activity level had picked up substantially at the start of this observational period. All patient spaces were now full with patients sitting on the corridor. Doctors were observed trying to assess patients on the corridor area. This involved partially undressing some patients. Some doctors used mobile screens, others did not. One patient was observed being examined without adequate privacy or dignity with other patients and relatives able to observe the assessment taking place while the patient was in a state of partial undress. The number of patients on the corridor was causing the corridor to be blocked or obstructed with patients, relatives, porters, wheelchairs and patient trolleys all having difficulty moving along the corridor.*
>
> (Observational Memo 11)

The waiting room was very busy and crowded with a shortage of chairs for patients and relatives. At the busiest times, there were no seats for new patients and relatives in the waiting room and some people were standing in the waiting area or sitting on window sills and on the floor. Patients in the waiting room were observed to have difficulty in accessing the Majors area as there was a secure door on the corridor that required a staff identity card to open it. This door prevented patients and relatives from accessing the treatment areas. Instead, patients and relatives waited until staff opened the door to call a patient in and then they walked past the nurse to gain access. Patients and relatives were stopped or asked if they needed help as they entered the door. This resulted in relatives and patients walking up to the nurses' desk frequently to enquire as to where they were situated in the queue of patients awaiting treatment or to ask which cubicle a patient was being treated in.

Relatives were observed walking in to the clinical area unchallenged and asked doctors/ nurses for an update on results and the remaining waiting time.

(Observational Memo 3)

The children's' waiting area was next to a main corridor. This area was full of children and their parents. There were not enough seats and children were running in and out of the room. The observational memo below illustrates the potential problems observed with this area:

Observation of the paediatric waiting area was conducted and showed a mix of children playing on the floor with toys while some other children were observed sitting in their parents' laps and crying. The area was very small with very little to distract the children. During the observational period, the door to the paediatric waiting area was open the whole time and children were observed to be reacting to what was going on in the triage and assessment areas, next to the main corridor for entry and exit from the department. Some children were observed playing in the main corridor where patients and staff were walking. (Observational Memo 6)

Background noise was an issue in the Emergency Departments with telephones ringing in the background and left unanswered as doctors sat writing notes and nurses hurried about tending to patients. At one stage the noise level became very high due to a large number of people in the department and the nurse manager called out loudly for 'quiet!'

5.5.2 Covering

The sickest patients were nursed in cubicles in the Majors area close to the nurses' station to allow for close observation and electronic monitoring of these patients' conditions. Both the CNM and other nurses were observed to 'eyeball' patients. In other words, they frequently engaged in rapid visual assessments of patients to identify patients in need of immediate attention or

patients who were deteriorating. This was a way of risk stratifying patients and continuously reassessing and prioritising patients.

Nurses appeared to anticipate what was needed for the delivery of care and pre-empted complications. This pre-empting of clinical needs was coded as an intuitive element of practice and developed the category of covering patients. Covering patients involves maintaining a minimum level of safe practice where nurses are 'trying to keep an eye on' patients and is discussed further in Chapter 6.

The triage or assessment area was observed in another episode. There was constant pressure of numbers with new patients arriving for assessment all the time. During the period of observation there was a constant backlog of patients awaiting assessment. Nurses 'eyeballed' arriving patients to pick out the very sick patients for priority treatment. The nurses postponed some of the assessments to deal with the immediate backlog of patients. There was a constant pressure to keep patients moving through the assessment process due to the backlog awaiting assessment and the anticipation of a serious case arriving such as a heart attack. Both in triage and majors areas nurses were sorting patients according to acuity and appeared to be always waiting for the next newly arrived patient or ambulance case.

5.5.3 Dignity and Privacy

Patients that were placed along the corridor had no privacy with doctors frequently undertaking examinations while the patient was lying on the trolley in the corridor. Sometimes doctors were observed using screens to maintain privacy but on other occasions this was not the case. Patients in the corridor had to eat in front of staff and visitors as there was a constant movement of people up and down the corridor going to wards and the x-ray department

> *Nurses were toileting a very dependant patient and having difficulty getting the curtain to close to ensure privacy. A visitor walked past*

and looked around the curtain of the patient being toileted during the observation.

(Observational Memo 2)

The trolleys on the corridor area were placed directly next to each other with very little room for other trolleys to pass along the corridor. This resulted in challenges for nurses in ensuring the comfort and privacy of patients:

Ensuring privacy appeared to become increasingly difficult as portable curtain dividers were placed between patients but they were inadequate. A male patient was placed next to a female patient who was crying out loudly and appeared to be in distress and pain.

(Observational Memo 9)

Patients were observed shifting and moving about on the trolleys trying to get comfortable. Some of the trolleys had a very thin plastic covered mattress, all of the trolleys observed were very narrow and without a pillow in many cases. The chairs were also narrow and plastic and very short. There were a few more comfortable looking armchairs but these were prioritised for some elderly patients.

5.5.4 Going up a Gear

The resuscitation room of an Emergency Department is where patients with life threatening or limb threatening illnesses are brought for intensive treatment to stabilise their condition while awaiting definitive treatment by a specialist physician or surgeon. The Resuscitation room was full with 3 patients-this took priority for the department and the nurses. Extra nurses were drafted in from Majors to help out with these most critically ill patients. In the Resuscitation room, there was a much noisier, busier environment. There were constant alarms from monitors.

The noise levels picked up when a patient was brought in for assessment. There were more alarms, and even more talking for a time. Against the background of all this noise, a patient was observed to be crying loudly. This added to the impression of a

noisy, busy and somewhat chaotic environment. In the Resuscitation room, nurses prepared equipment for the next step in treatment before being asked by the doctor for that equipment.

(Observational Memo 5)

In one episode, a patient started vomiting and called for assistance. Two nurses ran over to care for the patient. They quickly assessed the patient, provided immediate comfort measures and then arranged further treatment with the doctor. The nurses appeared to match their level of activity to increases in patient volume or acuity. Nurses were seen to suddenly 'go up a gear' when 'things kick off.' The environment made work difficult for the nurses observed. However, nurses modified the type and pace of their work to respond to this environment.

Nurses were observed to change effortlessly from the regular pace to a much faster pace when a critically ill patient arrived. The assessment was done very quickly with two nurses working rapidly to complete tasks and stabilise the patient. When the patient settled or stabilised the work pace returned to previous levels. Nurses spent some time explaining care to relatives and patients, answering questions and discussing what happens next to allay anxiety/fear. An ambulance arrived with another sick patient during a particularly busy period. One of the nurses asked "Oh no, what's coming now?" The ability to cope and the readiness for severely injured or sick patients was observed to be lessened by the busy workload. Nurses appeared less confident at coping with an additional workload when the existing workload was heavy.

(Observational Memo 8)

5.5.5 Maintaining Flow

In triage the nurse worked very quickly-she performed a rapid assessment with brief, focused questions for the patient. There were also some immediate treatments and first aid measures undertaken at triage such as bandaging and application of slings. The nurse prioritised the patients

according to the greatest clinical need-the sickest get highest priority for treatment. This was achieved using the Manchester Triage System of patient assessment. Very ill patients were brought in to Majors or Resus for immediate treatment and other patients were left to wait in the waiting room. However, there was often no space or trolley available when the nurse brought in a patient for treatment and other nurses and the CNM struggled to make space to accommodate these new sick patients in what was a very crowded Majors area.

> *Nurses also used other strategies to maintain flow. Nurses were observed suggesting to the CNM that she ask for in-patient teams to see patients directly in an effort to clear patients more quickly from the Emergency Department to wards and to allow patient flow.*
>
> (Observational Memo 4)

During observation in this area, rooms or cubicles were adapted by nurses for a variety of uses in the ED. On several occasions, patients were moved out to allow for another patient to be brought in for toileting. An assessment area was observed to be used as a makeshift treatment area when the Majors area was full. Sicker patients were frequently moved up to the nurses' station for closer observation whereas younger and less sick patients were often seen to be moved to the end of the corridor to continue their stay. Nurses were seen to be constantly moving trolleys and patients in and out of cubicles to facilitate assessment, treatment, and toileting. These observations generated the codes of moving patients and clearing patients. These concepts were used for comparison with and integration to the emerging grounded theory and are described later in Chapter 6.

There was an atmosphere of constant pressure caused by new patients arriving by ambulance awaiting assessment. As the ambulance crews waited to give patient handover, it was evident that there were now no trolleys free and nowhere for these new patients to be placed. So these patients were left waiting on the ambulance trolley until a hospital emergency trolley became

available. The CNM moved another patient off a trolley and out to the waiting area to make room for one of these patients. To make room for a patient the nurse or CNM needed to identify a trolley that was available or make one available. Then they had to make space to park the trolley by moving another trolley out on to the corridor. The nurse then had to decide the need for patient proximity to the nurses' desk based on acuity and clinical need.

5.5.6 Role of the CNM

Most of the activity was near the nurses' station/desk in the Majors area where the clinical nurse manager (CNM) was in charge of the shift and co-ordinated care and managed the running of the department. The CNM was based at the desk and called nurses to her to get updates on the condition of patients and their treatment progress. A large information board was on display near the nurses' station with patient names and corresponding doctors' names written down.

> *The patient information board was used by nurses and doctors as a way to visualise patients within the department and to identify priority patients and troubleshoot potential problems or potentially unstable patients. The CNM frequently referred to the board when asked about a patient's progress by another nurse, doctor or relative.*
>
> (Observational Memo 7)

Nurses in previous interviews had highlighted the importance of the Clinical Nurse Manager in 'setting the tone' for the shift. The CNM was observed to theoretically sample for this category. The CNM was observed discussing patient priorities for bed placement with bed management. The CNM discussed who needed high dependency beds, which patients needed isolation for infectious diseases or for those at risk of infection, which patients were for theatre and needed post-op beds etc. The CNM was constantly checking progress with doctors re patients-what test results were back, what potential delays arose, contacting specialist teams to review

patients and clarifying points with doctors, directing care and explaining the process to doctors, nurses and patients. The CNM maintained overall flow and escalated the hospital response when roadblocks arose such as no more trolleys to assess or treat patients, when more porters were needed, when there were prolonged delays in treatment and risk issues.

The CNM spent most of the time at the patient information board. The CNM had an overall view of patient flow and acuity and intermittently called a nurse over to check details and to make sure that care was being delivered safely and on time. The CNM also maintained flow by identifying patients who could move out of cubicles and onto the corridor to make room for new arrivals. The CNM liaised with bed management and identified when beds were required for patients and who gets priority for bed placement.

The CNM and to a lesser extent other nurses also frequently were observed to direct doctors on how to move patients on and complete their care to 'clear' patients from the department and maintain flow. This co-ordination of care was very important as doctors were constantly being interrupted and pulled away from one patient to deal with a sicker patient or deteriorating patient. This resulted in fragmented care and the doctor frequently forgot to return to a patient or did not realise until much later that they had forgotten to complete a task. Nurses were observed reminding doctors on numerous occasions to review or discharge patients.

5.5.7 Staffing Levels

Nurses were seen to supervise the work of junior nurses while agency and student nurses consulted with the staff nurses when they were unsure of what to do. In one department all cubicles were full since the beginning of the shift and one shift was short 2 nurses. Nurses commented that staff shortages were common.

Tasks were observed to be constantly interrupted by other nurses and care assistants. One nurse was observed to be repeatedly interrupted while trying to attend to a patient. A colleague called her for urgent help in a cubicle.

The nurse's current task was interrupted and left unfinished for the moment. When the nurse went back to complete the task, she was again repeatedly interrupted for the following reasons: a doctor seeking information on patient, another nurse looking for drug keys, another nurse looking for help with a task. Another nurse was observed being interrupted while drawing up IV medication. Relatives also interrupted nurses from tasks when calling for assistance for their relative. The nurse did not immediately leave the present task but acknowledged the relatives call with a 'be there in a minute' and finished the task.

The busy workload had an effect on nurses. On several occasions nurses were observed to be late going for breaks and breaks were shortened due to the intense workload. Other nurses were observed calling for help with toileting dependant patients as there were not enough nurses to manage the workload when it got very busy. There appeared to be a constant reliance on help from each other among nurses with constantly competing priorities. Nurses engaged in teamwork to support one another and complete tasks when unable to complete a task alone.

5.6 Chapter Summary

Each of the three participant hospitals in this study operates Emergency Department 24 hours a day, 365 days a year. All three Emergency Departments provide a wide range of services to undifferentiated acutely unwell patients. In addition, all three departments were observed to have varying degrees of patient overcrowding and staffing issues. Observational data obtained at each of the three sites paints a picture of busy, dedicated staff working in busy clinical environments and dealing with the various challenges presented by patient overcrowding, poor facilities and staff shortages. These service details and observational findings provide the context for this study examining moral distress among emergency nurses. The next chapter will describe the findings obtained from participant interviews and subsequent emergent grounded theory.

Chapter 6 Findings 2: The Theory of Adaptive Competence

6.1 Introduction

Grounded Theory studies begin with an area of interest on the part of the researcher that appears to be amenable to discovery and research. The grounded theory method then seeks to discover the main concern of participants i.e. the main issue or problem that affects them in relation to the area of interest under study and to explain how participants resolve this main concern or problem. In other words grounded theory uses data collected from participants to generate a theory that explains what the problem is and what is going on with participants when dealing with or trying to resolve the problem. The area of interest in this study was moral distress. The purpose of this study was to discover the main concern of Emergency Department nurses who experience moral distress and to explain how nurses resolve this main concern using the classical grounded theory method (Glaser & Strauss, 1978; Glaser, 1978). This study was conducted using grounded theory as originally developed by Glaser and Strauss (1967) and clarified and further developed in subsequent writings by Glaser (1978, 1992, 1998, 2001, 2002, 2006, 2008, 2009, 2012, 2014a, 2014b, 2014c). The findings of the study are presented in this chapter.

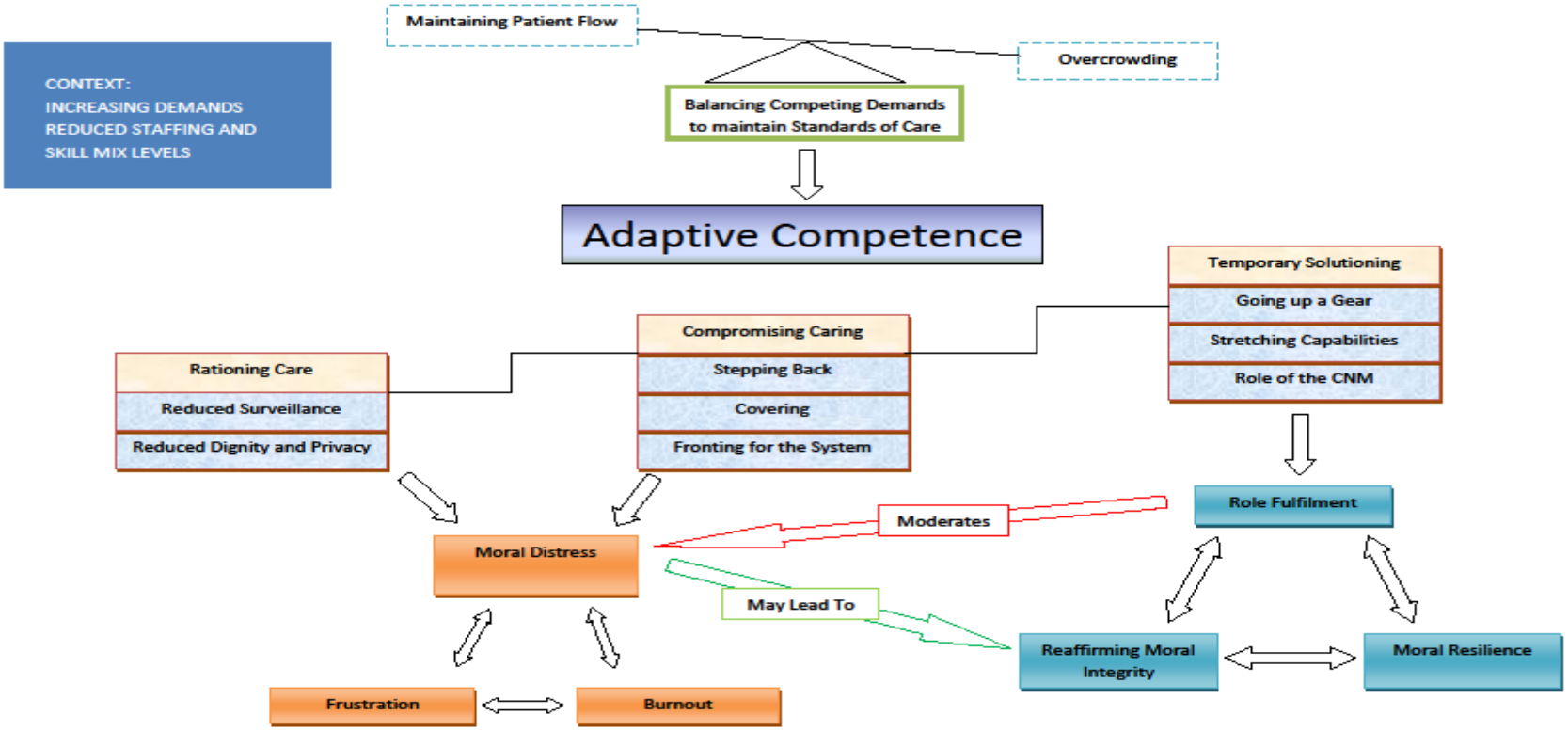
Participant interviews (n=42) yielded an enormous amount of rich data and it was evident as early as the pilot interviews that emergency nurses' experience of moral distress is complex. Further contextual data and theoretical codes were generated from approximately twelve hours observation of emergency nurses in the practice setting. The categories that emerged from this data were developed using the constant comparison technique (Glaser, 1965) combined with theoretical sampling to guide the collection of data to develop the theory and clarify the properties of the categories discovered in the data.

Glaser's (1978) theoretical coding family of the six C's (Causes, Contexts, Contingencies, Covariances, Consequences and Conditions) has been used to structure the presentation of findings. The findings are presented in

subchapters for contextual factors, main concern, core category and consequences of main category. Given that the grounded theory generated in this study is a basic social process, it seemed fitting that the basic social process theoretical framework (Glaser, 1978) was used to structure the findings.

The main concern of emergency nurses experiencing moral distress was *Balancing the competing demands of overcrowding and maintaining patient flow to maintain standards of care.* The core category which resolves this main concern was *Adaptive Competence.* The main concern and core category are shown in Figure 6.1. This chapter will discuss the theory of Adaptive Competence and constituent categories.

Figure 6.1 The Theory of Adaptive Competence



6.2 Contextual Factors

The findings of this study are described in the context of current Emergency Department service provision. When asked what it was like to work in an Emergency Department immediately began to discuss increasing demands and reduced staffing and skill mix levels. The impact of rapidly changing contextual factors emerged as an important theoretical code early in the study. It is important to note that the study context (as described here) was derived from the participants' descriptions of the contextual factors that were important to them and not from any contextual factors derived from the literature. Contextual factors derived from the literature are discussed in Chapters 1 and 2. A more detailed discussion of the study findings in the context of the literature is presented in Chapter 7.

6.2.1 Increased demands

The increased demands placed on nurses in Emergency Departments stem primarily from patient overcrowding. Patient overcrowding is caused primarily by admitted patients (Gilligan, et al., 2007; Hoot & Aronsky, 2008) waiting in the Emergency Department for a hospital or ward bed to become available. Admitted patients and emergency patients are both cared for by nurses in the emergency department, leading to overcrowding. Nurses described how this results in "two competing sides: admitted patients and Emergency Department patients" (Staff Nurse 2 Ref 1) resulting in nurses "trying to balance both" and "trying to make sure your patients are being looked after" (CNM 3 Ref 1). While attempting to cope with these increased demands on their time and practice, nurses inevitably have to compromise as they are unable to manage the workload. Some of the work "is being skimmed over a lot of the time because you just don't physically have the time" (Staff Nurse 3).

Participants highlighted that dissatisfaction with long waiting times and poor access to services has led to an increasing sense of frustration among attending patients (ANP 1 Ref 3, CNM 1 Ref 4), with family members "becoming annoyed because their elderly relative has been on a chair overnight" (ANP 2 Ref 9). One nurse (ANP 3) described how "frustrations

can spill over" due to the fact that nurses "can't provide the service" as they try to cope with "the competing demands from lodged patients and also those patients competing for space within the department" (ANP 3, Ref 12).

6.2.2 Reduced staffing and skill mix

In this study nurses report that when there are a lot of senior or experienced staff on duty it makes the job easier (Advanced Nurse Practitioner 5, Ref 1; Staff Nurse 15, Ref 2-7; Staff Nurse 13, Ref 1). There is a sense among nurses that experienced Emergency Nurses are being replaced by inexperienced and newly qualified staff nurses who do not have the same skill set (Staff Nurse 14, Ref 5).

> *"Well, if you've got inexperienced nursing staff, you're carrying other people I think your job is harder"*
>
> (Staff Nurse 14, Ref 3)

> *"Agency staff or staff from relief here in the hospital who might have worked in A&E before or may not have, and for them it's very difficult and then you've got people who have maybe worked in A&E, you know, for a year who are trying to cope with the environment they're working in and then also trying to help these new people that are coming down and that's adding stress to them as well."*
>
> (Staff Nurse 5, Ref 1)

The use of agency staff and inexperienced junior staff in the Emergency Department increases the workload for existing staff members and leads to increased stress and covering.

> *"There's an increasing reliance on agency staff which is a nightmare because not all of them are very good. It's a constant change of staff as well and it's agency so you can't get the same teamwork vibe going"*
>
> (ANP 7, Ref 9)

"No there are staff agency nurses, they reduced their shifts. So, yesterday instead of having four nurses in the section we had three and it just went on like this all day then. Stress, pressure."

(Staff Nurse 2, Ref 3)

"*You could have two agency on their own, which isn't kind of fair on them either because half the time they don't know the ins and outs of it. So, they can't cannulate. They can't do antibiotics."*

(Staff Nurse 7, Ref 1)

The level of experience on a given shift can set the tone for the shift as nurses quickly assess the number of nurses and their abilities when reporting for duty (Staff Nurse 6, Ref 3; Clinical Nurse Manager 4, Ref 1; Staff Nurse 12, Ref 1). High staff turnover rates and difficulties in recruiting adequately experienced staff have resulted in staff being placed in situations where they are too inexperienced to perform their function safely or adequately with one example offered by a participant of when "junior nurses triage a sick patient.....to be reviewed by a junior doctor" (ANP 1 Ref 2,3).

"Let's say if we're down two nurses. If you get a replacement through an agency and like there's more responsibility put back on the A&E nurses then straight away even though you might have your full complement of staff."

(Staff Nurse 15, Ref 3)

The skill mix available on a given shift and in particular the different levels of experience among nurses and doctors can impact on the smooth running of the Emergency Department also. Experienced emergency nurses are described by participants in this study as "very well skilled" and "the backbone of any A&E department" (Staff Nurse 15, Ref 2). Emergency nurses will quickly check "have staff that have gone out sick been replaced and how is the skill mix?" (ANP 2, Ref 2) or to check "the volume of patients within the department and who I'm working with both medical and nursing" (Staff Nurse 14, Ref 3).

This perfect storm of decreased staffing levels and poor skill mix levels coupled with increased demand has seen a dramatic rise in patient wait times in Emergency Departments internationally and in the frequency and severity of patient overcrowding in these departments. The combined problems of patient crowding and diminished resources due to financial pressures (Peterson, 2001; Kimball, 2004) have been reported in the emergency medicine and emergency nursing literature for a number of years now. However, solutions to this problem are complex and elusive, resulting in a pervasive chronic level of overcrowding in many hospitals Emergency Departments. This increased demand for diminishing physical and human healthcare resources provide the context for the present study and frame the findings of the study.

6.3 Main Concern of Participants

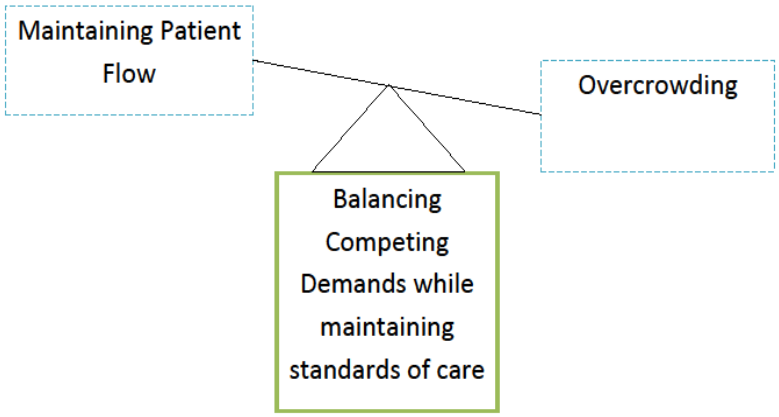
This section describes the main concern of participants in this study which was found to be *balancing the competing demands of maintaining patient flow and overcrowding to maintain standards of care*. *Balancing competing demands to maintain standards of care* describes how the two patient cohorts of admitted patients and emergency patients compete for nurses' time and attention. Nurses attempt to balance the requirements of these two patient groups by maintaining patient flow and managing overcrowding in an attempt to preserve standards of patient care.

This main concern is grounded in the data and arose from the application of the balancing theoretical code to this category. Balancing implies two opposite forces acting against each other and the attempt to bring these forces into a state of compromise and harmony. Balancing competing demands to maintain standards of care is exactly that-the opposing elements of admitted and emergency patients acting against each other by both seeking the time of emergency nurses. The opposing forces of admitted patients and emergency patients are manifest in the categories of overcrowding and maintaining patient flow respectively. Nurses describe this balancing as rarely succeeding and that the balance is more often than not weighted in favour of admitted patients and overcrowding. The sheer

volume of admitted patients in Emergency Departments means that while nurses seek or strive to balance these competing demands, balance is rarely achieved.

Nonetheless, nurses constantly strive to balance the competing demands for their time and care. The co-location of admitted patients who are awaiting a ward bed with emergency patients means that the needs of relatively stable admitted patients are competing with sicker Emergency Department patients. These two patient cohorts compete for space, facilities and nursing care or as one nurse describes, "*You're competing for space and patients are competing for your time*" (Advanced Nurse Practitioner 3). These competing patient groups place an enormous strain on Emergency Departments that are not designed to care for admitted patients for extended periods of time. A model of balancing competing demands to maintain standards of care is shown in Figure 1.

Figure 6.2 Balancing Competing Demands while maintaining standards of care



"(These patients are) deemed to be sick enough to need admission and this cohort of patients then are waiting in the ED to be placed for beds. When you have all those patients in one area within the Emergency Department and then you have your emergency work continuing as well, that doesn't stop."

(ANP 2 Ref 11).

6.3.1 Overcrowding

Overcrowding describes the situation in Emergency Departments when there is not enough room to treat patients due to the volume of patients currently in the department. Both admitted and emergency patients can contribute to overcrowding. Patients suffer from reduced standards of care when overcrowding occurs due to a lack of treatment spaces and due to prolonged treatment times from the increased workload placed on nurses and doctors. Nurses describe assessing the corridors of the department for overcrowding at the start of a shift as it sets the tone for the rest of the day:

"Well, I usually come in the door by the ambulance and if you see three ambulances before you as you come in, you kind of know it's going to be one hell of a day in one particular area."

(Clinical Nurse Manager 3).

One very experienced nurse describes how "You could go in the morning and the area that you normally work in can be full of patients who have been already been admitted and are awaiting beds elsewhere" (Advanced Nurse Practitioner 3). This places Emergency Department patients at a disadvantage when compared to admitted patients as admitted patients get priority for trolleys. This policy results in admitted and emergency patients competing for scarce physical resources such as chairs and trolleys to lie down on and for human resources such as nursing care and time speaking with staff. As one nurse pointed out *"this dual system that we're trying to operate has the same number of staff for two systems. It doesn't work. It doesn't work well."* (Staff Nurse 2, Ref 1).

When the Emergency Department becomes overcrowded with admitted and emergency patients, the department ceases to function properly as there is nowhere to examine or treat arriving patients as all chairs and trolleys are already full of patients. The system grinds to a halt as one nurse describes:

> *"There's nowhere to put the people who are in the cubicles. You know... the conveyor belt is full. There's no movement on it so everything has just stopped."* (Staff Nurse 4).

Overcrowding results in a "completely unsuitable" (Advanced Nurse Practitioner 1, Ref 13) physical care environment that is noisy, disruptive to patient care and described by one nurse as "frustrating to me and the patient" (Advanced Nurse Practitioner 1). The environment is generally regarded as being hostile to patients and staff and not conducive to caring. Nurses believe that the environment must appear chaotic and frightening to patients. The environment can contain drunk, abusive and aggressive patients. Relatives are sometimes prevented from accompanying the patients due to the overcrowding. The physical environment contains numerous hazards such as slip and trip hazards, infection control hazards, unpleasant smells, noise and bright lights. The nurses describe overcrowded departments as appearing "disorganised" to patients and representing "holding areas" with "patients in an overcrowded area, and a large proportion of the patients would be elderly and would be sitting in chairs" and may be placed next to "somebody who is verbally and physically abusive" (Advanced Nurse Practitioner 1). One male nurse describes his frustration with being unable to control the environment:

> *"One patient that I was managing had to wait in A&E for 3 days. It's completely unacceptable."*
>
> (Advanced Nurse Practitioner 1).

Nurses' frustration stems not just from the prolonged delays in treatment resulting from overcrowding but also from the impact that this has on the quality of care received by patients. Nurses describe how they feel

responsible for the failure of the system to adequately care for emergency patients. This responsibility stems from their moral and professional obligation to care for patients to a safe standard. The perceived lack of support from hospital managers can leave nurses feeling isolated as one nurse describes:

> *"There were no beds. There was nobody moved anywhere and I couldn't move anybody out to get the sick people in. It was dangerous and I felt that it was on me because I couldn't do anything to improve the situation. So, I just got to the point where I felt so frustrated. I just felt like I wasn't getting help from anyone. "*
>
> (Staff Nurse 11).

Overcrowding results in a situation that is "completely terrible" (ANP 1, Ref 13) and that "is very busy and packed" with "patients piled and pile and piled into these departments" (ANP 1, Ref 12). Overcrowding is one of the main negative factors that give rise to compromising caring and moral distress with many nurses describing it as a major concern and what causes them the most anguish. Advanced Nurse Practitioner 1 describes his regret at not being "able to get to them (patients) much sooner" and finding "that they had to wait all that time is distressing to me". The nurses empathise with patients' suffering and feel distress when they perceive that patients are distressed. Nurses seek to cope with overcrowding by attempting to maintain patient flow, covering patients and compromising caring.

Overcrowding leads to care delivery in inappropriate spaces such as corridors. Caring for patients on corridors epitomises the poor care environment. No matter how hard the nurses try to care for patients in these inappropriate spaces, they are constrained by the physical environment. Nurses describe how the environment impacts on patients' well being:

> *"But a corridor is a corridor, you know? It's not an area where somebody can be treated. You can't sleep. There's continuous noise. There are lights on. You know, it's... they're not there as long*

any more but people have been there three, four days. Sleep is needed for any healing of anything. It's needed for healing. Anything will show that and they're not really going to get proper sleep, you know." (Staff Nurse 3).

"The noise. There are people trying to sleep here. If you're sick, all you want to do is curl up in your little bed and have a pillow. You can't do that here. Lights are on here until 2 O' Clock in the morning. You know, they might go off then between 2 and 6 or something but then it's all systems go again and it doesn't necessarily mean that in those four hours that it would be quiet."
(Staff Nurse 4).

Levels of overcrowding have increased over time with what was once viewed as crisis levels of overcrowding now becoming normalised and acceptable to the system. This shifting of the moral goalposts poses further challenges for nurses as what has become normalised and acceptable to the system is not acceptable or compatible with their own moral values and professional identity.

"I suppose maybe initially when we started the corridor outside you know we might have had initially no one was on the corridor and then maybe there might have been four patients and then there was ten and then there was fifteen. You know, it's just increased."
(Staff Nurse 5).

When overcrowding reaches crisis levels, then nurses are no longer able to make space for new patients and the "nursing staff are unable to appropriately look after patients because there are just too many of them" (Clinical Nurse Manager 1, Ref 8). As the Emergency Department ceases to function properly, nurses describe it as "like trying to wade through thicker and thicker soup" (ANP 3, Ref 16) or 'like a train in Calcutta" (Staff Nurse 11, Ref 1).

Overcrowding may result in the dehumanising of patients and contributes to them being viewed as a number. One nurse felt so strongly about patient overcrowding that she compared it to "a form of torture." The environment makes it practically impossible to maintain patients' dignity and privacy. Nurses describe how "people are just stacked one next to the other on trolleys and you know, in some departments this could be on a corridor so you're stacked one trolley next to the other in a corridor with people constantly waking up and down which is a nightmare for infection control. " This dehumanising process is the very antithesis of nursing care and gives rise to rising frustration and moral distress. The following interview excerpts highlight how overcrowding erode a patient's individuality, dignity and value:

> *"Thinking of little old ladies and as much as we try our best and getting the comfy trolleys and everything, it's just not enough like. I think in this day and age it's a bit demeaning, you know, being on a corridor which is ridiculous like, you know. Yeah, so you'd be torn. No, it's a walkway. It's awful."* (Staff Nurse 6).

> "*Asking patients when did their bowels open or when did they go to the toilet last, when was their last period. You are asking them and the person next-door is hearing it. So, you just try to be discreet, I suppose."*
>
> (Clinical Nurse Manager 9).

> *"I've seen people being examined on corridors with a temporary screen around them which doesn't fit the entire trolley so that two screens still don't cover and then that actually blocks the corridor. They have to stop the examination so you can move the screen, so you can move another patient up and down the corridor."*
>
> (Advanced Nurse Practitioner 7).

Overcrowding has been shown to affect nursing care, patient dignity and prolong waiting times as the department fails to function with the growing

number of patients. Overcrowding also affects Emergency Department functioning by adversely affecting the environment.

6.3.2 Maintaining Flow

Maintaining Flow is one of the competing demands that nurses strive to balance. Maintaining flow involves admitting and discharging existent patients to create space to treat newly arrived patients. When there is a block to flow, most commonly from a lack of available hospital beds to transfer patients to, this prevents treatment of new patients in an efficient manner and results in prolonged delays. Maintaining Flow is usually achieved by *Making Space* and *Clearing Patients*. *Clearing Patients* refers to discharging patients to their destination. *Making Space* involves creating treatment spaces within the department. Nurses become very creative in identifying novel treatment areas such as offices, relatives' rooms or hallways. Nurses describe this process as "a matter of looking for little spaces in corners"(ANP 3, Ref 5) and "musical chairs"(Staff Nurse 3 Ref 3). *Making Space* improves patient satisfaction by giving the impression of progression in treatment and nurse satisfaction by giving a sense of achievement from a job completed. There is a constant back pressure to maintain flow due to the constant stream of new patients in triage.

If nurses cannot make space or clear patients, then all care stagnates and the situation becomes frustrating until there is a release when flow is recommenced by allocating beds or discharging patients. *Making Space* is a reaction or coping mechanism in the face of poor flow and an inability to clear patients. *Making Space* involves prioritising patients for treatment areas. Nurses describe having to "*think five steps ahead*"(Staff Nurse 6, Ref 1) as "*somebody might deteriorate and become more unwell so again you need to either move them to cubicles or to a monitored space or to Resus or whatever*"(Staff Nurse 5, Ref 4). Nurses are constantly moving patients in the department and they "*have to constantly be looking at patients, assessing patients. You know, moving those that are the least priority to more priority areas. The same again if you're reassessing a patient in the*

corridor in an area of low priority, if they get sick then again you're moving them to an area of more higher priority"(Staff Nurse 5 Ref 3).

When *Making Space* no longer achieves the goal of maintaining flow it becomes a negative experience for both patients and nurses. Participants described this as 'moving the deck chairs round on the titanic' (ANP 2 Ref 4) or 'musical chairs' (Staff Nurse 3 Ref 3). Moving patients sometimes results in compromising caring and apologising. Using inappropriate spaces results in equipment deficits as corridors do not have toileting facilities and nurses have to use mobile screens in an attempt to maintain patient dignity. Moving patients sometimes takes priority over patient care and compromises individual care to facilitate departmental requirements.

Clearing patients refers to moving patients through the department to their destination. It forms one of the temporary solutions to overcrowding and involves discharging patients or moving them to other wards and departments for definitive treatment. The nurses emphasised the importance of clearing patients to enable treatment of new incoming patients. When patients are not being cleared, there is a subsequent backlog of patients, lack of treatment spaces and delays in the ED. Triage and the waiting room also get busier when patients are not being cleared. Clearing is an element of maintaining patient flow and failure to clear patients is linked to overcrowding. An example of *Clearing Patients* would be nurses facilitating discharges by assisting a doctor in the RATing (Rapid Assessment and Treatment[9]) of patients.

Nurses resolve their main concern of *Balancing competing demands to maintain standards of care* by engaging in *Adaptive Competence*. *Adaptive Competence* involves nurses adapting their practice in response to changes in workload. Adaptive Competence is discussed in detail in section 6.4.

[9] Rapid Assessment and Treatment (RAT) involves a 'see and treat' approach to patient care where ambulatory patients are quickly assessed and treated by a senior decision maker such as a Consultant in Emergency Medicine or Registrar.

6.4 Core Category

The section describes how nurses engage in *Adaptive Competence* to resolve the main concern of balancing the competing demands of overcrowding and maintaining patient flow. Adaptive Competence is the core category of this grounded theory and is the process by which emergency nurses adapt their professional practice in response to competing work demands. This process consists of nurses engaging in practice at three levels along a sliding scale: temporary solutioning, compromising care and rationing care. The level of practice on the scale engaged in by the nurses is dependent on the level of overcrowding and the nursing workload. When nurses are able to engage in temporary solutioning, they engage in practice at the required professional level. As overcrowding increases and the ability to implement temporary solutioning is impeded, nurses engage in increasing levels of compromising caring and rationing care.

6.5 Temporary Solutioning

Temporary Solutioning describes the efforts that emergency nurses make to find 'work arounds' for the problems of overcrowding and competing demands. Nurses try to improvise and innovate to maintain quality of care and patient flow. Temporary Solutioning involves nurses *Going up a Gear* and increasing their work rate or *Stretching Capabilities* which involves extending their role. *Going up a Gear* is the opposite to *Stepping Back* care which is when nurses step back the level of care in response to overcrowding and competing demands.

Going up a Gear involves the nurses increasing their rate of work and working through a problem. This may involve working incessantly and without a break until the surge in work demand is met and the ED settles back to a more manageable workflow. *Going up a Gear* requires a greater degree of communication and collaboration between nurses and doctors. Examples of *Going up a Gear* include the Rapid Assessment and Treatment (RAT) of patients and the use of a triage sieve to sort patients who may be suitable for treatment directly by an in-house speciality such as Surgery or

for transfer to a different hospital for specialist referral. An example of *Going up a Gear* is given in this memo:

> *"Nurses were observed to change effortlessly from the regular pace to a much faster pace when a critically ill patient arrived. The assessment was done very quickly with two nurses working rapidly to complete tasks and stabilise the patient. When the patient settled or stabilised the work pace returned to previous levels".*
>
> (Observational Memo 8)

Stretching capabilities is a property of temporary solutioning. Stretching capabilities describes the response of participants to increasing demands as a result of overcrowding. Nurses stretch their abilities in an attempt to manage the additional workload. When stretching fails, nurses step back before attempting to engage in stretching again. *Stretching* involves nurses completing tasks that would not normally form part of their role and "push(ing) the boundaries of practice a little bit where you could make a real difference" (ANP 7 Ref 1).

Examples of stretching include discharging patients from triage, completing discharges of patients from the Majors treatment area and performing additional skills such as phlebotomy, cannulation and catheterisation of patients where required.

Consequences of Temporary Solutioning

Role Fulfilment

Role fulfilment arises when there is no compromising of care and nurses are able to balance the competing demands of the job successfully. A sense of role fulfilment occurs sporadically and usually follows a period of reduced overcrowding which allows nurses the time to provide optimal care. This category describes how nurses gain a sense of satisfaction in achieving a good standard of care. Emergency nurses describe "loving their job" and gaining a sense of satisfaction from "making a difference to patients". Role fulfilment is gained from an ability to use "all that knowledge and skill that I have built up over the last 13-14 years in the ED and using those skills to

ultimately make peoples' lives better and nurse them to health again" (Clinical Nurse Manager 1, Ref 4). Nurses describe this use of their skills and experience to save lives and help people as the reason why "they probably signed up as nurses".

Clinical autonomy also leads to an increased sense of role fulfilment. Nurses perceive emergency care as an area of practice that allows for increased clinical autonomy where their experience and training are valued by doctors and they are treated as equal team members and not as nurses subservient to medicine. In the following interview transcripts nurses describe the sense of fulfilment they get from clinical autonomy and from working as equal members of an efficient team that delivers high quality critical care:

> *"Like definitely for A&E nursing I think there's a lot of diagnosing done by nurses. Whereas, when you're the first person meeting them it's up to you. When you're triaging, you are giving a diagnosis before they see a doctor. I kind of like that. It's more challenging. The Resus aspect, that's when you can do the most for someone. Do you know, if they come in really bad condition, everything you do you can see a massive change, do you know. That's what I like."*
>
> (Staff Nurse 15, Ref 2).

> *"You probably get away with a lot more as well. You know you have more teamwork with the doctors and you know if I feel I don't know something is right for that patient, you have more input."*
>
> (Staff Nurse 18, Ref 2).

> *"I like the fact that nurses in A&E, we're respected more. Our opinions by the doctors are taken on board more so maybe than some of the doctors on the wards. You know, we're a lot more involved in their care from the start when they come in, you know what I mean? It's so varied, you know. I'm just very happy."*
>
> (Staff Nurse 19 Ref 6).

Emergency nurses also experience role fulfilment from using these skills in a wide variety of cases. The unpredictable and fast-paced nature of emergency care holds a certain allure and excitement for them and is one of the reasons that they were drawn to this area of specialised nursing practice in the first place. They describe emergency nursing as "an area where you could excel, where you could stretch yourself, where you could push the boundaries of practice a little bit and where you could make a real difference" (ANP 7 Ref 1). In addition, nurses describe the excitement associated with the fast pace of emergency nursing. They describe the "buzz" (Staff Nurse 3 Ref 1,2; Staff Nurse 18 Ref 1; Staff Nurse 20 Ref 5) and "adrenaline rush" (Staff Nurse 3 Ref 2) that they get from helping people and from not knowing "what's going to come through the door" next (Clinical Nurse Manager 8 Ref 2). Nurses also describe a sense of fulfilment from "really and truly making the difference between life and death and really make a difference to someone's life at their greatest need" like when "*you save a life with cardiac arrest or you save a child's life or something like that and it's amazing and there's no feeling like it and that's what you live for and that's the only reason that we continue to go back into our jobs day on day*" (ANP 7 Ref 8). The sense of role fulfilment gained from making a difference or from saving a life seems to act as a balance for moral distress and nurses derive a sense of satisfaction from these events that long outlasts the event itself. Indeed, these "little victories" in care delivery appear to be very potent moderators of moral distress and burnout.

Nurses achieve role fulfilment when they do not have to engage in rationing care or compromise caring. Increased clinical autonomy and team work can lead to an increased sense of role fulfilment. Nurses are able to engage in role fulfilment when they do not have to compromise their moral values and can deliver high quality care to patients without having to choose which patients receive care. Nurses experience role fulfilment when they have time to care for patients and can communicate effectively with them to assuage anxiety and ease pain and discomfort. Role fulfilment is closely associated with the delivery of comfort measures or what might be termed core caring. Engaging with patients and attending are properties of role fulfilment.

However, role fulfilment may be eroded when there is a perceived lack of support for nurses and they feel that they have no control over patient care decisions. Any degree of compromising caring detracts from role fulfilment. It seems to be more than just job satisfaction, which is a property of it. It is more akin to a sense of achievement or fulfilling the moral imperative. This leads to a reconnection with moral value and a strengthening of professional identity. Emergency nurses in this study achieve role fulfilment through advocacy, attending and team working.

Moral Resilience

Moral resilience arises from reaffirming moral integrity. When nurses are able to engage in meaningful acts that help them to gain a sense of role fulfilment it helps them to regain moral integrity. As moral integrity grows a greater sense of achievement and making a difference to patients emerges. Over time, regaining moral integrity has a cumulative effect of building moral resilience. Moral resilience helps to protect against future episodes of moral distress. Nurses "*take the little victories. The little victories are what keep you going*" (ANP 7 Ref 1). Nurses learn that if they can recover moral integrity in a morally distressing situation by delivering small achievable patient care goals, it can moderate the effect of moral distress.

6.6 Compromising Caring

Compromising Caring is the opposite of temporary solutioning and involves reducing the level of care provided in response to increased workloads. *Compromising Caring* has the properties of *Stepping Back, Covering Patients* and *Fronting for the System*. *Stepping Back* involves reducing the level of care in response to overcrowding and poor patient conditions. *Covering Patients* involves 'keeping an eye' on patients and maintaining a minimal level of surveillance and patient safety. Emergency nurses describe it as "*making sure that on a daily basis that they (patients) are safe and that they're breathing and that's it*." Covering patients involves continuous patient observation (covering), priority setting and maintaining safety or as one nurse described it "*becoming a bit of a warden". Fronting for the*

System involves apologising and explaining to patients the reason for prolonged waits on behalf of the hospital or healthcare organisation.

Stepping Back involves prioritising the sickest patients and the most important elements of nursing care and focusing on these. Nurses try to move patients to allow for treatment and maintain flow treatment in response to increased overcrowding but this at times is an impossible task. There is a sense of hopelessness and frustration that the general public is not aware of how bad the conditions are in EDs with overcrowding and that overcrowding is causing increased morbidity and mortality rates. Nurses feel that this level of care would not be acceptable if the majority of people knew what was going on. This frustration leads to "*huge distress as nurses are not able to provide adequate care to that* patient" (Clinical Nurse Manager 1).

Compromising caring consists of covering patients, accepting substandard care and prioritising patients, space and time. Compromising caring involves focusing on the present situation and prioritising surveillance or as one participant describes: "*concentrate on what I need to do at that moment in time and what are the 5 or 10 things that I need to do that makes my patients that I'm looking after lives a little better*." Nurses are unable to take in the enormity of the task that is being asked of them-they simply find it impossible to look after all the patients they have been allocated. In this scenario, nurses engage in *'covering patients'* where they attempt to 'eyeball' all the patients and pick out the sickest ones and prioritise these patients for treatment and observation. To this extent, nurses are engaging two separate systems of observation-one system of close observation of high acuity patients and another system of keeping an eye on everyone else and identifying deteriorating patients, or as one nurse describes it "thinking five steps ahead". In a sense, what emergency nurses are doing in this scenario is a form of patient triage. However, in this case, emergency nurses are engaging in a process that is more akin to military triage than Emergency Department triage. The following data excerpts demonstrate this process:

"I'm setting my priorities first, so my priorities, I don't go in and look at 50 patients on trolleys. You'd lose your mind if you were to do that. So, when I come in, even though I might walk down the corridor and there are fifty plus on trolleys, it doesn't bother me because my system is to break it down, where's the sickest patient in each section." (Clinical Nurse Manager 2).

"You're in those spaces you're trying to prioritise your patients and assess your patients and determine who can, who is stable enough or who you feel is stable enough to move from that area maybe to an area of less priority like a corridor to facilitate more patients coming in. So, you know, you're constantly assessing your patients. Constantly looking at who is safe enough to move or maybe who has deteriorated and needs to go to Resus or whatever. So, you're always constantly looking and prioritising and assessing your patients' needs because they can change, you know."

(Staff Nurse 5).

"Oh, yeah, constantly moving patients in the department. All the time, you know. You know you're moving them from majors to you know from priority areas to low priority areas all the time. You have to constantly be looking at patients, assessing patients. You know, moving those that are the least priority to more priority areas, you know. The same again if you're reassessing a patient in the corridor in an area of low priority, if they get sick then again you're moving them to an area of more higher priority."

(Staff Nurse 5).

Covering patients has an intuitive element where the nurse pre-empts problems and tries to identify a deteriorating patient before the event. Nurses describe covering patients as involving moving patients closer to the nurse to allow for greater observation and to maintain safety:

"Sometimes I might say to the girls in the corridor, maybe that patient should be up a bit higher in the corridor. I'd say that's what I think. " (Staff Nurse 8).

"I haven't done the corridor in a long time but what I used to do is put the sickest people in one to seven. They're nearest the desk and I watch them." (Staff Nurse 10).

Covering patients also involves re-allocating patients to a colleague or conversely taking responsibility for a colleague's patients for a period of time. Team working can offset the difficulties of compromising caring but this is dependent on staffing levels and skill mix. If patients are not being cleared, then the ability to cover patients deteriorates. Lack of clearing impedes patient flow, which in turn impedes covering. When compromising caring fails, it leads to rationing care and feelings of frustration:

"You're very thin on the ground and you're just doing very basic care with the patient. Going and doing their obs. Some patients, you

mightn't even get a chance to physically turn them."

(Staff Nurse 18).

"*The new patients coming in normally you'd obviously anyone that comes in that's a patient, you go and you assess that patient, you work that patient up, but then you mightn't get back to them for another three hours because you're trying to get back to those that are already there, that are waiting there."* (Staff Nurse 18).

"You could be taking obs and two of them and you feel that you have another patient and you haven't seen them for an hour and you don't even know what they look like or what's wrong with them or you come back and you've been allocated patients but no one has told you anything about them.

(Staff Nurse 19).

Nurses explain and apologise to patients for compromising caring even though it is often outside of their control. Compromising caring involves an acceptance of poor standards of care which is counter to the nurses own sense of morality. What is regarded as acceptable care has changed due to the prolonged nature of overcrowding. Nurses feel that staff have become numb or fatigued to unacceptable care and that this has allowed immoral and unsafe practices to continue. Nurses describe "having to chip away at their own standards" in response to chronic overcrowding and adaptive competence. Compromising caring involves lowering acceptable levels of treatment and risk taking e.g. 'getting a line in and giving a little morphine and hoping that they don't collapse in the chair'. Nurses are concerned that compromising caring can lead to clinical misses and errors. Nurses observe a lowering of standards among other staff too:

> *"I saw just recently a new doctor he told a young girl, she was in her twenties. Young maybe 19 or 20, really good-looking girl, he told her take off her top so she just had her bra on in the corridor and he was listening to her chest. He didn't see anything wrong with that. I know there isn't any privacy here but that..."* (Staff Nurse 2).

Another element of compromising caring is *Fronting for the System*. Fronting for the system involves communicating compromising caring to patients and relatives. Nurses are forced to defend the actions of a system that they believe to be flawed and unfair. As such, they are the front for management and government decisions that are not of their making. This involves representing the department, hospital, management or health system when communicating with patients. Fronting for the system has two properties; explaining the system and apologising to patients. Fronting for the system arises because nurses have a duty as employees to concur with a system of care that is in direct conflict with their professional and moral duty to advocate for patients and act in patients' best interests. When nurses are forced to work in a system that does not act in the best interests of emergency patients, they are forced to front for the system.

Nurses front for the system because they are in attendance 24 hours a day. They front for the non- attendance of managers and senior clinicians. Fronting for the system leads to frustration as nurses are required to front for a system that they feel is inherently unfair and unjust. They are forced to explain and justify a system that contradicts their values and morals. Fronting for the system gives rise to moral distress as it involves explaining and apologising for poor standards of care are not their fault but rather as a result of patient crowding and delays in clearing admitted patients to wards. One nurse explains that patients and their families are normally understanding when nurses front for the system:

> *"For the most part patients are very understanding but I suppose once it's explained to them and they're informed then there seems to be less tension."* (Staff Nurse 24).

However, other patients and their relatives can become "frustrated and aggressive". If the cumulative feedback from patients and relatives is negative, over time it can lead to distress and burnout. These nurses describe what it is like at the receiving end of frustrated relatives while fronting for the system:

> *"But like you get family giving out to you. You get negativity continuously thrown at you from family who some would understand the situation. They sympathise with it and they don't give us any grief, I suppose. But there are other families and they will just really set on you and it is us who get it being front-line. They won't speak with you and that would affect you and stress you out because you're constantly getting negativity thrown at you".*
>
> (Staff Nurse 24).

> *"The nurse is taking the stick every day and I think over years and over time that too much of listening to the same complaints can burn nurses out."* (Advanced Nurse Practitioner 6).

The triage nurse appears to bear the brunt of frustration from people in the waiting room:

> *"It backs on to people in the waiting room waiting to be seen. You know, there mightn't be sufficient A&E doctors on that day and the waiting times could be chaotic. Any time you go to call someone in triage you're constantly harassed, you're constantly being jostled, you know."* (Staff Nurse 18).

> *"The triage nurse would usually take that abuse. Then there's complaining about waiting for a bed so again it's the nurse who takes that.....They get fed up and then they get angry and if they don't get angry, their relatives get angry and I mean in a way I don't blame them."* (Advanced Nurse Practitioner 6).

This nurse explains how dealing with frustrated patients and relatives can result in nurse burnout:

> *"An awful lot of that is the system really and it's putting up with the complaints from patients that burns people out I think rather than the actual work. It's not the physical work. It's the psychological effects of listening to patients' grievances day in day out that the nurse takes all that and management don't really get it".*
>
> (Advanced Nurse Practitioner 6).

Fronting for the system erodes role fulfilment and professional identity by removing the ability of nurses to effectively advocate for patients and by removing the locus of control of clinical practice from professional nurses. Not alone are nurses required to act in a morally reprehensible fashion against their wishes but they are then forced to defend these morally corrupt decisions. In this way, fronting for the system erodes all sense of moral self and professional moral identity and contributes to frustration and moral distress.

Nurses explain or excuse the situation to patients. Nurses describe not having the time to explain what's happening to patients due to competing demands. Explaining frequently takes place in inappropriate spaces due to overcrowding. Explaining involves apologising for poor care and fronting for the system also. Nurses explain how they struggle to make the time to explain details to patients:

> "*Whereas some patients are a bit more anxious, worried. You know, so I suppose you just have to make time for them really. Try and make the effort to get to them and reassure them and I find that if you tell them exactly what's going on. That's what I think anyway. That you just need to explain to them like this is what the story is here. You're in this area. We're going to do this now."*
>
> (Staff Nurse 8).

> *"For the most part patients are very understanding but I suppose once it's explained to them."* (Staff Nurse 17).

Patients usually understand the reason for delays when it is explained to them and when they're informed there seems to be less tension, but sometimes explaining leads to frustration and aggression from patients:

> *"I think a lot of time you have to explain to the patient, I know this is totally wrong but there's nothing I can do about it. I'm working in this system, you know, it's not ideal for me. I would absolutely love for you to be up in your bed and you know, already have your operation done and whatever and you know, kind of explain there's nothing I can do. It's the system I'm working in. Unfortunately I don't have control over the beds. I can't discharge someone going up in the house and things, so it's unfortunately the waiting game and this is the health service we have at the moment. I can't change it or anything. I'm working in this area. I'm doing my best for you at present with what I have and the facilities we have around and there's nothing else I can do because they can start to get aggressive*

towards you again within those situations and it's like I can't make a dent like, I can't get it for you." (Staff Nurse 3).

Nurses apologise for poor standards of care. They apologise to patients and relatives. They find that they apologise for consequences that they have no control over. There is a sense of an external locus of control. Apologising is a manifestation of regret. Regret is a manifestation of the moral conflict arising from moral distress. Moral distress arises from the conflict between the very nature of nursing practice and institutional restraints. Apologising for poor care over which they have little or no control has a consequence of feelings of resignation, frustration and anger among nurses. Apologising is a property of fronting for the system. Nurses are confronted with the question of whether their best is good enough for themselves or the patient. Apologising emphasises the disconnect between ideal and actual care and leads to a further focus on the immediate situation and on priorities of care. Nurses apologise for the fundamentals of care that they feel unable to provide such as feeding toileting and medication management as described by these nurses:

"I'm really sorry about the long wait but you know, I can't do much about it. I'll give you pain relief. Do you want some tea? That's as much as I can do for you for now, but it can be upsetting."

(Staff Nurse 4).

"Yeah, definitely you know. You know you're apologising all the time. It's a constant thing, you know and I suppose you're apologising for the system. You're apologising for the overcrowding. You're apologising for the I'll bring you to the toilet or I'll bring you that cup of tea in twenty minutes or I'll you know, I'll bring you your meds. Now I know you're due them at 10 O' Clock. "

(Staff Nurse 5).

Nurses engage in substandard practice which then results in guilt and regret and they apologise for being unable to provide an acceptable standard of

care. Indeed, these nurses apologise for failing their patients and not being able to *nurse* them appropriately:

> *"So you are, you're constantly apologising for, you know, for I suppose what you're not able to do for them but again it's more to do with the environment in which you're working in and the situation that you find yourself in, you know? So, yeah you are and I suppose sometimes that can cause frustration in itself because in one sense it's not really your fault.*
>
> (Staff Nurse 5).

> *"The other thing is you find yourself apologising. You're constantly apologising to patients and saying I'm sorry, this is the situation. This is how it is. You know, we're doing our best but there isn't a lot we can do."*
>
> (Advanced Nurse Practitioner 7).

Initially, *Compromising Caring* consists of the middle ground in the process of adaptive competence. It is the bare minimum safe level of nursing that can be provided in response to the pressures of overcrowding. It involves a compromise on the quality of care delivered to maintain a safe level of care. As compromising caring patients involves a good deal of stepping back care on the part of the nurse, it represents a red line in the sand or bare minimum acceptable level of professional practice for emergency nurses. However, if compromising caring fails, nurses then have to engage in rationing of care which leads invariably to higher levels of frustration and moral distress.

6.7 Rationing Care

When care is compromised completely it can lead to a complete failure of care in extreme instances where care is rationed to the extent that it is non-existent. In other words compromising caring can lead to rationing care and an inability to fulfil the nursing role. This, in turn, leads to nurse moral distress.

Rationing Care lies at the bottom of the sliding scale of adaptive competence and represents the reduction of caring for patients to minimal unsafe levels in response to extremes of overcrowding and poor patient flow. This category describes how nurses cope with balancing competing demands to maintain standards of care especially when the demands become unsustainable. The nurses have to ration caring. This consists of reducing the amount of time spent with patients, inattentive listening, avoiding eye contact (all of which result in reduced surveillance), prioritising the sickest patients and focusing on core which results in reduced dignity and privacy for patients. Nurses describe not being "really able to interact with patients" when rationing care and "not having the time". The increased workload demands of overcrowding mean that "nursing staff are unable to appropriately look after patients because there are just too many of them". Furthermore, nurses state that they didn't "really sign up to be in a situation where you are having to ration your care" and that they "are having to ration what they are doing in such a way that they are providing the best for most."

Nurses try their best not to ration care as they understand that it has dire consequences for the quality of care received by patients and that patients will suffer from reduced dignity and privacy as a result of rationing care. They describe how "the plate is sitting in front of older patients because there is no one their available to feed them because staff members happen to be doing something else and the patient is not able to feed themselves and the food is going cold." Nurses are very clear as to the causes of rationing care. They blame the competing demands of admitted patients and emergency patients. They describe how "*it's very difficult to run two systems in the one place*."

Rationing time and focusing on the present are elements of rationing care. When nurses engage in rationing care, they are often unable to deliver even the most essential elements of care such as bathing, feeding, communicating or providing relief from pain and suffering. This is often the cut off point for nurses as to when compromise is acceptable and when it goes too far against the values of nursing. The failure to deliver comfort measures to sick,

dependant patients is discordant with nursing values and ethics. Nurses describe this level of rationing care in detail, naming the essential elements of nursing that they feel are not provided adequately:

> *"The likelihood that something else will happen to them at that moment are higher like pressure area the pressure areas developing because the trolleys are not adequate."*
>
> (Clinical Nurse Manager 1)
>
> *"The plate is sitting in front of older patients because there is no one their available to feed them because staff members happen to be doing something else and the patient is not able to feed themselves and the food is going cold."*
>
> (Advanced Nurse Practitioner 3)
>
> *"We have patients in open settings without curtains around them so when they need to use the bathroom we have to move patients out and back in and that is hindering our time management"*
>
> (Clinical Nurse Manager 1 Ref 14)

Rationing care impacts on many elements of nursing practice such as documentation, patient assessment and administration of pain relief. These nurses describe the impact of rationing care on these aspects of patient care:

> *"You come across patients that nobody has spoken to them in four hours. They haven't gotten pain relief. They haven't been turned. It happens way more often and you know it shouldn't happen. You prioritise something like giving someone who is in acute pain analgesia over someone who needs to be turned even though you know both things should happen."* (Staff Nurse 2).
>
> *"Yeah, exactly yeah or documentation. Somebody mightn't be documented on in six hours."* (Staff Nurse 2).
>
> *"Someone is complaining of severe pain. They need to be assessed*

again in five, ten minutes. They're not getting that done. You're probably getting back to the person an hour later. Even just talking to patients. That is being very much skimmed over a lot of the time because you just physically don't have the time to stand and talk to the person for a long conversation and that."

(Staff Nurse 3).

Rationing care is part of a process of reducing care to the bare essentials as nurses attempt to ensure patient safety and preserve life. Nurses focus on the present or immediate priority and then move on to the next task. Nurses have to allocate their time and care to the sickest patients. In these interview extracts emergency nurses describe how they prioritise these patients for care at the expense of other equally deserving patients:

"I suppose having people here who deserve beds, every patients should be in a bed, so what you're doing then is prioritising and give it to someone who deserves it more or someone you feel deserves it more than somebody else and that can be annoying obviously."

(Clinical Nurse Manager 9).

"You just come in that day and you decide. You prioritise in your own head like this person is in pain. That's more important than washing that person. You know, you just use your head. Or this person is having chest pain now so that's obviously more important than somebody who says I have a pain in my toe." (Staff Nurse 4).

"You do your work as much as you can and just prioritise and do your best for people. Or put all the people who need the most care nearest to me and then shove the people who don't need the most care away from me which is kind of like a bit, I don't know, wrong. Everyone needs care but the ones that need full-time care I put them near me in an area where I can do the basic nursing care.

(Staff Nurse 6).

When faced with an unmanageable situation, nurses break down the impossible into smaller do-able tasks. This is particularly evident in the interactions that nurses have with patients. Nurses limit the amount of time they spend talking to patients because they have many other patients waiting for pain relief, assessment and treatment. This forces nurses to cut conversations short and leads to inattentive listening and frustration on the part of the nurse when the patient causes them to be delayed, as these examples demonstrate:

> *"You know, you're almost short-tempered with some little old lady who is trying to take off her clothes but she's doing it slowly and you've got loads to do and she's trying to ask you about the weather. You're saying would you come on? That's not right but that's the way it is, you know.* (Clinical Nurse Manager 7).

> "*You know, or is it that you have too many patients to think of at once. You know, that you haven't the time to look at them all or speak to them all."* (Clinical Nurse Manager 8).

> *"You listen to their story but if there's ten waiting to be triaged and they're saying about is just not really relevant to why they're here now, we'd kind of have to discreetly cut it short."*
>
> (Staff Nurse 22).

Furthermore, inattentive listening and focusing on the present is sometimes taken to extreme levels when nurses simply ignore patients. Some nurses describe how they avoid eye contact and hurry quickly away from a patient because they have so many tasks to complete:

> *"I suppose then as a nurse as I said facing in to patients and relatives that you're passing in the corridor, I know we all develop this blank look. They're at the side and you walk up to tea room or you walk out of the department. I don't see them, I don't see them, and after awhile you don't see them."* (Clinical Nurse Manager 5).

"I think maybe nurses are not making eye contact with them because they're like oh God, I can't take another job."

(Advanced Nurse Practitioner 4).

Emergency nurses attempt to avoid rationing care by trying to stretch themselves and cover as many patients as possible. They describe it as "*working to a point where you're splitting yourself a couple of different ways to accommodate a high volume of people*" and like being "*pulled in all directions"*. Nurses revert back to task based nursing as a coping mechanism for the increased workload in an attempt to maintain minimal levels of patient care. However, when nurses ration care and are pulled in all directions trying to cover patients, their practice becomes inefficient and they fail to adequately cover all patients. In these interview transcriptions, nurses state that tasks are being left incomplete or forgotten altogether:

"So what happens is the less important things fall by the wayside. The basic nursing care that makes people really comfortable isn't done and it should be because it's more important."

(Clinical Nurse Manager 7).

"You can sometimes maybe not forget altogether but you forget what you're about to do because you've been interrupted and then when you remember, you know some time has passed and you realise that patient is still waiting or oh, I never went and did that particular job. You know, I think most of the time you will remember and do it and just be delayed but there must be incidences where people are forgetting things completely."

(Advanced Nurse Practitioner 7).

Rationing care leads to tasks being left incomplete or forgotten; nurses prioritise the sickest patients at the expense of others and nurses stop communicating effectively with patients. It is unsurprising then, that nurses feel that this situation is unsafe for patients. Emergency nurses in this study voice their concerns that serious clinical incidents are much more likely when patient overcrowding exists and care is rationed:

"Somebody is going to have a serious mishap. You just don't have the staff. You know, you're lucky to do their first bit of vitals. You rarely get in to do the second set. If you have a niggly feeling about somebody you say I must go back and check how she is, but you don't get to go back and check because there's far more pressing things." (Clinical Nurse Manager 7).

"You know, you're always running, you know and unfortunately you're always worrying in case something is going to go wrong and you're going to come back and you're going to find something wrong." (Staff Nurse 20).

"You stop communicating with patients as much because you haven't got time so you're constantly running from one job to the next."
(Advanced Nurse Practitioner 7).

Nurses prioritise the immediate task in an attempt to complete part of the workload and in an effort to maintain some sort of control over the situation. They do this, however, at the expense of other patients who may have a pressing need for nursing intervention. Nurses understand that what they are doing is morally wrong and they feel morally conflicted about their choice as evidenced in this extract:

"You're making judgements. You're making, it's not just a clinical judgement as to who is the sickest because that certainly comes into it and that's probably the largest part of the decision. You're also making even a social, moral judgements in that you're trying to say well, this elderly person should get the bed before this young person because the young person can manage staying on a trolley for another night, whereas this elderly person really can't or this elderly person is confused and should go into the bed ahead of this other elderly person who is not confused and you're making these judgements."
(Advanced Nurse Practitioner 7).

Rationing care is a major cause of moral distress as it is the anathema to the spirit of nursing or caring. This situation over which nurses have little control, forces nurses to compromise the high standards that they expect of themselves.

In extreme cases of rationing care, individual patients may receive no care at all if they are not prioritised. Rationing care is tied to overcrowding, poor physical environment and increased waiting times. The inability to care results in frustration and moral distress and is the complete converse of nursing and therefore nurses find it impossible to accept. Nurses feel that their personal standards for nursing and their own moral standards are completely compromised.

Consequences of Compromising Caring and Rationing Care for the Nurse

When nurses are faced with increased levels of overcrowding, their ability to fulfil the nursing role is impaired and they engage in compromising caring as a coping mechanism to deal with the increased level of patient demand. When compromising caring progresses to rationing care, the consequences become more pronounced and severe in nature. The consequences of compromising caring and rationing caring are described in this section and include frustration, moral distress and burnout.

Frustration

Frustration is part of the downward spiral that is composed of frustration, moral distress and burnout. Frustration may be experienced by nurses, patients and relatives in response to overcrowding and deteriorating conditions in the Emergency Department. In terms of the substantive grounded theory in this study, the category of frustration describes one of the feelings of nurses responding to compromising caring and rationing care. Nurses experience frustration due to delayed patient treatment and the presence of admitted patients awaiting beds in the department. Their frustration appears to arise out of an inability to fulfil the caring role or to change the situation and do what they have been trained to do. Emergency

nurses in this study express frustration at "not being able to get patients in" for treatment. They feel that they have no control over the situation and that the physical environment and overcrowding hinder nursing staff from fulfilling their role. Nurses are frustrated that they have to chip away at their own standards and reduce their own practice to a substandard level.

In addition, nurses describe how frustration can build to the extent that "you just want to blow a head gasket" and how nurses "feel fed up with" the work environment. Nurses sometimes vent their frustration at management. Nurses feel that they have to fight with management to get their position acknowledged and that management don't understand how an Emergency Department really works. The following passage describes the disconnect between managerial impressions of the work environment and emergency nurses experience of that same environment:

> *"One night and I was here and the night sister was introducing another new person starting to work the night shift and she was like aren't you great, aren't you fierce quiet? There's no one in Resus or anything and I was like oh my God like, you know. Your Resus department should completely be empty nearly always and she was like sure you've no one here. I was like, Jesus, like you don't even understand. Then she came down two hours later and the place was up to 90. There was stuff going on and I said see, now. They don't understand how ten steps ahead you have to be in emergency nursing. Like, everything has to be there and they just, I don't think they get it. Sometimes I don't. They only see things as numbers."*
>
> (Staff Nurse 6).

This frustration with management is not helped by the fact that management are perceived to be absent or not in attendance enough. There is a feeling among nurses that management pay lip service to the overcrowding problems in Emergency Departments. Frustration leads to feelings of guilt as the frustration is not vented or expressed and the cause of the frustration (moral distress) is unresolved or even irresolvable. In the following

interview extracts, nurses express guilt and frustration at not being able to give patients proper standards of care:

> *"It's really frustrating because you know it's not right. Guilty. You actually feel guilty, yeah and there's no sort of supports. There's no managerial support that says okay, we'll help you to do this. We'll move this person out. It's nothing. It's taking more from you than giving you. It's very irritating."* (Staff Nurse 2).

> *"You feel you've let them down, you're not giving them the care they deserve but you can only give so much of yourself. You come out the door at 8 O' Clock feeling crappy enough. You do. You feel I didn't do much today. You feel demoralised."*
>
> (Clinical Nurse Manager 7).

Finally, nurses' frustration builds over time as they see no improvement in patient conditions and perceive that the overcrowding issue persists and is outside of their control. Indeed, these nurses describe how they can't practice at reasonable expected levels due to the crowded environment:

> *"It's really frustrating because you know it's not right. Guilty. You actually feel guilty It's very irritating."* (Staff Nurse 2).

> *"There's nothing you can say and there's certainly nothing you can do. It's like moving deck chairs on the Titanic really ."*
>
> (Advanced Nurse Practitioner 2).

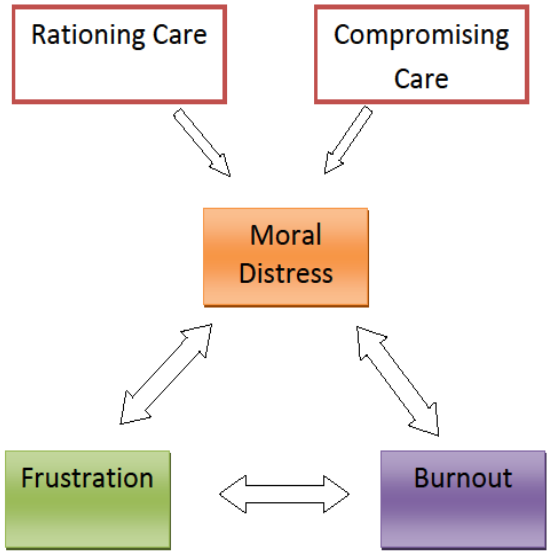
> *"You know what best practice is and you're not able to fulfil it and there's no way you can fulfil it in that environment."*
>
> (Advanced Nurse Practitioner 7).

Frustration at having to compromise competence and ration care is closely related to the next stage in the downward spiral of nurse experience and emotion, the stage of moral distress.

Moral Distress

Moral distress describes a process where nurses are prevented from providing quality care to patients due to overcrowding, poor staff skill mix and shortages and compromising care. Moral Distress emerged as a category early in the participant interviews. The category of Moral Distress was subject to constant comparison to ensure its earned relevance in the study. Multiple examples of Moral Distress were identified in multiple participant interviews. In this study, emergency nurses experience moral distress in empathy with the suffering of patients. Overcrowding and the poor care environment contribute to moral distress as they force the nurse to compromise and ration the care delivered. Compromising Caring and rationing care result in frustration and moral distress for the nurse, and in some cases to symptoms of burnout (Figure 6.3)

Figure 6.3 Compromising Caring, Rationing Care and Moral Distress



In particular, nurses find it difficult to manage the lack of comfort measures which result in physical distress among patients. This may be because they view the alleviation of pain and physical discomfort as one of the 'essential' elements of nursing care and they feel frustrated when they cannot deliver

these most basic elements of nursing care. In these examples, nurses seem to become particularly animated in response to elderly patients being left to experience physical discomfort:

> *"The elderly generation that I see quite often that I feel particularly distressed about sitting in an uncomfortable chair."*
>
> (Advanced Nurse Practitioner 1).
>
> *"It's so distressing, the noise and they must be terrified. Some of them must be terrified."* (Staff Nurse 6).

> *"They feel a bit distressed, I'd say, the elderly patients especially, because just the sheer volume of people walking around the desk like and the noise level can be fairly high during the day. I'd say they could be a bit like oh my God, they're going to forget about me or like pacing the corridor."* (Staff Nurse 8).

> *"You know, someone is looking for an extra pillow or blanket and you don't get to go back to them or you're quite delayed getting back to them and this all adds to the frustration, discomfort, pain and unpleasantness of the environment."*
>
> (Advanced Nurse Practitioner 7).

The sliding scale from compromising caring to rationing care results in the nurse compromising their own morality as they perceive the 'chipping away' at their own standards as an immoral act. This immoral act has the direct consequence of compromising the quality of care and in some cases, patient safety. By forcing nurses to compromise their morality, they feel that they are compromising their professional identity. This disconnect between desired practice and actual daily practice causes a severe *situational bind* (Nathaniel, 2006) for the nurse that results in moral distress. In emergency nursing the situational bind is not caused by nurses being forced to deliver care that they feel is unjustified or futile. In emergency nursing, moral distress is caused by the forced delivery of poor quality care that the nurses cannot reconcile with their own sense of morality. In addition, it is the

cumulative effect of minor daily reductions of what is deemed acceptable practice that lead to moral distress rather than a seminal event.

Nurses try to alleviate moral distress by temporary solutioning. When temporary solutioning is not achieved nurses engage in compromising caring and rationing care. The compromise forced by the inability to balance impossible competing demands creates the situational bind of moral distress and is almost like the line in the sand for nurses. It is the absolute minimum care to ensure patient safety that they reconcile with their own morality. Moral distress leads to further frustration and burnout unless it can be alleviated by role fulfilment and delivery of core caring. For some nurses the effect of prolonged or cumulative moral distress is too much and they resign from their post or leave nursing altogether.

Nurses also feel moral distress when a patient's privacy and dignity are compromised due to overcrowding. Nurses perceive that dignity and the moral integrity of the patient are inextricably linked and dislike how it is sometimes compromised in the Emergency Department. Dignity is compromised by overcrowding, use of inappropriate spaces foe assessment and treatment and impingements on privacy. The dehumanising of patients by forcing them to wait for prolonged periods diminishes the moral integrity and inherent dignity of the individual. This leads to the objectification of patients. The poor physical environment and overcrowding create an atmosphere where it is impossible to give patients the time required to acknowledge their individual needs. Rationing of care and reduced attendance by nurses contribute to the dehumanising process. The inability to maintain the dignity of patients is a significant source of moral distress as it involves the delivery of substandard care that is less than the patient deserves. Loss of privacy and inappropriate exposure of the body to strangers erode patient dignity. Toileting in inappropriate spaces is linked to impaired dignity. Loss of personal space secondary to overcrowding impairs maintaining patient dignity. Patients are forced to see other patients with terrible injuries, covered in blood as they are moved from through the department. This diminishes the dignity of the observer and observed alike.

Nurse moral distress can manifest as frustration, problems sleeping, poor coping behaviours and burnout. Alarmingly, nurses describe "not being able to cope anymore" and observing colleagues who are "angry and annoyed, peed off, upset, staff nurses crying because of the conditions." Furthermore, nurses describe some of their co-workers displaying signs of being "extremely stressed out or crying or dreading coming in tomorrow morning". These features of nurses' moral distress in response to coping with the persistent levels of patient distress display signs of burnout and poor coping among staff members. Some nurses describe how job stress impacted on their lives or the lives of colleagues:

> "*It got to a stage where I wasn't sleeping at night. I was dreading coming in the next morning, coming in the car park there. During the winter months it was tough. A tough year. It was an eye-opener.*
>
> (Staff Nurse 18).

> *"I think they become increasingly demoralised and stressed out and burnt out but for some of these staff there's no choice."*
>
> (Advanced Nurse Practitioner 7).

Team working and leadership support help alleviate moral distress. Less overcrowding and better patient flow also alleviate moral distress. Nurses experience moral distress and frustration in response to the observed distressed of patients. Nurses experience a cumulative form of moral distress as a result of not being able to adequately care for patients in overcrowded Emergency Departments.

Some nurses experiencing moral distress have the ability to use *Reaffirming Moral Integrity* to break this cycle and avoid the downward spiral from frustration to moral distress and burnout. The situational bind of moral distress forces them to self protect and use these strategies as a form of moral shielding. For nurses who lack the ability to use these strategies, they may progress to emotional burnout and exhaustion.

Burnout

Burnout has been described as a syndrome of emotional exhaustion, depersonalisation and reduced personal accomplishment that can occur among individuals who do "people-work" (Maslach, 2003). Nurses are therefore prone to burnout through the very nature of their work and prolonged contact with sick patients. In this study, emergency nurses experience burnout as a result of unrelieved moral distress. The prolonged nature of the moral distress suffered by nurses as a result of compromising caring and rationing care, in particular, results in symptoms of emotional exhaustion and burnout. Nurses describe feeling 'fed up with it' and 'frustrated' because they know they will 'come in to the same thing as yesterday'. The lack of relief from moral distress results in a certain level of hopelessness and helplessness among nurses:

> *"Whereas now it's very difficult to maintain your kind of, I suppose, bright outlook or to be happy about coming into work because you know that every day you're going to go through you're going to do the best you can and at the end of the day you're going to be leaving patients behind you in a corridor and tomorrow you could be leaving them there again. So, it's very demoralising. After a while I'm sure, I know myself, you start thinking what's the point?"*
>
> (Clinical Nurse Manager 5).

Burnout was mentioned frequently during interviews when nurses were asked about their work in Emergency Departments. Nurses noted symptoms of burnout among their colleagues and in themselves. Nurses describe colleagues who 'would be angry and annoyed, peed off, upset, staff nurses crying because of the conditions'. Nurses recognise the changes in their ability to cope that might signal emotional burnout and often state that they may leave emergency nursing or the nursing profession altogether so that they "don't end up like those nurses that are so bitter and cross'. Nurses also recognise changes in their colleagues that signal burnout. One nurse describes seeing *'a huge difference in colleagues in a year. Huge difference. Girls that were just good craic, very, very sound, great nurses have become*

bitter and short-tempered and negative and awful to relatives. I don't think it's them. You know it's the pressure that leaves them that way do you know?'

Manifestations of burnout reported include frustration, feeling tired all the time, blocking out or compartmentalising experiences, detachment from experiences, feelings of helplessness, annoyance, crying, bitterness, resentment, negative attitude, feeling fed up with work, guilt, and poor staff morale.

Some nurses do recover from burnout but they sometimes change and become harder or less caring. Patient overcrowding causes moral distress which in turn causes burnout over time. Burnout among emergency nurses in this study was as a result of a cumulative process of unresolved frustration and moral distress over a prolonged period of time. The cumulative nature of prolonged moral distress leading to burnout was evidenced on numerous occasions across different interviews and subjects, as described in the following data excerpts:

> *"The nurse is taking the stick every day and I think over years and over time that too much of listening to the same complaints can burn nurses out."* (Advanced Nurse Practitioner 6).

> *"It's putting up with the complaints from patients that burns people out I think rather than the actual work. It's not the physical work. It's the psychological effects of listening to patients' grievances day in day out that the nurse takes all that and management don't really get it."* (Advanced Nurse Practitioner 6).

> *"From the staff pint of view it is very tiring, it is very frustrating. It is emotionally draining. A lot of people get burnt out."*
> (Advanced Nurse Practitioner 7).

A perceived lack of change or progress in changing poor care standards may lead to burnout as nurses become demoralised and question what is the point of trying in such impossible conditions. The incidence of burnout varies between nurses based on their own inherent coping mechanisms and their perceived locus of control. Many emergency nurses appear to have a finite shelf life due to moral distress leading to burnout and burnout leading to high staff turnover rates.

Nurses attempt to rationalise symptoms of burnout by focusing on the present or immediate situation. Reduced engagement with patients and rationing of care are some of the manifestations of burnout among nurses. In this study of emergency nurses, burnout arises as a combination of cumulative stress and crisis points or critical incidents. For some nurses the crisis point is a Resus case, while for others it relates to compromises in essential nursing care and the inability to provide care or effect change as detailed in the following interviews:

> *"So, then you can be more tired. You can be more cross with patients. You can be short with patients. You're under pressure with time. There's so many patients coming in, such a workload. You have to limit the amount of time and you're constantly being pulled in all different directions."* (Advanced Nurse Practitioner 7).

> *"I think you work to a point where if you're splitting yourself a couple of different ways to accommodate a high volume of people, a high volume of need and you can do that, but I think then when it comes to all you need is a bad Resus that will just tip you. You might be getting on fine and it's just one thing will break you."*
>
> (Staff Nurse 13).

The attendance of nurses in the Emergency Department and the immediacy of nurse-patient relationships lead to closer empathy between nurses and patient suffering and higher burnout in some cases. In the following quote,

one nurse reports a complete lack of understanding of stress and burnout by management:

> *"So, for some people, they leave and for those left behind it's a constant struggle. You do become tired. You are stressed. It is difficult. People get very annoyed. They get annoyed with each other. They're cross with each other. They get very animated and cross with management of not addressing the problem."*
>
> (Advanced Nurse Practitioner 7).

The most alarming insight into the level of burnout detailed by nurses was the severity of the impact on nurses' personal lives. Several emergency nurses describe 'dreading coming in to work the next day', while one nurse describes not 'sleeping at night' and wondering *'Mother of God, what's going to be on today? It certainly had a dramatic affect on my mental health. I was very stressed out. Very stressed. So, happy (to be) out now'*. (Staff Nurse 18).

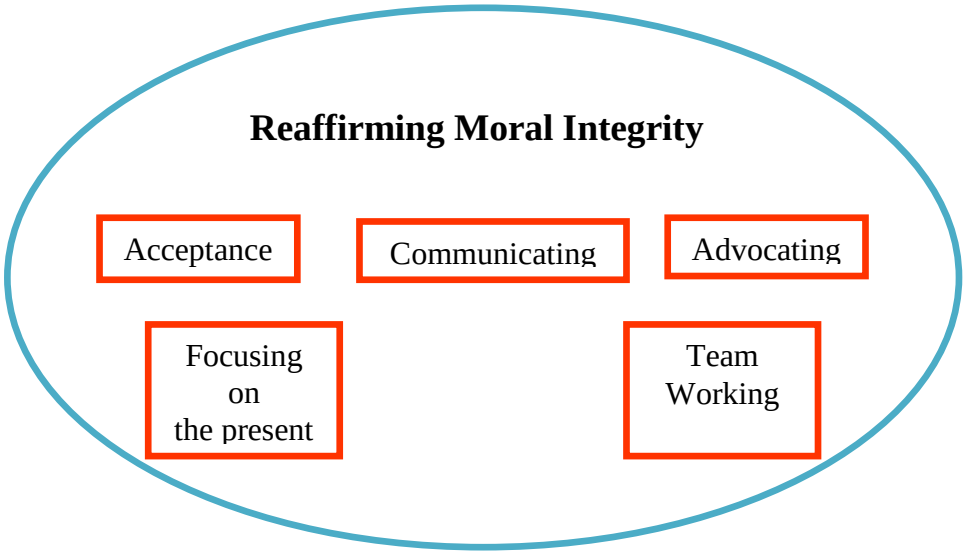
In this study, burnout was the end point of a downward cycle of negative emotion. When nurses are forced to ration care to levels that are incongruent with their own moral values, they feel immense frustration at their own inability to affect change or to advocate for their most vulnerable patients. The inability to vent their frustration adequately or to counteract the poor quality of care with direct action leads to moral distress. Emergency nurses are, in a sense placed in a situational bind as a result of the competing demands placed upon them by the healthcare system and their own moral values. When nurses are unable to resolve their moral distress they develop signs of burnout as described in detail in this section. However, some nurses are able to find a way to alleviate their moral distress. They do so through the concept of *Reaffirming Moral Integrity.* The following section describes this category and related properties in more detail.

Reaffirming Moral Integrity

Reaffirming moral integrity describes the way that nurses try to offset the effects of moral distress and frustration generated by compromising caring

and rationing care. These strategies for reaffirming moral integrity break the downward cycle of frustration and moral distress which results from rationing care. Some nurses, when confronted with the situational bind of moral distress, respond by using strategies for reaffirming moral integrity. Emergency nurses recover their moral integrity through a variety of morally driven actions including advocating, acceptance, focusing on the present and team working. The process of reaffirming moral integrity is illustrated in Figure 6.4

Figure 6.4 Reaffirming Moral Integrity



The first property of reaffirming moral integrity involves acceptance of the constraints placed upon the nurse by the healthcare system or organisation. The second phase of reaffirming moral integrity involves focusing on the present. This allows nurses to make some positive headway by completing smaller more manageable tasks. Finally nurses recover moral integrity by communicating with each other and with management to achieve advocacy and team working. Advocacy and team working are moral actions used to reaffirm moral identity. By engaging in moral action, emergency nurses regain a sense of their own moral values and reconnect with their own professional identity. This reaffirmation of a sense of morality justifies the stance that they take against compromising caring and rationing of care.

Even though nurses are unable to take the appropriate moral action, they feel that their moral stance is recognised and valued after reaffirming moral integrity. Therefore, reaffirming moral integrity can lead to a sense of role fulfilment and offset the effects of moral distress. Reaffirming moral integrity is a way for nurses to assert that compromising caring is an immoral act and that their stance was the correct moral position to take. This allows nurses to feel that the moral injury that they have suffered is recognised and sympathised with by other professionals and management.

Acceptance

Acceptance is the first property of reaffirming moral integrity. Acceptance describes the ability of the nurse to rationalise their moral position in the context of the intransience of the pervasive moral environment. There is a realisation from nurses that what is acceptable to them may have changed over time as they have become conditioned to overcrowding and poor standards of care. True acceptance in the context of reaffirming moral integrity then, describes the realisation among some emergency nurses that some situations are beyond their control or that the locus of control is external to them. It is important to differentiate between this form of true acceptance of the situation that aids reaffirming moral integrity from a sense of resignation. When nurses are unable to rationalise their moral position they describe a resignation that 'nothing can be done' and even a sense of despair rather than a true acceptance. Resignation describes the negative elements of acceptance only and conveys a sense of helplessness, whereas true acceptance empowers the nurse to move forward and recover her moral self.

Focusing on the Present

Focusing on the present is the second property of reaffirming moral integrity. It gives the nurse some semblance of control over an otherwise uncontrollable situation. This involves focusing on the task at hand and breaking the larger problem of overcrowding down in to smaller more manageable ones, as described by these nurses:

"I'm setting my priorities first, so my priorities, I don't go in and look at 50 patients on trolleys. You'd lose your mind if you were to do that. So, when I come in, even though I might walk down the corridor and there are fifty plus on trolleys, it doesn't bother me because my system is to break it down, where's the sickest patient in each section." (Clinical Nurse Manager 2).

"You have to accept that you can't do everything and you're going to have to prioritise and do the most important things first. If I can get to it, great. If I can't, I can't." (Staff Nurse 10).

"As I'm coming in the door now I just think 12 hours. 12 hours. Do what you can do. I'll do my best for everyone. We'll take whatever comes. We'll deal with whatever comes."

(Staff Nurse 11).

Focusing on the present appears to be a form of coping with competing demands and a means of counteracting moral distress. Nurses cope with competing demands and compromised care by blocking out some of what they see and focusing on smaller more manageable tasks. Focusing on the present is linked to moving patients and ensuring flow, as it involves prioritising the sickest patients and ensuring that they are safe. Nurses describe this as 'dealing with the biggest problem you have on the day' and 'doing the best that you can'. It also involves prioritising the fundamentals of nursing care, even though the other patients have to wait longer for care or may not receive care at all. Focusing on the present appears to be a way of reclaiming a small bit of that control with the immediate act of caring and prioritising. Focusing on the present is a method of placing a structure on a chaotic environment. It allows a small little piece of satisfaction for being able to complete a small task when the bigger task is impossible to achieve.

Advocating

Advocating is one of the properties of reaffirming moral integrity. It describes one of the strategies used by nurses to compensate for moral

distress. Nurses advocate to communicate the needs of patients or nurses' concerns regarding the patient to doctors, senior nurses or management. By verbalising unacceptable standards of care, nurses are attempting to advocate for their patients. They do this by discussing poor standards of care with supervisors, nursing management and with the wider public through friends and relatives. Nurses describe doing 'their best for the patient' but also 'being hindered' and having to engage in a 'constant battle' with management to advocate for their patients. Some nurses avoid discussing issues of care as they find they just get frustrated and angry when they do so. Emergency nurses describe themselves as a group that do their utmost to secure appropriate care for patients and see themselves 'as a patient advocate, to try and do what needs to be done' because 'the patient is at the centre of it all'.

In this study, nurses describe advocacy as 'speaking for those who have no family to speak for them, you're fighting for them" (Clinical Nurse Manager 4). Advocating invariably involves tension and conflict, most often with management. There are no descriptions of nurse-doctor struggles for advocacy. Nurses describe a lack of understanding or ignorance of the causes of overcrowding among the wider public and the need for nurses to better inform the public on these issues. Nurses advocate in particular for vulnerable patients such as the elderly or those without family-'with no-one to fight for them'. Nurses feel an inherent responsibility to fight or advocate for patients. Patients deserve better than the standard of care that they presently receive. Nurses advocate for basic dignity and privacy. Nurses describe frustration when they are unable to successfully advocate:

> *"We are their speaker and I find, I would find that frustrating. Then you have to decide which ones deserve the bed more and there's three little old dears lined up for two cubicles and really and truly each one deserves to be in a bed but we only have one. We can only allocate one bed. That for me is the upsetting bit, you know. I hate to see little old dears who don't really have a voice."*
>
> (Clinical Nurse Manager 9).

A key part of advocating is communicating nursing concerns to nurses, doctors and management.

Team working

This describes how nurses communicate to each other, help each other cover patients and support each other in a time of crisis. Team working involves trusting other nurses to cover you and support you when the workload increases. Team working involves 'pulling together' to care for patients. These nurses describe how when they work as a team that they can handle anything:

> *"No matter what comes in, you know there's going to be a good team effort. You can still enjoy it, do you know. So, if you feel that, let's say if you were on a good team, anything can be done."*
>
> (Staff Nurse 15).

Nurses respect other nurses that work hard and support each other by informally checking details with each other or 'bouncing' ideas off of each other to sense check what they are doing. Nurses are very aware of junior staff members and their need for additional support. Nurses try to protect them by offering more support and cover for these nurses especially if they are struggling with their workload. Team working involves assessing each other's skills and capabilities and then reacting accordingly. This dictates who will need support or covering and how much support or covering you can expect in return. Mutual respect between colleagues contributes to teamwork. Experienced nurses are better able to team work as they are familiar with the running of the department and have the requisite skills. These nurses describe the sense of achievement gained from working efficiently as a team to help patients:

> *"A patient comes in, there's something wrong with them. You treat them as a team. You get them feeling better, looking better. You have a diagnosis that can be treated somewhere else if not here and they're moved on."* (Clinical Nurse Manager 5).

"If you were good clinically you could really and truly make the difference between life and death and really make a difference to someone's life at their greatest need or at the hour of their greatest need." (Advanced Nurse Practitioner 7).

In addition, nurses gain a sense of achievement when other team members listen to them and acknowledge their clinical judgement and experience:

"I like the fact that nurses in A&E, in comparison to colleagues of mine who work on the wards still, we have a lot more say in a positive point of view with regards... we're listened to, I think, more. We're respected more. Our opinions by the doctors are taken on board more so maybe than some of the doctors on the wards. You know, we're a lot more involved in their care from the start when they come in, you know what I mean?"

(Staff Nurse 24).

Team working leads to a sense of achievement derived from successfully treating patients in an environment where the ability to treat patients efficiently is the exception rather than the established norm. Team working leads to role fulfilment among nurses and helps to re-establish the moral identity of the nurse by re-affirming the way that things should be done rather than how they are done at present. Furthermore, team working gives a sense of purpose by helping set a moral benchmark for efficient professional care. This benchmark is then used to assess current poor practice and the immoral acts of compromising caring and rationing care. This benchmarking helps re-affirm the moral position of the nurse and to aid the recovery of moral integrity and assuage the effects of moral distress.

6.6 Summary of Findings

The findings of this study are situated within the context of increasing demands on health services in Ireland and internationally. An ageing population and the increasing costs of healthcare are drivers for encouraging increasing numbers of patients with more complex medical needs to seek

care in Emergency Departments. In Ireland, this increased demand is exacerbated by cutbacks to funding and resources in recent years.

The main concern of emergency nurses experiencing moral distress is *balancing the competing demands* of emergency patients and admitted patients or the competing demands of maintaining patient flow and patient overcrowding to maintain standards of care. In addition, nurses have the competing demands of their own moral values and professional ethics competing with the institutional restraints placed upon them by hospitals and the wider management of the health system. The inability of nurses to balance these competing demands leads to a resolution through the process of *Adaptive Competence.* Adaptive Competence is the core category that resolves the main concern of nurses and that explains all the other categories together. In other words, adaptive competence is the centre point of the substantive grounded theory. Adaptive competence involves a process whereby emergency nurses engage in temporary solutioning in the absence of overcrowding or systematically step back the level of care that they provide to patients in response to increasing demands. This process of stepping back and restricting their practice is conducted along a sliding scale of compromising caring to the rationing of care.

As nurses' caring is compromised, they engage in covering patients. Covering patients involves a minimalist approach to prioritising care and maintaining safety. When nurses are unable to cover patients adequately they engage in the rationing of care. Rationing of care involves reducing caring to a dangerous degree where patients receive substandard care or no care at all. When nurses engage in rationing care in response to patient overcrowding in the Emergency Department it consists of preserving life and attempting to avoid harm for the sickest patients only with no care being offered to other, more stable patients. This extreme level of rationing care leads to immense frustration among emergency nurses as they are unable to perform their duties in an efficient manner and feel guilty at the poor quality of care provided.

If the frustration of rationing care is not vented, it leads to moral distress. Moral distress among emergency nurses is a cumulative process of distress caused by the inability to act morally when confronted with the immoral situational bind caused by patient overcrowding. This cumulative process may be peppered by critical incidents that exacerbate the level of distress experienced by emergency nurses. Many of the nurses in this study described signs of burnout recognised in their own or in colleagues' behaviours. This emotional cycle of frustration, moral distress and burnout persists and leads to some nurses leaving emergency nursing. However, some nurses break this cycle of moral distress and frustration to avoid burnout. These nurses find ways of reaffirming moral integrity to prevent moral distress and preserve some element of role fulfilment. This results in moral resilience and a better ability to cope with moral distress.

The findings of this study have generated a unique grounded theory of moral distress among emergency nurses that involves a complex social process of compromising caring, rationing care and temporary solutioning. The findings are discussed in detail and compared with the extant literature in the next chapter, helping to situate this theory within previously published studies and fulfilling Glaser's (1978) quality criteria for grounded theory studies of 'fit', 'work' and 'relevance'.

Chapter 7 Discussion of Findings

7.1 Introduction

This chapter discusses the grounded theory which emerged from the substantive area of interest of understanding emergency nurses' experiences of moral distress and compares this theory to the literature on the substantive area. The theory of Adaptive Competence emerged from the findings and was then compared to the concepts from a focused secondary literature review to ground the theory within the existing body of nursing knowledge (Burstrom, *et al.*, 2013).

The findings described in Chapter 6 described how Emergency Department nurses deal with their main concern of balancing the competing demands of maintaining patient flow and patient overcrowding. Nurses resolve this main concern by engaging in a sliding scale of professional practice which is summarised in Table 7.1. This sliding scale sees nurses alternate between different levels of temporary solutioning and compromising caring. Nurses tailor their level of professional practice to the demands placed upon them by a changing workload.

Table 7.1 Summary of Study Findings

<table>
<tr><td colspan="3">Balancing competing demands to maintain standards of care</td></tr>
<tr><td colspan="2">Maintaining Patient Flow</td><td>Patient Overcrowding</td></tr>
<tr><td colspan="3">Adaptive Competence</td></tr>
<tr><td>Rationing Care
Overcrowding has reached crisis levels. Patient care is inadequate or non-existent for some patients. Nurses engage in significant stepping back of care to cater for sickest patients only.</td><td>Compromising Caring
Care delivery is compromised due to significant overcrowding in the Emergency Department. Patient care is at a minimum basic level. Overcrowding and/or poor staffing have a direct effect on the ability to deliver care. Nurses engage in Covering and Stepping Back.</td><td>Temporary Solutioning
Temporary Solutioning involves finding novel ways to get patient flow going. These include:
Stretching Capabilities
Going up a Gear</td></tr>
<tr><td colspan="3">Consequences</td></tr>
<tr><td>Frustration</td><td>Frustration</td><td>Role Fulfilment</td></tr>
<tr><td>Moral Distress</td><td>Moral Distress</td><td>Moral Resilience</td></tr>
<tr><td>Burnout</td><td>Burnout</td><td></td></tr>
<tr><td colspan="3">Reaffirming Moral Integrity</td></tr>
<tr><td colspan="3">Contextual Factors</td></tr>
<tr><td colspan="2">Increasing Patient Expectations</td><td>Diminishing Financial Resources</td></tr>
<tr><td colspan="2">Increased Service Demands</td><td>Reduced Staffing Numbers / Skill Mix issues</td></tr>
</table>

7.2 The Theory of Adaptive Competence

The main concern of emergency nurses experiencing moral distress was balancing the competing demands of maintaining patient flow and patient overcrowding to maintain standards of care. Nurses resolve this main concern by engaging in *Adaptive Competence* which is the core category of this study. Adaptive competence is the category that explains the majority of the variance in all the other categories and gives cohesion to the entire grounded theory which emerged from the findings of this study.

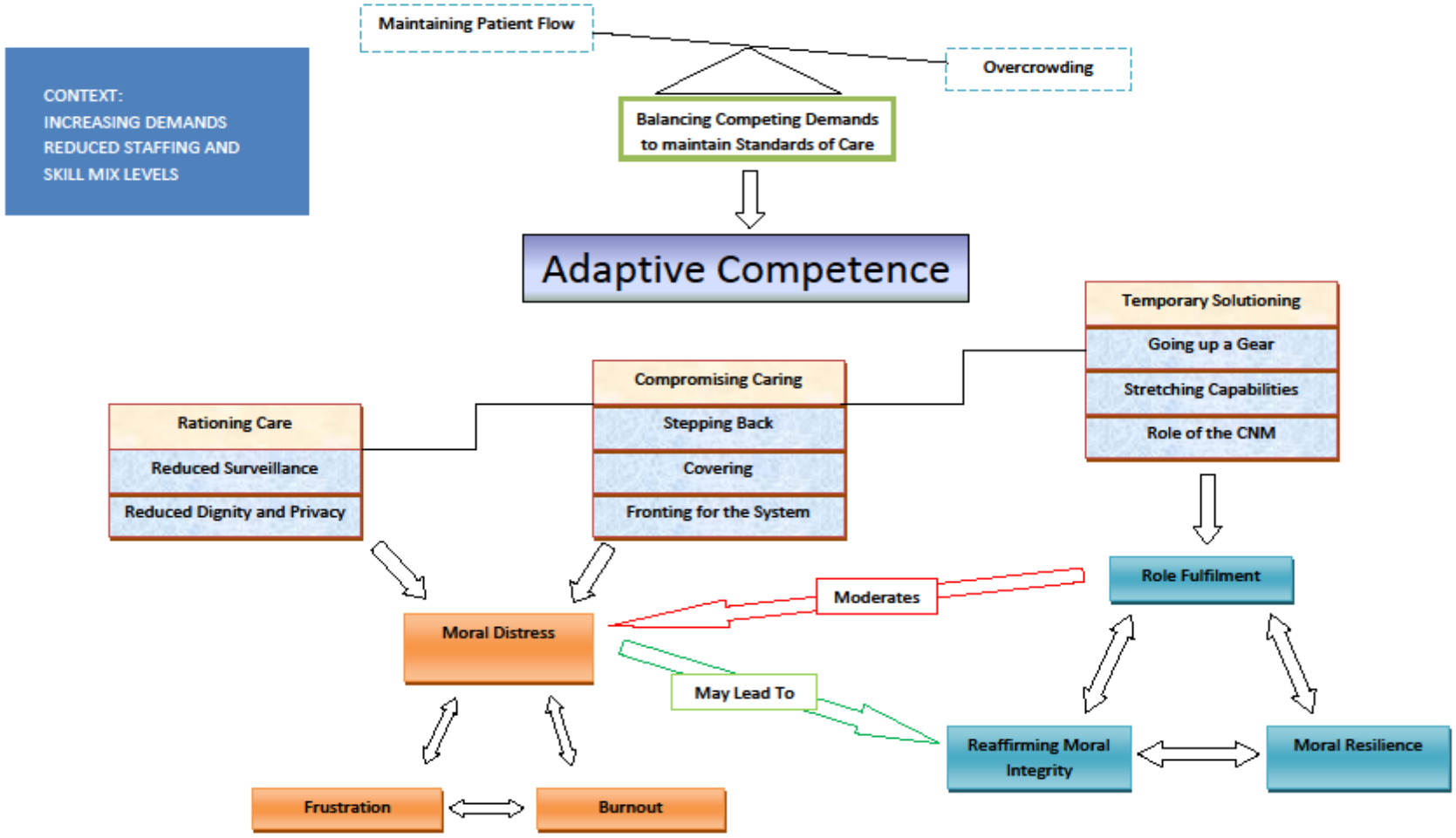
Adaptive competence is achieved by engaging in a sliding scale of competence ranging from *Temporary Solutioning* at the top of the scale to *Compromising Caring* as the default middle level and *Rationing Care* at the bottom of the scale. Temporary solutioning involves finding a temporary 'work around' for the problems of decreased patient flow and patient overcrowding. For example, nurses engage in temporary solutioning when discharging patients from triage, identifying patients suitable for Rapid Assessment and Treatment (RAT) and extending their practice to include additional skills such as venepuncture and cannulation. Temporary solutioning helps to re-affirm moral integrity and develop moral resilience among nurses and leads to increased role fulfilment. Compromising caring involves the conscious curtailment of nursing care to certain patients to concentrate on the sickest patients. Rationing care involves reducing care to unsafe levels in response to overwhelming overcrowding. Compromising caring and rationing care have the effect of causing moral distress and frustration among nurses, which may in turn lead to burnout.

Along the length of the scale, emergency nurses engage in variable levels of *Temporary Solutioning* and *Compromising Caring*. In other words, when quality practice is being achieved, the emergency nurse engages in more temporary solutioning and less compromising caring. When rationing care is being employed, the emergency nurse engages in severe compromising caring and temporary solutioning becomes impossible to achieve.

When clinical demands are met and overcrowding is minimal, Adaptive Competence may result in role fulfilment, where the nurse is able to practice without real compromise and maintain safe standards of care. Compromising Caring involves a bare minimum level of practice where the priority is to prevent harm to an increasingly unmanageable number of patients. The final potential outcome of Adaptive Competence is Rationing Care which involves the disordered, ineffective prioritising of the most critically ill patients at the expense of safe standards of care for other patients. Compromising Caring and Rationing care result in frustration, moral distress and, in some cases, burnout. A diagram depicting adaptive competence is shown in Diagram 7.2.

The grounded theory of Adaptive Competence takes place in the context of increasing patient demands and diminishing healthcare resources exemplified internationally by nursing staffing shortages and service cutbacks.

Figure 7.2 Theoretical Model of Adaptive Competence



7.3 Critical examination of the theory

In this section, the study findings are compared to the published literature, using the theory of adaptive competence as a framework to structure the discussion. The literature is checked for *emergent fit*[10] (Glaser, 1978) with the theory of Adaptive Competence to situate the study findings within previous theories and modify the theory as required. It would be impossible to compare the findings to all of the published literature covering topics as diverse as patient overcrowding, healthcare rationalisation and moral distress. Instead, the literature was reviewed for relevant concepts and theories that relate to the main findings of this study.

7.3.1 Contextual Factors

Increasing Demands

The findings of this study reflect the available literature relating to increased demands on healthcare resources internationally. Nurses work in increasingly difficult environments that are characterised by increasing demands on nurses (American Association of Critical Care Nurses, 2005; Glasberg, *et al.*, 2007b) and fiscal reductions and reconfiguration of services (Dunn, *et al*., 2005; Comptroller and Auditor General Appropriation Account, 2013; Nolan, *et al*., 2014). Patients with increasingly more complex healthcare needs (Sigma Theta Tau, 2001) are also demanding more intensive and complex services (Cox, *et al*., 2005). This increase in case complexity and patient numbers has had a knock on effect on nursing workload and job satisfaction (Aiken, *et al*., 2001; Sigma Theta Tau, 2001) in all areas but in particular in specialist areas such as emergency nursing. This is borne out in this study where nurses described struggling with the workloads experienced in overcrowded Emergency Departments.

Bed occupancy levels in acute hospitals in Western countries range from 82%-85% and frequently exceed 100% in Ireland (Deloitte & Touche, 2001). The issue of high bed occupancy has been compounded by an overall

[10] Emergent Fit refers to the process of constantly comparing findings to a pre-existing theoretical framework to check that the findings 'fit' with the framework. In this case, the framework is the previous literature on the subjects of overcrowding, moral distress etc.

reduction in the number of Emergency Departments and available acute hospital bed capacity. The problem is exacerbated by year on year increases in the number and complexity of cases attending Emergency Departments in many countries and particularly in the Western World (Aiken, *et al*., 2001; Sigma Theta Tau, 2001). This has resulted in perennial reports of patient overcrowding in Emergency Departments with a subsequent reduction in quality of care and patient safety (Higginson, 2012; Carter, *et al.*, 2014; George & Evridiki, 2015). Emergency Departments in this study have experienced ongoing overcrowding issues over a number of years in keeping with national overcrowding figures (Hughes, 2015). Nurses reported a significant reduction in the quality of care in EDs as a result of overcrowding and that unacceptable care had become normalised as ethical standards of practice have fallen. This is exemplified by the fact that where previously one or two patients were nursed on corridors, there are now multiples of that number boarded on corridors.

Patient overcrowding in Emergency Departments has been described as a "national epidemic" in the USA (IOM, 2011) and as an emergency in Ireland (The Irish Times, 2006). In the United Kingdom the crisis in Emergency Care provision has been described as being at "breaking point" with physicians warning that they can no longer safely provide care (Cooper, 2013; Withnall, 2013). In this study, nurses describe a system under immense strain where they are unable to provide adequate care and resort to *covering* patients and *rationing* care in response to overcrowding. These increasing demands take place alongside a marked decrease in the staffing numbers and skill mix available to nurses.

Diminished Resources

The reduced staffing levels and poor skill mix referred to by nurses in this study reflect the wider reduction in healthcare funding in Ireland and the difficulties in recruiting nurses and especially specialist nurses, back to Ireland. Increased demands on available resources have coincided with dramatic cuts to the available healthcare infrastructure (Dunn, *et al.*, 2005) in Ireland and internationally. Hospital closures, reconfiguration of services

and fewer Emergency Departments have coincided with an international shortage of nurses (American Nurses Association, 1992; Aiken, *et al*., 2001), particularly in specialist areas such as Emergency Department nursing. The international shortage of registered nurses (Kimball, 2004; Aiken, *et al*., 2014) is impacting the quality of patient care in several western countries and has been recognised as being unparalleled (American Association of Colleges of Nursing, 2001) and more acute than previous shortages (Kimball, 2004), with a truly global impact on healthcare delivery (Sigma Theta Tau, 2001; Aiken, *et al*., 2014). The current nursing shortage has been exacerbated in many countries by an ageing nursing workforce, an ageing population with increasing healthcare needs and increased financial pressures to reduce the cost of healthcare delivery (Kimball, 2004). The problem is not just one of a shortage of nurses per se, as even when there are adequate trained nurses; shortages may exist because nurses are unwilling to work in the current healthcare environment (Buchan & Aiken, 2008). These findings are corroborated by participating nurses in Emergency Departments in this study who describe a consistent lack of nursing staff evidenced by daily shortages and a reliance on agency cover. The reduction in nursing numbers in Emergency Departments is corroborated by the fact that healthcare funding in Ireland was reduced significantly between 2008 and 2013 from €15.4 billion to €13.6 billion (Nolan, *et al*., 2014) with a concurrent removal of 11,000 healthcare posts since 2007 (Health Service Executive, 2013).

7.3.2 Competing Demands of Overcrowding and Maintaining Flow

In the literature, Emergency Department overcrowding is classified as having three causes: input factors, throughput factors and output factors (Hoot & Aronsky, 2008). The major input factor relates to non-urgent attendees seeking treatment in EDs. The most common throughput factor impacting on crowding levels was the provision of inadequate staffing levels and the most common output factor influencing overcrowding was the boarding of admitted patients in the Emergency Department (Hoot & Aronsky, 2008). It is important to note that the input factor of low acuity patient attendance does not significantly impact on overall overcrowding

levels (Forster, *et al*., 2003; Spirivulis, *et al*., 2005; Rathlev, *et al*., 2007; Schull, *et al*., 2007; Trzeciak & Rivers, 2009). Similarly, in this study, participants did not identify input factors and the attendance of low acuity patients as being a major factor in the levels of ED overcrowding.

The findings of this study indicate that the throughput factor of nurse staffing impedes nurses' ability to manage patient overcrowding. While nurses in this study did not identify nurse staffing as a cause of overcrowding, they did describe how poor staffing levels and inappropriate skill mix can hamper efforts to manage overcrowding and worsen the problem. Participants highlighted that working with inexperienced nurses and agency staff can cause increased work demands and stress on staff nurses as they have to supervise inexperienced nurses in addition to their own patient load.

In this study, the main factor affecting overcrowding highlighted by nurses was the boarding of admitted patients in the Emergency Department. From the earliest interviews, this output factor was identified by participants as being the major cause of patient overcrowding. This finding is in keeping with the published literature which shows that the most important factor influencing ED overcrowding is the boarding of admitted patients (Forster, *et al*., 2003; Spirivulis, *et al*., 2005; Gilligan, *et al*., 2007; Rathlev, *et al*., 2007; Schull, *et al*., 2007; Trzeciak & Rivers, 2009; Pines, *et al.,* 2011). This finding would also tally with the fact that Ireland has a below average number of hospital beds when compared to international standards (Hickey, 2006) and a recognised need for the provision of more acute hospital bed capacity (Department of Health & Children, 2002).

Patient overcrowding has been linked to poor patient flow due to impaired access to ED care (American Academy of Paediatrics, 2004; Hoot & Aronsky, 2008) and the poor performance of doctors working in this overcrowded work environment (Derlet & Richards, 2000). In particular, caring for patients on hospital corridors has been linked with delays in care (Richards, *et al*., 2014). In one Irish hospital, 80% of admitted patients

were cared for on ED corridors (HIQA, 2012). In fact, the nursing of vulnerable patients on trolleys on corridors was a major trigger for moral distress among Emergency Nurses. In this study, ED nurses also found that patient overcrowding impaired patient flow and the ability of the ED to function properly. This forms the main concern of nurses in the study who attempt to *balance the competing demands* of overcrowding and maintaining flow.

7.3.3 Impact of overcrowding on emergency nurses

Emergency Department overcrowding has been shown to affect nurse job satisfaction, stress levels and intention to leave a post among nurses (Keough, *et al*., 2003; Sawatsky & Enns, 2012). Furthermore, it has been suggested that high stress levels among Irish nurses may be linked to overcrowding and moral distress (Kilcoyne & Dowling, 2007). The findings of this study have confirmed that nurses experience moral distress due to overcrowding with some nurses leaving emergency nursing as a result. Gilligan & Quin (2011) have highlighted that overcrowding adversely affects the quality of patient care and Kilcoyne & Dowling (2007) have previously shown that nurses experience frustration due to the inability to ensure patient dignity and privacy (Kilcoyne & Dowling, 2007). This study also showed that nurses experience frustration due to poor quality of care and the inability to ensure patient dignity. The important difference found in this study was that this frustration can result in moral distress and burnout. In addition, the moral distress experienced by emergency nurses was not caused by futile care or patient deception but was rather as a result of being forced to practice poor standards of care and being unable to deliver patient care that was commensurate with their personal and professional standards. These findings would suggest that the causes of moral distress may be influenced by practice contexts.

7.3.4 Balancing and Compromising

In this study, the category of Balancing competing demands to maintain standards of care emerged from the data as the main concern of participants. The fact that balance is difficult to achieve would suggest a system that is

unbalanced one way or another. Indeed, participants stated that this was the case and that the care given to patients was compromised due to a lack of space and facilities. This concept of attempting a 'balancing act' between competing demands is congruent with other studies of moral distress (Irurita & Williams, 2001; Thulesius, *et al.*, 2003; Rose & Glass, 2006; Austin, *et al.*, 2008; Curtis *et al*., 2012). Austin, *et al.* (2008) examined moral distress among psychiatrists who attempted to fulfil the dual roles of caring for the individual patient and society's wider expectation that they will 'do the right thing'. The duality of the ethical problems generated resulted in an attempt by psychiatrists to find balance between these conflicting demands (Austin, *et al.*, 2008). Emergency nurses in the present study experience moral distress as a result of trying to balance the competing demands of attending to admitted patients and emergency patients who compete for the nurses' time and attention.

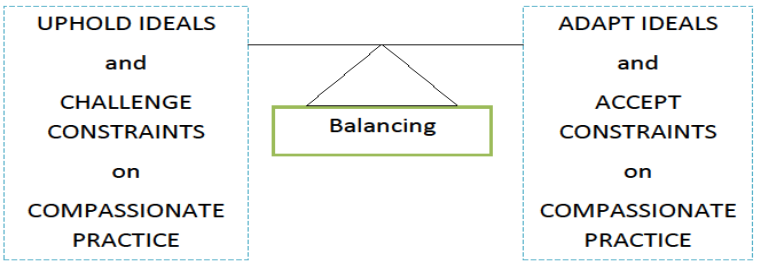
The end result of trying to balance unrealistic competing demands is a compromise. Emergency nurses achieve this compromise by engaging in adaptive competence to manage this balancing act. Balancing invariably results in middle of the road solutions and compromise. The compromise is what brings some degree of balance to the situation to achieve a resolution (Glaser, 2005). Indeed, balancing and compromising are sometimes used as a single theoretical code as they invariably occur together. For example, the grounded theory study by Irurita and Williams (2001) examined patients' and nurses' experiences of nursing care delivery in acute care hospital settings. The present study of emergency nurses found that the shared problem between nurses and patients of threats to integrity was resolved by the theoretical code of *Balancing and Compromising*. Balancing was used to gauge the relative weight of conflicting demands and compromising was used deliver an outcome where concessions were made on both sides of the balancing equation, so that the outcome was an intermediate position or unfavourable outcome (Irurita & Williams, 2001). A balancing code is also used in the present study to explain how nurses strive to balance the competing demands of managing flow and managing overcrowding. Balancing among emergency nurses is resolved by the theoretical code of

Adaptive Competence. In the present study the unfavourable outcome of balancing is compromising care and rationing of care.

The concept of balancing and compromise was another important finding in community palliative care (Rose & Glass, 2006). A literature review found that community nurses' ideals for care are compromised by competing practice demands. Community nurses were found to work in an objective system that was philosophically removed from most of their values and principles. A lack of adequate resources and staff shortages were found to be causing increased time demands and causing stressful work practices (Rose & Glass, 2006). The present study found that emergency nurses struggle to reconcile the difference between professional standards of practice and the reality of nursing in overcrowded EDs 'at the coalface' of care. In emergency care this disconnect arises due to increased work pressures and stressful work practices caused by overcrowding. Staff shortages in Emergency Departments compound the problem of work pressure. In Emergency Departments the concept of compromised practice is explained by the categories of adaptive competence, compromising caring and rationing care found in this study.

In a grounded theory study of student nurse socialisation in compassionate practice, Curtis, *et al*. (2012) found that student nurses were vulnerable to dissonance between their professional ideals and practice reality. Students manage the uncertainty associated with delivering compassionate practice by balancing their professional ideals with the need to adapt these ideals in the real world setting of clinical practice (Figure 7.8)(Curtis, *et al,* 2012).

Figure 7.8 Balancing ideals and constraints (Curtis et al, 2012)



However, unlike Curtis's model (2012), Emergency Nurses who experience moral distress seem unable to fully balance the competing demands of practice in overcrowded departments as they cannot accept the institutional constraints on their practice and struggle with adapting their professional ideals. The consequence is that emergency nurses experience frustration and moral distress.

A further example of the balancing code is found in the grounded theory of balancing in end of life cancer care (Thulesius, *et al.*, 2003). Balancing as applied to end of life care involved the stages of weighing the needs of the patient against available resources, shifting of balance and expectations and compensating or counterbalancing. There are numerous similarities between the model of balancing in end of life care and the model of balancing and compensating used by emergency nurses. In end of life care the needs of the patient are weighed against resources. However, as the present body of work in Emergency Departments demonstrates, this process of weighing patient needs against available resources is what causes moral distress as the resources are never adequate for patient need due to the imbalance caused by overcrowding. Overcrowding pitches the balance out of kilter, resulting in emergency nurses compromising caring and their own ethical standards.

The compromise that results from balancing in end of life care has the properties of time prioritising, time stretching, innovating and improvising

(Thulesius, *et al.*, 2003). Time prioritising involves identifying the most urgent concerns at the expense of other less urgent healthcare needs. The difficulty for Emergency Nurses is that the need to prioritise the most urgent patients is at the expense of less urgent cases and can lead to a breakdown of care characterised by compromising caring and rationing care. Emergency nurses prioritise time through the concept of attending to the sickest patients and non-attending of less acute patients. When resources are scarce in end of life care, time is 'stretched' where staff work extra hours to fulfil tasks. In emergency care, nurses engage in 'stretching' where they adapt their practice to 'cover' as many patients as possible when dealing with severe overcrowding. The stretching of resources and capabilities in response to constrained resources describes similar theoretical codes in both settings, albeit applied in different contexts. Furthermore, the concepts of innovating and improvising in response to changing priorities in dynamic situations in end of life care also apply to the strategies employed by emergency nurses adapting competence to balance competing demands. The difference between the settings is that Emergency Nurses engage in innovative strategies by temporary solutioning. Temporary solutioning explains the unique approach of nurses in this study to maintain flow by engaging in *stretching* of their scope of practice and *going up a gear* in an attempt to increase their work rate and power through the workload.

7.3.5 Covering Patients

Emergency nurses engage in covering patients as a property of compromising caring in response to increased levels of patient overcrowding. The goal of covering is 'to keep an eye on' as many patients as possible and to ensure a minimal level of safety. Essentially nurses are 'acting as wardens' and ensuring safety by constantly observing an increasing number of patients for signs of deterioration. The goal of covering is to prevent a patient 'going off' and deteriorating quickly. If a patient does deteriorate suddenly, then the goal of covering is to quickly recognise that sudden change in status and to respond accordingly to stabilise the patient.

Another grounded theory that identified a similar concept to 'covering' was described by Hutchinson (1996) who examined the survival practices of rescue workers for her PhD. Rescue workers initiate covering as a coping strategy for the uncertainty involved in clinical scenarios and work environments encountered by rescue workers Covering was described by Hutchinson as a protective mechanism in which rescue workers attempt to quickly visualise or 'case out' the patient and their environment before categorising the patient according to their priority and transporting them to the appropriate service. There are a number of parallels with covering as a concept among emergency nurses. Emergency nurses also use covering as a coping mechanism for uncertain environments encountered in overcrowded Emergency Departments. Visualising is also an element of surveillance or covering patients by emergency nurses when they describe 'keeping an eye on' a large number of patients to visualise and intuitively predict deterioration among patients. Categorisation is also a feature of covering in Emergency Departments when nurses constantly assess new patients to identify the most seriously ill individuals. Emergency nurses, like rescue workers, also engage in disposition of patients after categorisation when they rapidly move the deteriorating patient closer to the nurses' station for closer observation or when they transfer the patient into the Resuscitation Room for stabilisation.

The concept of covering patients has also been described in a number of studies involving firemen. In a grounded theory of leadership and sense making within dangerous contexts, Baran and Scott (2010) discovered leaders in high pressure roles such as fire fighting, police and emergency services face the challenge of rapidly making sense of changing contexts in dangerous environments. Their study found that leaders in these contexts engage in a basic social process of organising ambiguity which involved three stages; framing, heedful inter-relating and adjusting. Framing involves pattern recognition and the use of prior experience to contextualise the current problem. Potential hazards are recognised based on similarities to current and past events. Firefighters engaged in framing are using pattern recognition based on experience to rapidly assess and prioritise actions

during a crisis. Similarly, emergency nurses engaging in covering patients use their intuitive knowledge based on pattern recognition and experience to identify the patients most likely to 'go off' or deteriorate. This pattern recognition informs patient observation and action. Heedful inter-relating describes how leaders in dangerous situations engage in sense making by fixing meaning to environmental cues. Emergency nurses engage in a similar process when fixing meaning to changes in vital signs, patient colour and behavioural cues to indicate patient deterioration. The final stage of organising ambiguity involves adopting a flexible posture to allow for adjusting action in response to changes in the environment which is akin to the nursing process of triage as a process of continuous assessment intervention and evaluation in response to changing patient acuities.

The organising ambiguity model proposed by Baran and Scott (2010) has a number of similarities to the work of Klein (1999) who also studied decision making among fire-fighters. Klein developed the recognition-primed decision model which describes how fire-fighters use intuitive knowledge and mental simulations to develop alternate options for managing a dangerous situation and then adopt the option that most closely matches their professional experience of similar situations. This recognition primed model of decision making emphasises the importance of intuition and past professional experience. Participants in this study highlighted that experienced nurses were leaving and that there was an increasing reliance on agency nurses who may not have the same emergency nursing experience. This loss of experienced Emergency Nurses has implications for the ability to monitor patients for deterioration and failure to rescue[11] scenarios. Emergency nurses engaged in covering patients also use their professional experience and intuition to 'keep an eye on' the bigger picture of patient safety when facing increasing levels of overcrowding and a rapidly changing clinical environment. Intuitive knowing and contextualising of indicators of worsening patient status have also been examined in the intensive care context by Andrews & Waterman (2005). In

[11] Failure to Rescue describes scenarios where a potentially preventable serious deterioration in a patient's condition occurs resulting in patient harm or death.

the intensive care setting, intuitive knowing and contextualising were used to make credible the concerns of nurses to ensure appropriate action by medical staff.

In summary, when emergency nurses engage in covering patients, they engage in a process of rapid assessment, intuitive decision making based on pattern recognition and professional experience which is similar to decision making in pressured environments described by Baran and Scott (2010) and Klein (1999). Action is then modified according to contextual cues and adapted to a rapidly changing environment. However, when covering patients is not effective due to severe overcrowding or poor staffing levels and skill mix, then adverse outcomes such as failure to rescue may occur.

7.3.6 Failure to Rescue

Failure to rescue describes the sequence of events that occur when healthcare staff are unable to save a patient's life after a complication (Schmid, *et al.*, 2007). Failure to rescue has been used as a measure to evaluate the quality and safety of hospital care and involves a series of events that constitute systemic failure (Silber, *et al.*, 1992; 1995). Key elements of failure to rescue are the surveillance of patients and the instigation of prompt action to save the patient's life (Clarke & Aiken, 2003; Shever, 2011). The surveillance of patients by nurses in failure to rescue is similar to the covering of patients engaged in by emergency nurses in the present study. Surveillance involves frequent assessment, recognition of cues that the patient's status is worsening and recognising complications. Taking action to prevent failure to rescue involves alerting other staff members and initiating emergency patient stabilisation or life saving measures. (Clarke & Aiken, 2003). Failure to rescue then is what occurs when surveillance or the corollary of covering patients in Emergency Departments fails (Schmid, *et al.*, 2007). The deteriorating patient is not assessed frequently enough, the complication is not recognised or communication failures lead to a delayed or inappropriate response (Andrews & Waterman, 2005). These elements of failure to rescue have been identified as properties of *Compromising Caring* among emergency

nurses in this study who describe *Rationing Care* from some patients and the inability to engage in covering patients when overcrowding reaches crisis levels. The difference is that the practice of *Compromising Caring* and *Rationing Care* is widespread when Emergency Departments become overcrowded. This results in the conscious reduction of surveillance of some patients by the Emergency Nurse. Considering that the impact of failure to rescue is serious and may involve the death of a patient, the implication that reduced surveillance is commonplace as a result from patient overcrowding and rationing care is an alarming one.

7.3.7 Rationing Care

Rationing of care among emergency nurses is implicit, in that the nurse does not tell the patient that they are going to reduce the level of care provided, rather they say that they 'will be there in a minute'. The conscious rationing of care by emergency nurses to ensure the safety of the most critically ill patients is the frontline manifestation of the wider reduction in healthcare budgets and services both nationally and internationally. Frontline healthcare rationing is imposed on nurses as a result of the institutional constraint of reduced resources decided by politicians and enacted by healthcare managers. This constrained environment leads to a conflict between the intended standards of care that the nurse would like to deliver based on professional standards and practice norms, and the actual standard of care delivered with reduced resources. The ensuing conflict has an ethical element as it rails against professional standards and individual professional values, forces a moral compromise and results in moral distress (Papastavrou, et al., 2014; Humphries & Woods, 2015).

The funding of healthcare involves balancing costs and benefits and finding the best way to use limited budgets to maximum effect (Appleby, 2015). The fiscal constraints applied to healthcare are part of a wider neoliberal context of reform and healthcare rationing (Varcoe, *et al.*, 2012). The wider context of healthcare rationing internationally frames the present study of moral distress among emergency nurses. While it is accepted that a certain amount of healthcare rationing is necessary and indeed inevitable (Devlin, *et*

al., 2003), what is not clear is how rationing permeates down to frontline services. The rationing of care through reduced bed capacity and reduced service provision is an example of what Mechanic (1995) has described as implicit rationing. Implicit rationing is a form of rationing by stealth that is used frequently as it is less likely to cause conflict and political consequences (Mechanic, 1995; Robinson, *et al.*, 2012). The present study gives the frontline views of nurses dealing with the effects of rationing and the impact rationing has on patient care. The findings of this study have shown that when faced with severe rationing of resources in Emergency Departments, nurses resort to rationing direct care provision. Nurses feel that they have no choice but to compromise their professional standards by rationing care to the sickest patients as a coping mechanism for overcrowding and staffing and skill mix issues.

7.3.8 Causes of Moral Distress

One significant area of deviation between the present study of moral distress among emergency nurses and the literature centres on these specific causes of moral distress. Corley, *et al*. (2001) identified the causes of moral distress as being related to deceiving patients in relation to their illness, carrying out care that was not in the patient's best interest and items related to the nurse not acting morally or being complicit in immoral care. Emergency nurses did not report or describe any of the items from two of the categories on Corley's (2001) scale, *'not in the patient's best interest'* or '*deception'* as causes of moral distress. Rather, and most importantly, nurses working in Emergency Departments relate moral distress directly to the affect that patient overcrowding has on the provision of safe levels of care.

This is in keeping with several authors who reported unsafe or inadequate care as a major trigger of moral distress (Mobley, *et al.*, 2007; Rice, *et al.*, 2008; Silen, *et al.*, 2011; McCarthy & Gastmans, 2014). In the moral distress literature, there appears to be a marked difference between the quantitative studies which use Corley's (2001) scale and studies which found other causes of moral distress. Corley's (2001) scale examines deception, futile care and personal responsibility as causes of moral distress.

These findings have been replicated in other critical care studies that use Corley's scale. However, other studies point to more varied and complex causes of moral distress (Mobley, *et al*., 2007; Rice, *et al*., 2008; Silen, *et al*., 2011; McCarthy & Gastmans, 2014). In this study, moral distress was also found to be a complex concept with causes not fully explained by Corley's (2001) model. Emergency nurses find the lack of essential comfort measures for patients such as pain relief, provision of a bed, toileting and the provision of dignity and privacy as key triggers of moral distress as the failure to provide these essential basic elements of care is perceived by the nurses as a personal and professional failure to nurse.

In fact, emergency nurses described only two items of the total 30 items on Corley's (2001) scale as a whole. The two items are 1. Staff so low that care is inadequate and 2. Unsafe levels of nurse staffing. In a further study of medical and surgical units, Corley, *et al.* (2005) found that the highest scored item causing moral distress was again poor nurse staffing levels. Poor staffing levels are also identified as a cause of moral distress by McCarthy & Gastmans (2014). The findings of this study support the assertion that poor staffing levels contribute to moral distress (Corley, *et al*., 2005; McCarthy & Gastmans, 2014). Emergency nurses in the present study described being 'stretched' and having to engage in 'covering patients' due to work pressures and staffing levels. In addition, emergency nurses describe working with agency nurses and junior inexperienced nurses as exacerbating the situation. It is not just the number of staff that matters but their experience of working in an emergency setting. The skill mix available on a shift affects the ability of nurses to cope with overcrowding and the management of critically ill patients. Experienced nurses are able to recognise and respond to patterns and anticipate the deterioration of a sick patient. Participants in this study state that agency nurses and nurses with low levels of experience in emergency care are less able to recognise these subtle patient signs and that this places emergency nurses under additional pressure to try to 'cover' these patients

Furthermore, emergency nurses describe having to ration care and being unable to complete tasks due to inadequate staffing levels in overcrowded Emergency Departments. Nurses did not describe any examples of deception or care being carried out against the best interests of patients as being causes of moral distress.

Poor work environments and in particular, poor ethical work environments also precipitate moral distress by failing to provide institutional supports that give nurses the authority to advocate and engage in moral action (Jameton, 1993; McCarthy & Deady, 2008; Austin, 2012; Lutzen & Kvist, 2012; Varcoe , *et al.*, 2012; Jameton, 2013). In other words, if the hospital does not support the delivery of morally sound care, nurses will not be able to deliver morally sound care. Individuals alone will have difficulty carrying out morally correct actions unless there is a culture of morally robust care. Indeed, unhealthy ethical environments can lead to morally uninhabitable workplaces (Lutzen& Kvist, 2012) which may lead to nurses leaving the organisation. Participants in this study reported work environments characterised by a perceived lack of support from management who 'don't understand what's going on'. This lack of support is demonstrated by managers tolerating the intolerable (Thomas & McCullough, 2014). Emergency nurses also describe a practice-managerial disconnect and describe how the 'unacceptable has become the norm' with a 'moving of the goalposts' or shifting standards of acceptable care with a gradual deterioration of those standards over time. The absence of an ethical work environment can make the sustenance of professional integrity impossible (Chervenak & McCullough, 2005) and lead to depersonalisation of patients (Thomas& McCullough, 2014).

7.3.9 Moral Distress Models

The original description of moral distress by Jameton (1984) emphasised the role of institutional constraints acting to thwart the moral agency of nurses. It was postulated that institutional constraints that prevented moral action and forced a compromise upon the nurses. Therefore, institutional constraints are an integral part of the original description of moral distress.

The findings of this grounded theory study of moral distress among emergency nurses also found that institutional constraints had a direct and pervasive effect on moral agency and moral distress. In this study nurses described experiencing moral distress as a result of being unable to care for their patients to the requisite personal and professional standards. This forced nurses into compromising care and rationing care. Institutional constraints acted on emergency nurses in two ways. Firstly, the constraints are local in that hospital management decide upon the bed allocation and prioritisation of patients for bed placement among admitted patients. This restricts the moral agency of nurses, who prioritise patients for beds but who have no control over the wider issue of bed availability and bed shortages in the hospital. This lack of moral agency leads to moral distress and frustration. In turn, institutional constraints are part of a wider healthcare management strategy of cutbacks, re-organisation of services and managerialism (Varcoe, *et al.*, 2012). This wider policy driven healthcare agenda results in a system that does not always prioritise the sickest most acute patients that present to the hospital from the Emergency Department for admission.

Moral distress has also been defined as having a reactive element (Jameton, 1993) where nurses may experience distress after the morally difficult situation has arisen and which may lead to moral residue (Webster & Bayliss, 2000) where the nurse carries some of the moral anguish from the event with them. Moral residue can build over time and lead to a crescendo effect (Epstein & Hamric, 2009) where the nurse reaches a crisis point of moral distress which may lead to moral action or burnout. Nurses in this study described how overcrowding forces them to 'chip away' at their own standards over time. Nurses also described how levels of overcrowding and poor patient care that were once deemed unacceptable have now become the new normal. These descriptions of the work environment by nurses display reactive moral distress and moral residue which has been show to have a detrimental impact on nurses' well-being. The fact that many nurses in the study also describe signs of compassion fatigue, emotional exhaustion and burnout in themselves or among colleagues shows how pervasive and far

reaching the effects of moral distress can be. It is also very important to note that several nurses left emergency nursing during the course of the study and that the three nurses who left that were interviewed all described obvious signs of emotional distress, moral distress and burnout e.g. tearfulness, compassion fatigue, exhaustion and lack of involvement (Maslach, 2003).

The experience of moral distress among emergency nurses also mirrored elements of Wilkinson's (1987-88) model of moral distress. In Wilkinson's model, nurses engage in effective coping behaviours which result in an ability to continue nursing and deliver good quality care and ineffective coping behaviours that result in 'damage to the wholeness of the nurse', poor patient care and the nurse leaving the profession in some cases (Wilkinson, 1987-88). The findings of this study support this conceptualisation of moral distress with emergency nurses describing how when they engaged in compromising caring and stepping back as a coping strategy, it could lead to moral distress, frustration and burnout. This would suggest that compromising caring and stepping back are ineffective coping strategies that lead to moral distress. On the other hand, when emergency nurses engage in temporary solutioning, they are able to reaffirm their moral integrity and develop moral resilience which in turn leads to feelings of increased role fulfilment. This would suggest that temporary solutioning is an effective strategy in response to overcrowding which is supported by the finding that temporary solutioning and the 'little victories' sustained the moral needs of nurses long after the event and helped offset moral distress.

These “little victories” are analogous to the positive feelings and moral courage that Corley (2002) identified as resulting from successful moral action. Corley (2002) suggests that nurses derive moral comfort from whistle blowing and moral heroism. Similarly emergency nurses derived moral resilience and a sense of role fulfilment from advocacy and successful moral action, for example, when pushing for an elderly patient to be prioritised for bed placement. In the model of Moral Distress (Corley, 2002) the wider consequences of moral distress on the individual nurse, the patient

and the healthcare organisation are considered with failed advocacy resulting in increased patient suffering. Similarly, failed advocacy among emergency nurses resulted in patients spending inordinate amounts of time on a trolley or chair while awaiting bed placement.

Moral distress may lead to burnout, resignation and nurses leaving the profession in Corley's model (2002) which is similar to the detrimental effects described by Wilkinson (1987-88) in her model. The present study involved the theoretical sampling of a number of nurses who had left emergency nursing as a result of moral distress as part of the theoretical sampling used for the category of burnout. The nurses who had left their positions due to moral distress all stated that they felt that they had not been supported by management in their role and in particular in relation to overcrowding and the deterioration in standards of nursing care. Two of the nurses felt that their feelings of frustration and distress had accumulated over time. One of the nurses pointed to a cumulative stress which reached crisis point when she witnessed the inappropriate care of one elderly woman. These findings correlate with the literature on reactive moral distress (Jameton, 1993) and moral residue (Webster & Bayliss, 2000; Epstein & Hamric, 2009).

The theory of moral reckoning (Nathaniel, 2006) encompasses moral distress as part of a three stage process of making sense of morally difficult situations. Nurses begin with a stage of ease where there is comfort in the workplace and congruence between the nurses' values and the values of the institution. There follows a situational bind where there is conflict between the nurses values and those of the institution which leads to a stage of resolution which involves taking a stand for the moral issue. Finally there is a stage of reflection where the nurse tries to make sense of the experience. Moral distress experienced by emergency nurses also involves a situational bind where there is a conflict of values between the nurse and organisation. However, the stage of ease was not very evident among emergency nurses as they describe the causes of moral distress as being constant and pervasive in nature. Moral reckoning theory accords with both Wilkinson's (1987-88)

and Corley's (2002) theories of moral distress. All three theories involve potential positive and negative resolutions to the situational bind of moral distress. Similarly, emergency nurses who engage in temporary solutioning and successful advocacy develop moral resilience and role fulfilment as a positive outcome which in turn, improves the care experienced by the patient. Emergency nurses who engage in stepping back and rationing care as coping mechanisms for moral distress may experience further negative outcomes such as increased frustration and burnout.

7.3.10 Consequences of Moral Distress

Moral distress has personal consequences for nurses including disconnection from practice, blaming management, job dissatisfaction, job turnover, burnout and nurses leaving the profession (Corley, 2002; Epstein& Hamric, 2009; Hamric, 2012; Lutzen & Kvist, 2012; Pauly, *et al.*, 2012; Varcoe, *et al.*, 2012; Jameton, 2013; Johnstone & Hutchinson, 2013; McCarthy& Gastmans, 2014). Moral distress can lead to compromised moral integrity (Laabs, 2011) and the individual nurse becoming 'morally undone' (Thomas & McCullough, 2014) where the moral coherence provided by integrity is replaced by moral confusion and dysfunction. The compromise to moral integrity may lead to intense feelings of burnout, depression or withdrawal from patient care (Wilkinson, 1987-88; Corley, *et al.*, 2001; Hamric & Blackhall, 2007; Epstein& Hamric, 2009). Routine, repeated violations of moral integrity are the most damaging and lead to moral distress, moral crescendo and burnout (Thomas & McCullough, 2014). The findings of this study of moral distress among emergency nurses included nurses reporting signs of burnout (Maslach, 2003) and a number of nurses who left their jobs as a result of moral distressing situations.

7.4 Chapter Summary

Emergency nurses did not describe the reported causes of moral distress (Corley, *et al.* 2001) of futile care and patient deception. Instead, nurses working in Emergency Departments relate moral distress directly to the provision of inadequate care due to patient overcrowding, in keeping with several other authors (Mobley, *et al.*, 2007; Rice, *et al.*, 2008; Silen, *et al.*,

2011; McCarthy & Gastmans, 2014). In particular, emergency nurses find the lack of essential comfort measures for patients as key triggers of moral distress. Furthermore, emergency nurses describe reactive moral distress (Jameton, 1993) or moral residue (Webster & Bayliss, 2000) caused by the pervasive and cumulative damage of moral conflict and compromise to their moral and professional integrity which is concurrent with the findings of Laabs (2011) and Thomas & McCullough, (2014) that repeated violations of moral integrity are the most damaging and lead to moral distress, moral crescendo and burnout.

Emergency nurses experiencing moral distress cope with overcrowding and patient boarding by engaging in *Adaptive Competence*. The theory of Adaptive competence explains and integrates the various categories of overcrowding, compromising caring, moral distress and rationing care. In Emergency Departments, overcrowding pitches balance out of kilter, resulting in compromising caring and 'stretching' where nurses attempt to 'cover' as many patients as possible. Emergency nurses engage in innovative strategies called *Temporary Solutioning* to maintain patient flow. The properties of *stretching* and *going up a gear* are all improvisations to deal with overcrowding in Emergency Departments.

Emergency nurses use covering as part of an intuitive process based on pattern recognition and experience to identify changes in vital signs, patient colour and behavioural cues to indicate patient deterioration. This process is similar to decision making by emergency workers in pressured environments described by Baran and Scott (2010) and Klein (1999). Covering also resembles the process of patient surveillance which when unsuccessful leads to incidents of *failure to rescue* (Clarke & Aiken, 2003; Shever, 2011). There are similarities between elements of failure to rescue and the properties of rationing care and the inability to engage in covering patients when overcrowding reaches crisis levels in Emergency Departments.

Institutional constraints are part of a wider healthcare management policy of rationalisation and rationing of services (Varcoe, *et al.*, 2012) which act to thwart the moral agency of nurses (Jameton, 1984). The institutional rationing and restricting of resources leads to the conscious rationing of care by emergency nurses. This causes moral distress as it forces a moral compromise on the part of the nurse (Papastavrou, *et al.*, 2014; Humphries & Woods, 2015).

The consequences of moral distress include 'damage to the wholeness of the nurse' (Wilkinson, 1987-88), disconnection from practice, blaming management, job dissatisfaction, job turnover, burnout and nurses leaving the profession (Corley, 2002; Epstein& Hamric, 2009; Hamric, 2012; Lutzen & Kvist, 2012; Pauly, *et al.*, 2012; Varcoe, *et al.*, 2012; Jameton, 2013; Johnstone& Hutchinson, 2013; McCarthy & Gastmans, 2014). Emergency nurses described the consequences of stepping back as moral distress, frustration and burnout. However, when emergency nurses engage in temporary solutioning, they derive comfort akin to the moral heroism described by Corley, *et al.* (2001) and develop moral resilience and a sense of role fulfilment.

Moral Distress has wider consequences for patients and for healthcare organisations. Increased job dissatisfaction, among nurses experiencing moral distress leads to higher job turnover rates, burnout and nurses leaving the profession (Corley, 2002; Epstein& Hamric, 2009; Hamric, 2012; Lutzen & Kvist, 2012; Pauly, *et al.*, 2012; Varcoe, *et al.*, 2012; Jameton, 2013; Johnstone & Hutchinson, 2013; McCarthy& Gastmans, 2014). This increases the workforce planning difficulties encountered by hospitals in recruiting emergency nurses. The increased levels of job attrition among nurses experiencing moral distress have a detrimental impact on staffing levels and skill mix levels which, in turn, affect patient care.

Chapter 8 Conclusion and Recommendations

8.1 Introduction

This chapter discusses the conclusions of the study and the implications of the grounded theory of *Adaptive Competence* for nursing education, practice and future research.

8.2 Conclusions

The most important outcome of this study is the theory of Adaptive Competence. The grounded theory of Adaptive Competence explains how patient overcrowding competes with maintaining flow for nursing resources in Emergency Departments. Emergency Nurses in this study experience changes in workflow due to increasing levels of overcrowding and patient boarding in the ED. While some of the categories described in the theory have similarities to other concepts and theories, Adaptive Competence is the only theory that explains the strategies that emergency nurses use to resolve moral distress i.e. *Temporary Solutioning, Compromising Caring* and *Rationing Care*. Furthermore, this study explains the relationships between overcrowding, adaptive competence and moral distress.

The causes of moral distress among emergency nurses are fundamentally different to those identified in the literature by Corley, *et al.,* (2001). Specifically, emergency nurses do not experience moral distress as a result of futile care or patient deception which are the most recognised triggers for moral distress (Wilkinson, 1987-88, Corley, *et al*., 2001). Moral distress among emergency nurses resulted from being unable to deliver the most fundamental aspects of nursing care as a result of overcrowding. This would suggest that the context of emergency nursing practice has a unique affect on nurses' experiences of moral distress.

The finding that moral distress is caused by *Compromising Caring* and can result in *Rationing Care is* of significant concern as nurses describe that when rationing care, they are unable to ensure the proper surveillance of all patients and patients may experience delayed or missed care. The fact that

moral distress was so evident from participant interviews and that several nurses left emergency nursing as a result of moral distress would indicate that this is a significant issue affecting emergency departments.

The importance of delayed or reactive moral distress was also highlighted in this study. Participants described how moral distress was a cumulative phenomenon punctuated by critical incidents that worsened the experience. The mediating affect of reaffirming moral integrity and developing moral resilience against the effects of moral distress was an important finding in this study. The role of institutional supports for moral integrity in potentially reducing the incidence and/or severity of moral distress warrants further study. Moral integrity has been supported in the past by developing ethics education for nurses (Lang, 2008; Epstein & Delgado, 2010; Burston & Tuckett, 2012; Woods, 2014), facilitated ethics conversations where nurses can discuss moral problems (Helft, *et al.,* 2009; Perry, 2011; Burston & Tuckett, 2012) and by facilitating debriefing sessions for nurses after difficult cases (Wilson, *et al*., 2013).

The findings of this study were used to generate the substantive theory of *Adaptive Competence* among emergency nurses. This grounded theory provides a unique explanation of how nurses working in emergency departments cope with the competing demands of overcrowding and maintaining patient flow. The theory has a number of novel concepts including the categories of *Compromising Caring, Temporary Solutioning and Rationing Care.* The core category of *Adaptive Competence* offers a novel explanation of how emergency nurses respond to changing work contexts and adapt their professional practice accordingly. The theory of *Adaptive Competence* explains how nurses adopt a flexible approach to overcrowding in an effort to maintain patient flow and reduce care provision only when absolutely necessary to maintain patient safety and often at great cost to themselves and to patients.

These findings may have wider applicability to emergency nurses working in similar environments in other hospitals in Ireland or internationally, given

that patient overcrowding and poor staffing levels are international problems in emergency care. The possible extension of the findings to develop a formal theory of adaptive competence in other contexts outside of the healthcare arena may also be a possibility.

8.3 Implications of the study

This study has generated a number of findings which contribute to the body of knowledge of Nursing. The major contribution of this study was the generation of the substantive grounded theory of *Adaptive Competence* which contributes to the understanding of moral distress. The argument that understanding the practice context for how moral distress is experienced and its consequences, discussed in Chapter 2, is upheld. It was found that the causes of moral distress for emergency nurses are different to the causes for critical care nurses.

Managing Preconception

The use of the self interview is a novel means to avoid preconception by constantly comparing the self interview codes with codes emerging from the substantive data. This study provides an explanation of the use of the self interview in grounded theory studies and will add to the literature on managing preconception.

Theoretical Sampling

This study used a number of different techniques to theoretically sample for data. These techniques included theoretically sampling for people, behaviours and data. Theoretical sampling for people involved interviewing nurses of different grades and in three emergency department sites to check for different codes and categories which may be site specific or related to the individual nurse's grade. Nurses who had experience of a particular behaviour or concept were theoretically sampled to generate properties of that behaviour. Examples included sampling for nurses who experienced moral distress and for nurses who had left their job. Data was theoretically sampled by using codes from early interviews to inform the questioning in later interviews in a process called theoretical interviewing (Glaser, 2001).

Data was also theoretically sampled by using early interview codes to guide the observation of practice.

These techniques add to the methodological knowledge of grounded theory through the combination and elaboration of these techniques as applied to the present study.

Ethical Issues

This study has examined in detail the issues arising from gaining consent from very ill patients in a busy emergency department. This study provides an interesting case study in the ethical issues involved in gaining consent from vulnerable populations and how a workable solution may be found by adhering to ethical first principles and best practice. The use of grounded theory in this study allowed the observation of nurses in clinical practice without directly impacting on patient care. Furthermore, the unit of observation in this grounded theory was initially the nurse and then quickly became the behaviour of the nurse. Patients were not the unit of observation which helped preserve anonymity and confidentiality and allowed for verbal consent to be obtained from patients and showed that written consent from patients was not appropriate to this type of observation of nursing practice when patients are vulnerable and may be unable to provide informed consent due to the severity of their illness or injury.

8.4 Study Recommendations

Recommendations for Practice

The most pervasive cause of moral distress in this study was the dissonance between personal and professional standards of care and the standard of care experienced by emergency nurses in practice. This differs significantly from the more recognisable causes of moral distress in critical care environments such as deceiving patients and providing care that is not in the patient's best interest reported by Corley, *et al.* (2001). The first step in addressing the problem is recognition of the unique causes of moral distress in Emergency Departments related to the poor standards of care caused by overcrowding. The second step is for Nurse Managers and healthcare administrators to

adhere to mandatory minimal staffing levels in line with those proposed in the United Kingdom (Drennan, *et al*., 2014) and in the United States of America (Emergency Nurses Association, 2011; 2013). In addition, initiatives that aim to improve standards of care consistently in line with professional standards will help to reduce moral distress and allow nurses to have a voice and successfully advocate for their patients.

Managers should be cognisant of the perceived disconnect between frontline staff and senior hospital management and politicians. Emergency Nurses reported a lack of support from managers and poor communication as aggravating factors of moral distress. This perceived lack of support compounded the feeling of poor moral agency of nurses and led to failed advocacy and a 'lack of voice' when highlighting patient safety and quality of care issues in the Emergency Department.

The key role of the Clinical Nurse Manager 2 as shift leader and the impact that this role has in supporting nurses needs to be recognised. Healthcare managers need to support the supervisory element of this role and allow the shift leader to act as a resource to support emergency nurses. In practical terms, this would require the Clinical Nurse Manager 3 in departments to take a more active role in bed management and maintaining patient flow, so that the shift leader is able to supervise emergency nurses and evaluate the quality of patient care on a daily basis. Alternatively, the division of the role of Clinical Practice Support from the Clinical Facilitator role would satisfy the requirement for a supervisory support role for Emergency Nurses.

Nurses need to be involved in identifying which elements of care provision are falling short as a result of overcrowding and in developing practice guidelines to increase their ability to voice these concerns and ultimately to lessen the negative effects of overcrowding on patients and nurses alike.

The moderating effect of temporary solutioning and the relationship between moral distress, moral integrity and moral resilience warrants further study to better explain the properties of these concepts and help deliver

strategies to moderate moral distress, improve job satisfaction and reduce turnover among emergency nurses.

Nurse educators need to be cognisant of the unique features of moral distress identified in Emergency Department contexts and the links with patient overcrowding. Formal and informal educational initiatives to improve the recognition of moral distress and the development of initiatives to improve moral resilience such as facilitated ethics conversations (Helft, *et al.*, 2009) should be considered. These educational interventions have the potential to reduce moral distress, burnout and the intention to leave a post.

Recommendations for Further Research

The goal of grounded theory research is to generate a substantive theory that explains what is going on at practice level. This substantive theory can later be developed into a formal theory through further theoretical sampling (Glaser & Strauss, 1967, Glaser, 1978, 2011; Andrews, 2011). Grounded theory can also be used to structure more in-depth studies of a topic by identifying the main issue(s) relating to an area of interest. This study of moral distress has identified a number of features of moral distress unique to emergency nurses. The fact that the causes of moral distress are substantially different in this study from previous iterations (Corley, *et al.*, 2001) suggests that further elaboration of the causes of moral distress among emergency nurses warrants investigation.

In addition, the theory of adaptive competence describes three processes of coping with competing demands. The impact of *Compromising Caring* and *Rationing Care* on the quality of care and the ethical implications of restricting care to a cohort of patients, however well intentioned, has profound implications for nurses, patients and managers. The serious consequences that may result from rationing care in particular, as described in this study, such as reduced surveillance, missed and incomplete tasks and delayed treatment warrant further research. The ability of nurses engage in *Temporary Solutioning* explains a unique coping mechanism employed by Emergency Nurses to cope with overcrowding. This study was focused on

emergency nurses experiences of overcrowding and institutional constraints. However, the wider applicability of the theory to other clinical areas characterised by overcrowding, competing demands and poor staffing would suggest that other clinical contexts should be investigated for similarities with the current findings.

Recommendations for Policy

The implications of this study for policy relate to the findings that nurses are unable to deliver safe standards of care in overcrowded Emergency Departments. This study described the consequences for both nurses and patients in maintaining the status quo. Poor surveillance linked to rationing care and the inability to provide basic comfort measures or maintain privacy and dignity of patients has a devastating effect on the patient awaiting bed placement in the Emergency Department and on the nurse delivering the care. Policy initiatives in this area will have to address the low acute bed numbers and staffing levels in public hospitals that are well below the international norms (Deloitte&Touche, 2001; Health Service Executive, 2013; Nolan, *et al.*, 2014). This will require further investment in our health services that may necessitate higher taxes or prioritisation of health services over other fiscal demands on exchequer funding. Rationalisation and re-organisation of services alone will not eliminate the problem of inadequate hospital bed capacity to meet patient demand and subsequent Emergency Department overcrowding. If funding is not identified for service improvements, the problem of patient overcrowding will continue and may worsen with an ageing population.

8.5 Study Limitations

This grounded theory examined moral distress among emergency nurses in three acute general hospitals and is limited to that setting and context. The study did not include doctors or other healthcare professionals who may also suffer moral distress due to difficult work environments in Emergency Departments. Furthermore, the ability to theoretically sample some participants was limited, in particular in relation to nurses who had left their post due to moral distress. This restriction on theoretical sampling may have

hindered the discovery of some of the properties of moral distress that lead to burnout and nurses leaving their post. In addition, the discovery of the relationships between cumulative moral distress, burnout and factors intrinsic to the individual nurse were limited due to constraints of access and ethical concerns with interviewing nurses who had suffered moral distress to the extent that they suffered burnout and left their post.

The grounded theory presented in this study is one possible explanation for how emergency nurses cope with the competing demands of their practice environment. In keeping with grounded theory methodology, other theories and explanations are possible. However, the theory of *Adaptive Competence* has immediate grab and fit with the issues affecting emergency nurses and is supported by the positive feedback from participants when presented with the findings of this study.

8.6 Chapter Summary

This grounded theory study examined moral distress among emergency nurses in three hospitals in the Republic of Ireland. The theory of adaptive competence emerged from the findings. Nurses resolved their main concern of balancing of competing demands by adapting their competence to changing work contexts. Adaptive competence involved stepping back care in response to increased levels of patient overcrowding and temporary solutioning as a way of finding a 'work around' for difficult work environments. Stepping back care can result in moral distress and burnout whereas temporary solutioning has a moderating effect on moral distress by increasing moral resilience and role fulfilment. The implications of the theory of adaptive competence for nursing research, practice and education have been discussed. The limitations of the study and contribution to knowledge development have been discussed in this chapter. This concluding chapter recommends initiatives to help support nurses moral practice and develop moral resilience.

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Appendix 1 Ethics Approval

Our ref: ECM 4 (t) 03/04/12

21st March 2012

Dr Adeline Cooney
Senior Lecturer
School of Nursing & Midwifery
Aras Moyola
National University of Ireland
Galway.

Re: Understanding emergency nurses' experiences of moral distress.

Dear Dr Cooney

Expedited approval will be granted to carry out the above study in:

- Hospital

subject to receipt of the following:

- Participant Information Sheet and Consent Form.

The following documents were approved:

- Application Form
- Interview Distress Guide.

We note that the co-investigator involved in this study will be:

- Gerard White.

Yours sincerely

Dr Michael Hyland
Chairman
Clinical Research Ethics Committee

Appendix 2 Interview Guide

Moral Distress Study

Ethical Protocol for interview (to be explained to all interviewees prior to interview)

There is a clear moral and professional obligation on the nurse to report any unethical or illegal action unearthed during the research process (Munhall, 2007). In this study, the anonymity and confidentiality of the participants will be maintained unless there is an overriding ethical concern (for example, health or safety) justifying the release of such information or if such release is required by law.

1. Opening Question

What is the most important issue for you working daily in the Emergency Department?

2. Additional questions

What is the main issue for you in your everyday work?

Appendix 3 Letter of Invite / Information Sheet to Nurses

Dear Colleague,

We are currently undertaking research which aims to understand the experiences of moral distress of nurses working in Emergency Departments.

Why are we doing this work?
Modern acute care work environments place a myriad of conflicting demands on nurses who must try to balance increased work load with diminishing resources, staff shortages and financial cutbacks (Aiken, *et al.*, 2001; Pendry, 2007). When a conflict arises between a nurse's own moral code and the demands of the clinical situation, the nurse may experience moral distress (Bell & Breslin, 2008). The impact of moral distress on nurses (Gutierriez, 2005; Peter, *et al.*, 2004), patients (AACN, 2008) and healthcare organisations (Corley, *et al.*, 2001; AACN, 2008) has previously been reported. However, relatively little is known about moral distress among emergency nurses. This study aims to improve our understanding of moral distress in Emergency Department settings.

What is involved?
If you agree to participate we will arrange to interview you at a time and place convenient to you. It is anticipated that the interviews will take no more than 30 – 40 minutes. The period of observation will last for a few hours on a single shift. We are interested in your experience of morally difficult situations in the Emergency Department.

What do we guarantee you?
Your privacy will be safeguarded and in no way will you be identifiable in the study write up. Your participation is strictly voluntary and you can withdraw at any time.

Does the researcher have permission to conduct the study?
Approval has been granted by the Clinical Research Ethics Committee of the Cork Teaching Hospitals and by the Directors of Nursing in each hospital.

Who do I contact to find out more?
Once again, thank you for your support for this nursing research project. Should you require any more information or have any queries, please contact Gerard White on 087 9973335.

If you are willing to participate please complete the included consent form and return to _____

With many thanks,

Gerard White
Research Investigator

Appendix 4 Consent form

Research Title: **Understanding Emergency Nurses experiences of Moral Distress**

Researcher(s): Gerard White
Dr. Adeline Cooney

I confirm that I have read the information sheet and received an explanation on the nature, purpose, duration and effects of my involvement in the study.

I understand that my participation is voluntary and that I am free to withdraw from the study at any stage if I so wish, without giving an explanation.

I have had the chance to ask questions and all my questions have been answered to my satisfaction.

I consent to take part in an initial interview of 30-45 minutes, a period of observation of my work in the Emergency Department and a final interview of 30-45 minutes.

I consent for the interviews to be digitally-recorded.

I understand that I may decline to answer any question during the interview.

I understand that on completion of the interview the content of the tape(s) will be transcribed, anonymised and stored in a secure facility.

I understand that the tapes will be destroyed once transcribed.

I understand that the information may be published but my name will not appear on any part of the study, nor will any information that may identify me be used in the study.

This is to certify that I ……, give my consent to be included in the above study.

Signature of participant .....Date……

In order to preserve privacy this record of consent will be stored in a locked, secure press away from the tapes and written transcripts. The record of consent will only be made available should the Ethics Committee have questions concerning the ethical practices of the study.

Please return the complete form to

Appendix 5 Ethical Protocol

The nurse researcher shall intervene in patient care only when:

- in an emergency situation, such as a cardiac arrest, collapse or similar episode and no suitably qualified staff are present or staff request assistance.
- a patient is at risk of immediate harm e.g. from a fall or fire and no suitably qualified staff are present or staff request assistance.
- a patient's safety is at risk from maltreatment or inappropriate treatment from a student or staff member.

The nurse researcher shall report any unethical or unprofessional clinical practice that could place patients in jeopardy or which militate against safe standards of practice to the relevant authority (An Bord Altranais, 2000).