What’s going on?
How do New Zealand emergency nurses cope with the occupational stress that is associated working in the emergency department?

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“Hope has two beautiful daughters; their names are Anger and Courage. Anger at the way things are, and Courage to see that they do not remain as they are.”

(Augustine of Hippo 354-430)
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DECLARATION OF ORIGINALITY

I declare that the work presented in this thesis is, to the best of my knowledge and belief, original and my own work, except as acknowledged in the text and reference pages.

Jaki Boyle

Date: 21 February 2015
ABSTRACT

Aim: The aim of this research is to determine what factors influence stress levels amongst emergency nurses in New Zealand.

Background: International studies suggest that increased workloads, organisational culture and health determinants impact on the working environment for nurses in the emergency department. This position however, has not been fully studied within the New Zealand context. This thesis sought to identify some of those factors that contribute to the stress of nurses working in the emergency departments in New Zealand.

Research Design: This study used a quantitative descriptive design using an online survey to gather information related to those factors contributing to work related stress of emergency nurses. The framework used for this study was based on Healy and Tyrell’s (2011) research conducted in Ireland, and also using a content analysis to collate the data into themes.

Participants: The research participants were nurses who were members of the College Emergency Nurses New Zealand (CENNZ). Distribution of the online survey was completed by CENNZ to maintain anonymity of the participants.

Results: One hundred and seventy eight individuals completed the online questionnaire, with a response of 51.44% nurses who were members of the CENNZ. The data supported international research.

Conclusion: Factors that cause stress in the ED cannot be viewed in isolation. Issues such as the overcrowding, patient care, organisational dynamics and the imposition of national health targets all have a cumulative effect on stress levels amongst nurses. Mitigating the effects that these factors have is essential and requires further inquiry to formulate strategies that will assist in reducing the impact that these elements have on New Zealand emergency nurses.
ACKNOWLEDGMENTS

This thesis would not have been completed without the support of my family, friends and colleagues whose encouragement and help has been incredible on so many levels:

To my family for putting up with me being “busy in the dining room” for so long and just keeping everything happening on the home front. I couldn’t have done this without you all. To my friends Shane and Jackie for the wine breaks!

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Finally I would like to thank the executive of the College of Emergency Nurses New Zealand and the amazing emergency nurses whose honest and sometimes alarming contributions to this study have motivated me to tell your story so that we can try and make things better.

“To do what nobody else will do, in a way that nobody else can in spite of all we go through; is to be a nurse”

(Rawsi Williams, n.d.)
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<tr>
<td>ACEM</td>
<td>Australasian Emergency College Medicine</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>Accident &amp; Emergency</td>
</tr>
<tr>
<td>CENA</td>
<td>College Emergency Nurses Australia</td>
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<tr>
<td>CENNZ</td>
<td>College Emergency Nurses New Zealand</td>
</tr>
<tr>
<td>CNM</td>
<td>Clinical Nurse Manager</td>
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<tr>
<td>DHB</td>
<td>District Health Board</td>
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<tr>
<td>ED</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>ENA</td>
<td>Emergency Nurses Association</td>
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<tr>
<td>ED6</td>
<td>Emergency Department 6 hours</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<tr>
<td>MASH</td>
<td>Mobile Army Surgical Hospital</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>NCNZ</td>
<td>Nursing Council of New Zealand</td>
</tr>
<tr>
<td>NP</td>
<td>Nurse Practitioner</td>
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<tr>
<td>NZNO</td>
<td>New Zealand Nurses Organisation</td>
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<td>RN</td>
<td>Registered Nurse</td>
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<td>SSED</td>
<td>Shorter Stays in ED</td>
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CHAPTER ONE

“Tell me and I forget, teach me and I may remember, involve me and I learn.”

(Benjamin Franklin 1706 – 1790)

1.1 INTRODUCTION

Emergency nursing is a profession that can expose nurses to high levels of stress (Josland, 2008). While it is acknowledged that there are pressures in most areas of healthcare (Gilbert & Daloz, 2008), the unpredictable nature of presentations to the Emergency Department (ED) can impact on the health and wellbeing of nurses (Healy & Tyrell, 2011; Josland, 2008; Lim, Bogossian & Ahern, 2010). Globally, the ED is acknowledged as the front door of the hospital system interfacing between primary and secondary level care (Barnett & Malcolm, 2010; Carson, Clay & Stern, 2010; Fisher, Salman & Cooke, 2010; Greer, 2012; New Zealand Technology Assessment, 1999). In smaller New Zealand communities the ED is often viewed as being of fundamental importance in terms of the accessibility and affordability of primary care to the wider population. The ED is open twenty four hours a day for trauma and medical emergencies. However, this service also extends to minor illness such as colds and influenza, which are more commonly seen by a community medical practitioner.

Brim (2008), suggests that there is an increasing use of the ED as a source of primary care because it is free, whereas the General Practitioner (GP) practice charge a fee. This is supported by Jones and Thornton (2008) and Mattock (2010) who propose that this contributes to overcrowding in the ED which is a factor that influences the stress levels of ED nurses. Many patients with minor ailments often use the ED in place of primary care practices due to a lack of understanding as to what constitutes an emergency and because it is cheaper to attend the ED rather than seeing a community medical practitioner (Kamali, Jain, Jain & Schneider, 2013; Toloo, Rego, Fitzgerald, Vallmuur & Ting, 2013).

The mix of minor and major injury and illness that presents to the ED is often complicated by the number of patients under the influence of drugs and alcohol (Ardagh & Richardson, 2004). According to Erikson (2008) emergency nurses often become...
frustrated by their inability to expedite immediate care for sick patients when distracted by the unpredictable nature of alcohol and drug intoxicated patients. The additional workload created by the effects of alcohol and substance abuse across the lifespan contributes to the ED’s ability to manage care when the department is already busy. Abuse of addictive substances, such as seen in alcohol and drug presentations, is also acknowledged by health professionals as a dominating factor that contributes to family violence, child abuse and traumatic injuries directly related to domestic violence (Connor, Broad, Jackson, Vander Hoorn & Rehm, 2005; Connor, You, Casswell, 2009; Leonard, 2005; Oscar-Berman, 2003). Alcohol is also known to be a contributing factor to chronic long term health conditions and increased injuries due to falls particularly amongst the elderly (Kool, Ameratunga, Robinson, Crengle & Jackson, 2008; Rehm, Baliunas, Borges, Graham, Irving, Kehoe et al., 2010).

The use of abusive substances is not the only issue that is increasing the workload of ED practitioners. Emergency presentations to the ED by patients with acute exacerbations of medical conditions attributed to lifestyle are also increasing (Ministry of Health (MOH), 2013c). Lifestyle conditions such as obesity and smoking affects the health of one million people in New Zealand. This is a contributing factor to chronic diseases including cardiovascular disease, asthma, stroke and diabetes which are common conditions cared for by nurses in the ED (MOH, 2013c). The serious health complications of these complex cases contribute to the nursing workload in the ED as they can take more time and more care than the traditional minor injury type patient (Ardagh & Richardson, 2004). The aging population is also becoming an additional entity in the health equation. In New Zealand, the average lifespan is increasing. Aged persons often have multiple co-morbidities that require additional attention even when they are admitted with minor illnesses to the ED (Gerritsen, Stefanogiannis & Galloway, 2008; Rehm et al., 2010).

In the ED, nurses usually complete the initial triage and assessment of patients as well as providing most of the ongoing care at the bedside (Ardagh & Richardson, 2004). The increasing complexity and number of presentations to the ED has therefore had an effect on the workload of nurses. The increasing numbers of patients has also resulted periods of overcrowding in the ED which, as Ardagh and Richardson (2004) suggests, causes delays in the triage and treatment of patients, further exacerbating nursing resources.
This is supported by Erikson (2008) who contends that overcrowding contributes to longer patient stays in the ED, which places additional pressures on already busy departments including nursing workloads. The MOH (2009) has delineated shorter ED stays as one of its major health targets. The “shorter stays in emergency departments (SSED)” aims to have patients assessed, treated and discharged within six hours. The pressure to achieve the target time of six hours has created an added pressure, particularly on ED nurses who provide the majority of care at the bedside. The factors that contribute to patient flow include issues such delays in accessing in-patient bed for ED patients. Jones and Olsen (2011) suggests that this has an influence on the stress levels of ED nurses who try to balance patient care with looking after more patients and endeavouring to meet the six hour target. Mortimore and Cooper (2007) suggest that increased nursing workloads impacts on clinical effectiveness in the ED as nurses are distracted having to care for new arrivals and sudden emergencies. Jones and Olsen (2011) indicate that the capacity for nurses to provide effective care for patients is being pressured in an effort to meet the SSED target.

There are a number of national and international studies that have researched occupational stress in emergency nursing (Chang et al., 2007; Ditzel, 2009; Jennings, 2008). The emphasis of these studies is often focused on specific factors such as violence and aggression. Other research focuses on analysing issues such as job satisfaction, staff recruitment and retention, workplace bullying, critical incident management and debriefing, role definition, education and training (Gacki-Smith et al., 2009; Gillespie, Gate, Miller & Howard, 2012; Kowalenko et al., 2012; Lim, Bogossian & Ahern, 2010; Ogundipe et al., 2012). While there is a wealth of research into the cause and effect of issues related to the functioning of the ED, there is less inquiry into the actual factors that influence the stress levels of emergency nurses (Potter, 2006). A systematic review that was undertaken by Lambert and Lambert (2001) highlighted important issues that influence the stress levels of nurses in the ED. Their research was conducted in seventeen different countries with little research from New Zealand and Australia identified on this topic. This limited research represents a gap in the knowledge that relates to what factors that influence the stress levels for ED nurses in New Zealand.
The unpredictability of the presentations to the ED and the increasing workload caused by a variety of factors can have an effect on the working lives of ED nurses. Access and affordability of healthcare in the community and the influence of chronic conditions have increased ED attendances. This issue, combined with a rise in alcohol and drug related presentations has resulted in issues such as overcrowding and extended waiting times. The concept of the ED and the role of emergency nurses is important to understand the pressures that working in this environment. The following section discusses the ED in New Zealand.

1.2 EMERGENCY DEPARTMENTS IN NEW ZEALAND

The ED is an area designed to treat people with acute or serious illness or injury in need of emergency interventions. The concept of the ED has its origins with surgeons in the Napoleonic wars treating injured soldiers on the battle field. A more formal structure that incorporated the design and staffing of the ED was outlined in the Platt Report (1962) and has been adopted by hospitals worldwide. This included the establishment of a dedicated department that was open twenty four hours providing efficient and specialized care in medical and traumatic emergencies. There was also the development of structured training programme for doctors and nurses to staff the ED and the formalization of emergency medicine as a specialty (Sakr & Wardrope, 2000).

In more recent years the ED has become an important link in the provision of more generalized healthcare due to issues such as access and affordability (Brim, 2008; Jones & Thornton, 2013; Mattock, 2010). Although the cost of primary healthcare has been suggested as a cause of the increasing attendances to ED, Jones and Thornton (2013) propose the reason may also include the person’s notion as to what ailment or injury constitutes an emergency. This has seen an increase in the number of presentations to ED of minor health complaints which could easily be managed by community healthcare providers. ED attendance in New Zealand has risen to approximately one million people on an annual basis which Bonning (2013) suggests is placing a strain on resources including staffing. Patients arrive at the ED in three different ways.

Presentation to the ED is via ambulance services, primary care practitioners or as a self-referral. Patients are triaged on arrival and further assessment and treatment is based on an acuity system with the most unwell seen first (MOH, 2011). Minor injuries or illness wait the longest and often represent the most significant proportion of ED attendances.
This is due to the triaging of patients using a tool known as the Australasian Triage Scale which assists in determining the order and time patients need to be seen based on the severity of their presenting complaint. Minor injuries and illnesses often have extended waiting times as more serious presentations are seen before these patients. This has an influence on other hospital resources, overcrowding and decreased patient satisfaction due to the waiting times and extended length of stay (Richardson & Mountain, 2009). Nurses are an important part of the staffing structures in the ED. The next section outlines the role and responsibilities of and ED nurse.

1.3 EMERGENCY NURSING

Emergency nursing is a specialized field where nurses provide care to patients across the lifespan. This is a diverse and challenging career that requires a wide range of skills and knowledge, adaptability, an ability to work under pressure and exposure to the stresses of sudden emergency situations that present to the ED (Evans, 2003; Holder, 2004a; King & Jatoi, 2005; McQuillan, Von Rueden, Hartsock, Flynn & Whalen, 2002). ED nurses develop expertise in triage, a process that prioritizes treatment to patients based on the severity of their presenting condition. There is also an emphasis on becoming proficient in the assessment and treatment of patients and being able to respond rapidly in response to initial phases of acute injury or illness. Defining the role of an emergency nurse is necessary to understand the complex nature of nursing in the ED. The College of Emergency Nurses New Zealand (CENNZ) (2005) defines an emergency nurse as;

Registered nurses who demonstrate the application of speciality knowledge and expertise in the provision, delivery and evaluation of emergency nursing. Decision making is based upon assessing and prioritising urgency of care in unpredictable, wide ranging and emotional situations. These nurses advise, advocate, and implement procedure and care for a diversity of cultures encompassing individuals, families whanau and others across the life span in a safe and trusting environment (p. 38).

Nurses who work in ED are repeatedly exposed to stressful events such as life and death situations including complex medical conditions and serious traumatic injuries (Erikson, 2008). These major events are combined with patients presenting with minor ailments who also require attention. Unpredictable workloads and an increased exposure to violence, child abuse, alcohol and drug related presentations are also factors that emergency nurses have to contend with. As a consequence, nurses working in the ED may experience higher than normal stress levels. This is supported by research done by Hallin
and Danielson (2007), Laposa, Alden and Fullerton (2003) and Potter (2006) who all reached similar conclusions about the stress of nursing staff in the ED. Factors that contribute to stress levels of emergency nurses are outlined further in the following section.

1.4 HEALTH TARGETS IMPORTANT FOR THE CONTEXT OF THIS STUDY
Blakely and Simmers (2011) presented a snapshot of inequalities that impacted on health outcomes in New Zealand. They suggest that there is a close link between health and social determinants such as housing, income and employment which are factors in health inequities. These issues are important to understand as these factors contribute to increased ED attendances for minor health problems that would usually be seen in the community. This is supported by Brim (2008), Jones & Thornton (2013) and Mattock (2010) whose investigations into why patients attend ED suggested access and affordability as being a cause. Baker (2012) noted the significant increase in hospital admissions in New Zealand due to infection was an increasing factor in ED workloads. Other health issues such as chronic diseases attributed to conditions such as diabetes and cardiovascular disease are also having an impact on ED attendances (Bonning, 2013). Cornwall and Davey (2004), propose that there are increased attendances by older persons who are more likely to have complex health issues that require more nursing care in the ED. Health targets such as the SSED are designed to alleviate congestion in the ED and are outlined in the next sections.

1.4.1 SHORTER STAYS IN ED
The SSED target was introduced in New Zealand by the MOH with the aim of reducing waiting times, overcrowding and better outcomes for those being admitted for in-patient care (Pines & Hollander, 2008; MOH, 2009). This is in response to research that has demonstrated the association between patient mortality and increased length of stays in ED (Richardson, 2006; Sprivilis, Da Silva, Jacobs, Frazer & Jelinek, 2006; Gilligan, Winder, Singh, Gupta, Kelly & Hegarty, 2008; Forero, Hillman, McCarthy, Fatovich & Richardson, 2010). This health target is part of an initiative by the MOH (2009) aimed at improving health services and is one of several performance measures that has been prioritised by the government.
The health target is important as international research indicates that the longer patients stay in ED’s and the more overcrowded they are, has a direct impact on the outcome of care (Geraghty, 2013). Overcrowding has a domino effect in terms of increased length in-patient stays and mortality (Liew, Liew & Kennedy, 2003; Richardson, 2006; Richardson, 2001; Sprivilis, Da Silva, Jacobs, Frazer & Jelinek, 2006). The longer a patient stays in ED, the less nursing care is available as nurses often have to change their focus of attention to incoming emergencies. Critical incidents such as serious injury car accidents and medical emergencies like heart attacks require the immediate attention of ED staff. The added distraction of having to treat non-urgent health complaints that would be better placed in primary care is a factor that influences the stress levels of ED nurses (Richardson, 2012).

The premise behind the six hour target known to many as ED6 has been endorsed by the Australasian College for Emergency Medicine (ACEM) and CENNZ and was aimed at improving patient flow out of ED. The SSED target has been deemed as reasonable to ensure appropriate and effective clinical care in a timely manner and was based on the recommendations of a report from The Working Group for Achieving Quality in Emergency Departments (2008). Other government targets that are measured in the ED include smoking cessation advice statistics and screening for family violence.

1.4.2 SMOKING CESSATION

A target that is aimed at improving population health is smoking cessation advice (MOH, 2013a). Lancaster and Stead (2004) argue that there is an opportunity to screen patients who smoke when they seek hospital care. This is supported by Stead et al., (2013) who suggest that there are better opportunities to provide smoking cessation advice in the ED than other health spheres. In contrast, Bensberg, Kennedy & Bennetts (2003) and Katz et al., (2012) argue that the nature of emergency work which is centered on acute care and has significant pressure points may have limited time to provide smoking cessation advice. The addition of health screening in the ED has become a factor in nursing workloads in the ED and this is adding to the stress of nurses who are already busy managing sick patients. The contribution of achieving these targets adds to the pressures to complete nursing tasks and may be considered as a further cause of stress for nurses in the ED.

1.4.3 FAMILY VIOLENCE INTERVENTION PROGRAMME IN EMERGENCY DEPARTMENTS
In New Zealand it is estimated that the police attend five domestic violence events every hour (New Zealand Police, 2010). A considerable number of these family violence incidents end up in the ED. In 2002, the MOH published guidelines for the screening of victims of family violence and child abuse (MOH, 2002). Emergency nurses are often the primary caregivers for victims of family violence and child abuse in the ED and this can be time consuming and stressful (Gunasekara et al., 2011). Koziol-McLain and Gear (2012) comment that recent high profile cases have brought the importance of screening for domestic violence and reporting of abuse to the fore. Elder abuse is another facet of family violence that has become more commonplace. Nurses in the ED are often tasked with identifying older patients that may be at risk of abuse which is becoming more commonplace (Glasgow & Fanslow, 2006). This faction of emergency nursing can be very stressful, particularly when there is significant injury and abuse.

1.5 THE ALCOHOL EPIDEMIC

The consequence of alcohol misuse results in accident, injury, psychological insults, and self-harm events. Alcohol also features as an increasing factor in chronic disease pathologies (Connor et al., 2005; Gunasekara et al., 2011). Although all health disciplines are exposed to the endemic effects of alcohol abuse, the ED is at the forefront of providing treatment for a vast number alcohol related presentations (Gunasekara et al., 2011; Mackenzie, Harrison & McClure, 2010; Connor et al., 2005; Charalambous, 2002). Gunasekara et al., (2011) suggest that nurses bear the brunt with increased exposure to verbal and physical abuse, life threatening traumatic events and health events directly attributable to alcohol. This is supported by Rolls (2006) who explored workplace violence in the ED. A press statement released by ACEM (2013) stated,

Emergency physicians are sick and tired of dealing with the ‘bloody idiots’ who drink alcohol to excess and end up in the ED. If you work in an ED with 1 in 5 patients affected by alcohol, it’s more like a pub than a hospital. This is intolerable for staff and unfair on other patients. Imagine attending an ED with a sick child or elderly relative and having your care disrupted or delayed by a person affected by alcohol (ACEM, 2013 n.d.).

The effects of alcohol abuse contribute to a raft of illnesses and injuries that often end up in the ED. This is supported by Humphrey, Casswell & Yan (2003) who identified that alcohol related injury presentations to the ED represented thirty five percent of all ED presentations. It is suggested by Indig, Copeland, Conigrave and Rotenko (2009) that these presentations may impact on the care of other patients by nurses as they spend a
lot of time having to manage difficult intoxicate patients. Research into the impact of these presentations on nursing staff suggests that this is a cause of considerable stress with increased exposure to violence and abuse. (Charalambous, 2002; Gunasekara et al., 2011; Rolls, 2006).

1.6 BACKGROUND TO THE RESEARCH
What began as an undertaking to answer questions in my own sphere of practice has provided the impetus to begin this study. This led to realising that the effects of workload and the factors that influence the stress levels of on ED nurses in New Zealand needed further research? I have been involved in emergency medicine for many years, firstly as a Paramedic for the ambulance service and more recently as a nurse in the ED of a provincial hospital. Throughout my career, I have been witness to the stress brought about by exposure to traumatic events and devastating illnesses.

An awareness of the factors that influence the stress levels of emergency nurses is important. There is little investigation into how the government health targets impact on nursing workload and the challenges associated with these targets. This also includes screening patients for smoking and family violence which is more often managed by nurses and can be time consuming in a busy working environment such as the ED. Other influences such as the management of challenging behaviors associated with alcohol and drug related attendances also requires further consideration as this can expose the nurse to violence and abuse. Organisational structure and culture may be an additional source of stress for nurses if factors such as workplace bullying and conflict and a perceived lack of support is not acknowledged or managed. Latterly, the increase in workload in the ED brought about by access and affordability of primary healthcare has also become a factor. The pressures created by deal with acute presentations and minor ailments can influence the stress levels of ED nurses in New Zealand. The challenges of emergency work are complicated and varied with nurses having an important role in the ED. Emergency nursing is a sphere of nursing that has some unique elements that influence stress levels which merits further enquiry to contribute to nursing knowledge in New Zealand.
1.7 THE RESEARCH QUESTION

What’s going on “How do New Zealand emergency nurses cope with the occupational stress that is associated working in the emergency department?”

Determining a research question that focused on the stress levels of emergency nurses required consideration as this is such a large topic (Brown, 2008). The research question is fundamental to both the research method and information that will be gained (Weaver & Olsen, 2006). The question was framed around a strategy known as the population, exposure, outcome (PEO) strategy which is often used in qualitative research (Figure 2) that identified the population, influences and outcomes or themes that the question sought to answer (Holmes, 2013). PEO format

<table>
<thead>
<tr>
<th>Population</th>
<th>Emergency nurses in New Zealand</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exposure</td>
<td>What factors that influences the stress levels of ED nurses in New Zealand?</td>
</tr>
<tr>
<td>Outcomes or Themes</td>
<td>Themes that emerge from answers to the questionnaire and free text sections of the survey.</td>
</tr>
</tbody>
</table>

Figure 1: PEO format for qualitative research (Holmes, 2013, p. 1)

1.8 SIGNIFICANCE OF THE RESEARCH

Gaining insight into the factors that influence the stress levels of emergency nurses in New Zealand may highlight key issues that impact on nursing workforces and provide a platform for further research. This under explored aspect of emergency nursing is important as identifying these factors may assist in implementing strategies that will support some of the challenges that ED nurses face. Nurses are essential members of the ED team and are important in delivering patient centred care. The consequence of health related issues that impact on nursing workload in the ED and government objectives are this has on the stress levels of nurse’s warrants further investigation.

1.9 RESEARCH METHOD AND DESIGN
Descriptive research describes situations that occur naturally and involves the collection of data that will provide a description of a situation or experience. This method is common in nursing research as it allows for factors implicated in the research to be identified and discussed with the aim of providing evidence that can support nursing practices in the future (Borbasi & Jackson, 2012; Keele, 2010). The method in this study is a quantitative descriptive design using an online survey to gather data about the factors that contribute to the stress levels of emergency nurses in the ED. The framework for the study was Healy and Tyrell’s (2011) research into occupational stress in the ED. The inclusion criteria for participation in this study are nurses who are members of the CENNZ. This is a convenience sample as it is likely that they have the convictions, attitudes, traits and characteristics that are generic to emergency nursing. The data will be collated into themes which will be discussed further in chapter five (Borbasi & Jackson, 2012).

1.9.1 DATA COLLECTION

Collection of data took the form of a research questionnaire designed to extract transferable information such as demographic and professional data using closed questions and personal opinion through the use of three open-ended questions. An important facet of data collection is the confirmability, credibility and transferability of the data which in qualitative research is the equivalent of validity (Borbasi & Jackson, 2012). The transferability of the data relates to how this would fit into other situations (Guba & Lincoln, 2005). This will be further discussed in chapter three.

1.10 THE AIMS AND STRUCTURE OF THE RESEARCH

The intent of this research is to provide insight into the factors that influence the stress levels of emergency nurses in New Zealand. Healy and Tyrell’s (2011) study suggests that nurses engaged in providing care in this environment are subject to periods of excessive stress due to the nature of emergency work. There is also an undercurrent of gratuitous stress due to internal and external tensions created by ED overcrowding brought about by excessive capacity and demand, unmitigated numbers of alcohol and substance abuse presentations that impact on the care of others. In addition, the exposure to violence, collegial pressures such as bullying, peer pressure, challenging behaviours and the fiscal,
regulatory and legislative demands have an influence on stress amongst nurses in the ED (Healy & Tyrell, 2011, Rolls, 2006).

Chapter one will examine the role of emergency nurses in New Zealand and the setting that they work in. This includes a description of the factors and targets that nurses have to deal with and some of the issues associated with working in the ED. There will be a brief outline of the researcher’s personal interest and experience that is the background to the research. The aims and significance of the research will also be summarised.

Chapter two will feature a review of the literature and healthcare determinates that impact in ED presentations as well as the professional and educational requirements specific to emergency nurses in New Zealand. In addition this chapter will include a synopsis on the literature that has been reviewed and a summary of the findings that is depicted in both local and international articles and studies.

Chapter three discusses the research design and methodology that applies to this research. A descriptive study will utilise an online survey to collect information on occupational stress from emergency nurses. This method preserves anonymity and negates the need to protect identities and localities whilst providing unfettered information for the purpose of the research. Detail on ethical considerations and the application and acquirement of ethical approval will be included in this chapter.

Chapter four will present the data collected from the online survey in table format with simple statistical information.

Chapter five will analyse the content of the data using a qualitative approach. Comments from the participants generated from the sections of the survey that provide options for participants to add statements will be used to highlight key points of this study.

Chapter six will provide a discussion on three themes that were identified key factors as influences of the stress levels of ED nurses in New Zealand. Occupational stress is often presented in a fractured format that suggests that stress is detached into individual aspects. However, the global considerations indicate that the cumulative features of stress require critical attention to ensure nurses do not become overwhelmed by their chosen occupation.
Chapter seven will describe the limitations some recommendations as to how occupational stress could be managed in the emergency department and discuss options for additional research into the issues confronting emergency nurses in New Zealand. This chapter will conclude the research.

1.11 SUMMARY

This chapter has introduced the premise of the research into factors that influence the stress level emergency nurses in New Zealand. The background of the research links to the researcher’s personal interest and experiences as an emergency nurse. An outline of the research methodology, design, data collection and analysis has been presented alongside the ethical considerations that influence this study. Emergency nursing, the ED and some of the intrinsic health factors and targets that predominate nursing practice in emergency nursing has been outlined as these constitute key tenets that impact on emergency nursing in New Zealand. It is hoped that this research will provide the foundations for ongoing and new research into this topic and provide valuable insight to support ED nurses in the future.
CHAPTER TWO

Literature Review

Employ your time in improving yourself by other men’s writings so that you shall gain easily what they have laboured hard for (Socrates, n.d.)

2.1 INTRODUCTION

Chapter two examines literature that relates to the research question. The premise of the literature review allowed for the synthesis of previous research material that formulates the relationship between the literature and the research. Understanding what other research has been conducted is fundamental to determining what gaps exist on the subject (Boote & Beile, 2005). Occupational stress is widely researched through a number of disciplines, so narrowing down the search criteria to focus on literature and research on emergency nursing studies conducted since 2000 provided a comprehensive theoretical base that supports the need for this research (Copi, Cohen & Flage, 2007). This literature review provided the opportunity to critically appraise, analyse and summarise existing literature relevant to the proposed study.

2.2 STRATEGIES FOR THE LITERATURE REVIEW

The literature search employed strategies to elicit information from a variety of sources. Access to printed articles, academic journals, publications and textbooks was made through the university and hospital libraries, private collections, MOH websites as well as medical and nursing journals. Key words used were ‘nursing’, ‘emergency nursing’,
accident and emergency’, ‘trauma’, ‘occupational stress’, ‘stress’, skill mix’ and ‘staffing levels’ and ‘burnout’. This search was conducted through online search engines that included CINAHL, EBSCOhost, MEDLINE and The Cochrane Library. Cross referencing of articles was added to the search strategy and proved a valuable source of relevant references. Results were filtered by date and English language with the literature search primarily concentrating on literature from 2000 onwards. Abstracts were assessed to establish relevance to the key words used for the search. Inclusion of articles prior to this date was based on relevance to the research enquiry. Additionally, in order to establish some clarity to the context of occupational stress amongst emergency nurses additional searches were required based on keywords which included ‘New Zealand government health targets’, ‘alcohol’, ‘violence’ and ‘aggression’, ‘workload’ and ‘interpersonal conflicts’.

A wealth of information on occupational stress in nursing was revealed. Studies that centred on emergency nursing and occupational stress were less plentiful particularly in New Zealand. Much of the older literature discussed stress and burnout experienced by emergency nurses, however more recent studies are examining important issues such as workload, reduced quality of patient care and the implications that organisational culture has on the stress levels of nurses. Reference to literature from other studies that examines occupational stress and factors that influence the stress in other specialties was also reviewed. This was used to determine if there were similarities in the influences of stress amongst emergency nurses. The next section outlines aspect of the literature that was common to ED nurses as an occupation.

2.3 EMERGENCY NURSING

Understanding the dynamics of emergency nursing is important in comprehending why those engaged in this profession are exposed to so much stress. The Emergency Nurses Association (ENA), (2011) defines emergency nursing as “Emergency nursing is an independent and collaborative specialized area of practice. Emergency nurses require a broad scope of practice to deliver quality urgent and complex care within a limited time span to health care consumers” (p. 1). Historically, nursing care was provided by nurses who were called in when a patient arrived in to the ED. As numbers of patients to EDs increased, so too did the expertise of nurses, and the need to employ nurses to staff the department on a regular basis. Emergency nursing emerged as a professional nursing discipline with distinct knowledge
and skills to provide urgent care for the sick and injured in a department that was open twenty four hours a day (ENA, 2006; Frank, 2000).

2.4 STRESS

Stress is a word that is used in a multitude of ways to describe any number of situations although the exact meaning is a phenomenon that is subjective and often misused. Selye (1936) provided a definition that was considered applicable where he described stress as being “the non-specific response of the body to any demand for change” (p. 32). The Oxford Dictionary defines stress as “state of mental or emotional strain or tension resulting from adverse or demanding circumstances” (Oxford Dictionary Online, 2014). Challenges occur when stress becomes constant and cumulative such as that may be experienced in the workplace which can lead to long term health problems or stress disorders. Identifying what factors influence the stress levels of ED nurses is important so that nurses and organizations are able to manage these elements. Factors that influence stress levels of ED nurses in New Zealand are discussed further in the following sections.

2.5 OCCUPATIONAL STRESS IN EMERGENCY NURSING

The physical and emotional demands of emergency nursing are highlighted by Healy and Tyrell (2011) in their study of stress in the ED. They suggest the constant exposure to debilitating injury and illness as well as the death of patients is physically and emotionally tiring. According to Healy and Tyrell (2011) acts of violence and aggression are becoming more commonplace while organisational demands and collegial conflicts are adding to the tensions experienced by emergency nurse in the ED. This study replicated findings highlighted in other international studies with similarities in the factors that influence the stress levels amongst nurses (Adrienssens et al., 2013; Adrienssens et al., 2012; Adrienssens et al., 2011; Healy & Tyrell, 2011; Jonsson & Halabi, 2006; Ross-Adjie, Leslie & Gillman, 2007; Adeb-Saeedi, 2002; Gillespie & Melba, 2003, Laposa et al., 2003).

In a similar study conducted in Australia, the issues that confront emergency nurses were ranked from highest to lowest causes of stress. Workplace violence and heavy workload dominated the list. Safe staffing levels, inappropriate skill mix and dealing with traumatic cases such as the death or abuse of children also ranked highly (Ross-Adjie et al., 2007). A Canadian study indicated interpersonal and collegial conflict as a significant factor that influences the stress levels of nurses in the ED (Laposa et al., 2003). Supporting this trend
are studies in the Middle East, Asia and Japan that suggested workload, constant exposure to death and dying and interpersonal conflict as being stressful for emergency nurses (Wu, Sun & Wang, 2011; Uda & Morioka, 2010; Jonsson & Halabi, 2006; Adeb-Saeedi, 2002).

Healy & Tyrell’s (2011) study revealed that there was little organisational support in dealing with stress and what did occur was generally inadequate. This finding was supported by research done by Jonsson and Halabi (2006) who implied that there is a connection between occupational stress and organisational support amongst emergency nurses. Acknowledgement of the tensions experienced by emergency nurses is essential to maintaining a safe working environment (Lewis, Yarker, Donaldson-Fielder, Flaxman & Munir, 2010). Many of these tensions are presented in the form of incident reports. Sir John Wakefield (2009), in his report on patient safety in Queensland suggests that “merely collecting data about clinical incidents would be pointless without analysing what went wrong and learning from the incident” (p. 9). The point of reporting incidents generated by emergency nurses is to improve both patient and nurse safety. Failure by managers to respond to these events discourages nurses to report incidents in the future. This can further erode the confidence of emergency nurses in the organisation and can be deemed as a lack of support by management (Lewis et al., 2010).

Two Australian studies that examine stress in the ED report an array of stressors such as relentless workloads, poor skill mix, lack of time, critical incidents, inadequate debriefing and lack of higher level support as significant factors that have a physical and psychological impact on nurses (Chang, Hancock, Bidewell, Johnson, Lambert & Lambert, 2006; Ross-Adie, Gavin & Gillman, 2007). Both studies engaged questionnaires to examine stress and stressor in emergency nursing, and though the emphasis varied, the results implied that this is a significant issue that requires urgent attention to ensure the health and longevity of nursing staff. Healy and Tyrell (2011) also used a questionnaire to find out about what affects stressful incidents in the ED. The result of this study suggests that immunity from stress is not guaranteed by constant exposure to critical incidents. The study also proposes that emergency nurses may lack coping mechanisms which may have a damaging effect on their health and wellbeing (Healy & Tyrell, 2011). This is supported by other studies that indicate that long term exposure to workplace stress can
be injurious (Siegrist et al., 2010; Gilbert & Daloz, 2008; Lambert, Lambert & Yamase, 2003).

Acts of violence and aggression are becoming more commonplace in the ED (Anderson, FitzGerald & Luck, 2010). In addition, organisational demands and collegial conflicts are adding to the tensions experienced by emergency nurse in the ED. This study replicated findings highlighted in other international studies with the sources of stress being very similar. These similarities suggest that although occupational stress may have local influences that impact on emergency nurses, there is comparative data that illustrates important issues (Healy & Tyrell, 2011; Jonsson & Halabi, 2006; Ross-Adjie, Leslie & Gillman, 2007; Adeb-Saeedi, 2002; Gillespie & Melba, 2003, Laposa et al., 2003). In a similar study in Australia, the issues that confront emergency nurses were ranked from highest to lowest causes of stress. Workplace violence and heavy workload dominated the list. Safe staffing levels, inappropriate skill mix and dealing with traumatic cases such as the death or abuse of children also ranked highly (Ross-Adjie et al., 2007). A Canadian study indicated interpersonal and collegial conflict as a significant stressor in ED’s (Laposa et al., 2003). While studies in the Middle East, Asia and Japan placed a high emphasis on workload, constant exposure to death and dying and conflict with medical staff as being stressful for emergency nurses (Wu et al., 2011; Uda & Morioka, 2010; Jonsson & Halabi, 2006; Adeb-Saeedi, 2002).

2.6 WORKLOAD

Workload was highlighted in several studies as being one of the most significant factors that influenced the stress levels of nurses. An investigation into the literature surrounding workplace stress in nursing suggested the main sources of stress were workload, professional conflict and the emotional costs of caring (McVicar, 2003). McVicar (2003), determined that interventions from organisations are having limited effect and that a better level of support is required. A recent study undertaken in Australia placed workload, aggression and role conflicts as important factors in workplace stress amongst nurses (Lim et al., 2010). This is supported by Jones and Johnston (2000), who reviewed the relationship between workplace stress, workload and patient outcomes. Jones and Johnston (2000) also suggest that recognizing the signs and symptoms of stress is important as this may affect performance as well as health and wellbeing.
Several studies have identified what factors influence stress in the workplace. Categorising of workplace stressors in these studies provides valuable information to assist in addressing these issues. French, Lenton, Walters and Eyles (2000) determined that workload, interprofessional conflict, patient deaths and organisational management as being the main contributors to stress amongst nurses. This was determined from a questionnaire distributed to nurses in a range of practice settings. Based on the nursing stress scale (Gray-Toft & Anderson, 1981), the researchers developed an expanded nursing stress scale to measure the perceptions of stress amongst nurses in Ontario, Canada (French et al., 2000). A study published in 2001 replicated these findings citing workload, conflict with nurses and physicians and over observation of performance by managers as predictors of stress amongst nurses (Stordeur, D’Hoore & Vandenberghe, 2001).

In a study conducted by Patrick and Lavery (2008) a recommendation was made that manageable workload was paramount in ensuring the health and wellbeing of nurses. This investigation into burnout amongst nurses determined that emotional exhaustion and workplace pressures were the principle causes of stress (Patrick & Lavery, 2008). Gillespie and Melba (2003) encountered similar results concluding that increased stress levels amongst ED nurses may contribute to burnout and attrition if sufficient interventions are not in place. A study on stress by Adrienssens et al., (2013) argued that the factors that influence stress levels remain an issue for many ED nurses. Issues include staffing levels and skill mix that are contributors to stress are of concern to ED nurses.

2.7 SKILL MIX AND STAFFING LEVELS

Inadequate skill mix in ED is often seen as a critical pressure point. Conversely, nurses with less experience in ED feel they are subjected to unnecessary pressures as they are expected to up and running more quickly due to the demands of the ED (Lyneham, Cloughnessy & Martin, 2008). Establishing the correct skill mix in the ED is often a dilemma. The range of experience in an ED varies from new graduate nurses and enrolled nurses to senior nurses working at an advanced level. If the balance of skill is uneven then this may be deemed as putting patients at risk (Aiken, Clarke & Sloane, 2002).
A study conducted amongst surgical nurses by Aiken et al. (2002), examined patient risk associated with poor skill mix in hospitals in the United States. This study revealed decreased job satisfaction and burnout amongst nurses in hospitals where skill mix on shifts was an issue. The authors also indicated a strong correlation between skill levels and mixed outcomes for patients (Aiken et al., 2002). They concluded it was difficult to determine if nursing skill levels were the sole influence on the outcomes which detracted from the results. However, other studies of a similar ilk supported these outcomes suggesting that skill mix and a lack of senior level nursing staff did impact on patient outcomes (Lin & Liang, 2007; Adams & Bond, 2003). This was further demonstrated in a study on problems with in the workforce and the working environment amongst nurses in Belgium. While there were several issues highlights in this study, staffing ranked as a source of considerable stress (Milisen, Abraham, Siebans, Darras, & Dierckx de Casterlé, 2006).

Quality of patient care, nursing shortages and skill mix are a global concern. The assembly of an international consortium to address the issues of nursing stress has provided data on this subject from a multitude of countries (McCloskey & Diers, 2005). The information gained from these nursing based surveys further supports the issues of stress, burnout and decreased job satisfaction highlighted by Aiken et al., (2002). A quantitative study undertaken by Lyneham et al. (2008) investigated the relationship of inexperienced and experienced staff and workload in Australian ED’s. This study determined that compromised patient care and undue workload created pressures for emergency nurses that were likely contributors to stress, burnout and conflict (Lyneham et al., 2008). These findings were also reflected in Paw’s (2007) study conducted in English ED’s. Paw (2007) established that nursing ratios and skill mix issues were inadequately addressed and there was little research to support the relationship of stress and the benchmarking of nursing levels in the ED. The release of a position statement by CENNZ (2006), stated “the College of Emergency Nurses believes that Emergency Departments must have appropriate infrastructure and staffing requirements so emergency nurses have the environment to provide safe quality patient and family centred care ensuring optimum patient outcomes” (p. 1). This statement is underpinned by documents from New Zealand Nurses Organisation (NZNO) and ENA that address the issue of safe staffing levels for ED nurses. (NZNO, 2003; Ray, Jagim, Agnew, Ingalls McKay & Sheehy, 2003).
Skill mix in the ED remains an issue. In a report on staffing and skill mix in the ED issued by the MOH (2002) the variations emergency nursing roles was examined. The recommendation was that nurses’ skill and experience should be adequate to provide safe staffing levels (p. 10). It was also stated in this report that historically, new graduate nurses did not have a role in ED. The report deemed that the lack of experience was insufficient to meet the demand of the ED. However, the report did indicate that new graduate nurses could be employed in the ED if they remained supernumerary and their practice was supported (MOH, 2002).

The aging workforce and predicted shortages of emergency nurses in New Zealand (NCNZ, 2013) has prompted hospitals to rethink the position of new graduate nurses in EDs. Patterson, Bayley, Burnell and Rhoads (2010) completed a descriptive study on the orientation of new nurses into the ED. They determined that new nurses needed to receive well-structured education, training and support to be able to adjust to this challenging environment. This was also evident in a more recent qualitative study that investigated the outcomes of a structured internship for new nurses in the ED. Three distinct themes emerged from this study suggesting that skill acquisition and a well-supported programme that enabled a successful transition from student to nursing was imperative (Patterson et al., 2010).

Whilst new graduate nurses in ED is a solution to staffing and succession planning, it is also a source of stress for many emergency nurses. The integration of these new nurses into the skill mix in a busy ED adds pressure to the workload of senior nurses (Paw, 2008). Less experienced nurses may require more support and supervision in the ED and lack the confidence and competence of their more proficient and skilled colleagues. Adams and Bond (2003) suggest that it is difficult to determine if skill mix is a factor that used as a predictor in staffing ratios or merely a rostering issue. However, the correlation between staffing level, skill mix and occupational stress, remains a source of concern for emergency nurses (Yi-Chun, Jih-Chang, Hsaio-Ting, Hsi-Che, & Wen-Yin, 2010). The exacting nature of emergency nursing suggests that inadequate skill mix is a factor that may influence workload and stress which contributes to attrition of nursing staff in the emergency department (Aiken et al., 2002).

Globally there is an accumulation of data that underlines the importance of staffing levels in emergency departments to safer patient care and outcomes (College of Emergency
Nursing Australasia (CENA), 2008; Doidge, 2013; Robinson, Jagim & Ray, 2004). In February 2013 a newspaper article by Donna Page detailed staffing levels at an Australian Hospital as disgraceful and suggesting that staff were under inordinate pressures due to low staffing numbers (Page, 2013). Whilst this situation may not be widespread it does exemplify the need to ensure the ED has sufficient staffing resources to match the demands of the patients to provide safe care (Page, 2013).

2.8 THE IMPACT OF ALCOHOL ON THE EMERGENCY DEPARTMENT

The extensive problems that confront emergency nurses when dealing with alcohol misuse was revealed in the literature search. The dearth of enquiry into this increasing societal issue is significant although much of the research is internationally based. Gunasekara et al., (2011) conducted an exploratory study in Wellington Hospital’s ED which exposed some important issues for staff. The researchers explored the impact of alcohol related presentations on workload, increased exposure to violence, quality of care and staff morale. While this was a small study it revealed the negative impact that alcohol related admission had on emergency staff. Issues of workload, safety, assaults and the compromise of care to other patients were identified as causes of stress in the ED (Gunasekara et al., 2011). The damage caused by alcohol related injury is a global problem. McKenzie, Harrison and McClure (2010) identified that “500,000 hospitalisations occur annually at a cost of over two billion dollars in Australia. Furthermore the burden of alcohol related hospital admission was underestimated by approximately 62% which is a major concern” (p. 152).

The disproportionate representation of alcohol harm events linked to high mortality and morbidity amongst youth is concerning (Kalafatelas, 2000). A study into alcohol and drug related ED presentations concluded that over a twelve month period alcohol users were the largest presenting group (Tait, Hulse, Robertson & Sprivilis, 2002). Over 30% of youth involved in trauma cases screened positive for ‘risky’ alcohol consumption (Tait et al., 2002, p. 1270). However, alcohol related injury is not confined to the younger generation. Alcohol related mortality caused by injury that occurs before middle age is also problematic (Connor et al., 2005) while an international study conducted in Auckland suggests that 35% of all ED attendances due to injury are caused by alcohol ( Humphrey, Casswell & Yan, 2003). The cost of alcohol related harm is significant, with problem drinkers having more hospital admissions and visits to the ED than other consumer
groups (WHO, 2007; Indig et al., 2006). In a global report on alcohol and injury in emergency departments it was stated that “injured patients who have consumed alcohol tend to be male, young, poor and regular heavy alcohol drinkers” (WHO, 2007, p. 8).

Alcohol is also a factor in the increase in aggression and violence in the ED. Nurses are continually exposed to the destructive behaviours that are often linked to alcohol. Reports of verbal abuse and assault against emergency nurses have increased markedly but despite this there is still limited research into this in New Zealand. In the survey conducted at Wellington Hospital over half the staff reported being assaulted by intoxicated patients with nurses being overly represented in the statistics (Gunasekara et al., 2011, p. 16). It was noted there was a direct association with an increased workload although respondents did not feel that the quality of nursing care was unduly influenced. However, the destructive influence of alcohol related presentations on other patients was a concern as drunken patients required more managing as clinical assessment and treatment was time consuming and difficult (Gunasekara et al., 2011).

Emergency nurses are at the forefront in the provision of care to patients whose admission to the ED is related to alcohol. The complexities and challenges associated with alcohol related admissions are discussed in a study by Darwood (2008). It is suggested that emergency nurses are in a prime position to provide screening and intervention to this vulnerable group of ED consumers (Darwood, 2008). A further study of Taiwanese emergency nurses also concluded that the ED is a promising environment to provide assessment and interventions for alcohol misuse. This study did acknowledge the barriers that exist for emergency nurses in dealing with intoxicated patients including the perception that this was not a necessary part of nursing care and could be considered as adding to the nursing workload (Tsai, 2009).

2.9 VIOLENCE AND AGGRESSION

Aggression and violence towards emergency nurses is not limited to alcohol related presentations. Other contributing factors include increased waiting times and overcrowding, particularly in the waiting room and triage areas of the ED (Jones & Lyneham, 2000). International studies implicate violence and aggression as a significant factor in workplace stress for emergency nurses. Needham, Abderhalden, Halfens, Fischer and Dassen (2005) suggest that the constant exposure to verbal abuse and
physical assault not only erodes confidence, but is a contributing factor in attrition from the field of nursing. There is limited research in New Zealand on the effects of violence and aggression towards emergency nurses. In her dissertation on workplace violence in the emergency department, Rolls (2006) identified two studies by McKenna, Poole, Smith, Coverdale & Gale (2003) and Wilkinson and Huntington (2004) which surveyed new graduate nurses and district nurses on workplace violence (Rolls, 2006, p. 16). Rolls (2006) concluded that there was a serious need to provide a safe working environment and address the issues of aggression and violence towards emergency nurses in New Zealand (p. 59).

An Australian article confronts the issue of nurses being exposed to increasing violence and aggression in the ED. Chapman and Styles (2006) suggest that management strategies to deal with this issue are not effective and this is also contributing to the attrition of emergency nurses from the workforce. The combined effect of aggression and violence is not only jeopardising the safety of nurses. It is suggested that the loss of experienced nurses from the ED will ultimately impact on patient outcomes as well as the financial cost to healthcare organisations (Chapman & Styles, 2006).

Emergency department nurses experience a high rate of aggression and violence in the workplace. In a study completed by Crilly, Choyer and Creedy (2004) it was determined that physical assaults against ED nurses was considerably higher than in other nursing specialties. These findings have been replicated in numerous other studies of violence against emergency nurses. An American study undertaken in Michigan hospitals recorded that this was a significant issues for emergency nurses and impacted on occupational stress and patient care (Kowalenko, Walters, Khare & Compton, 2005). A cross-sectional study of Iranian emergency nurses also suggested that the risk of violent and aggressive acts was considerable in the ED (Esmaeilpour, Salsali & Ahmadi, 2011).

An integrated literature review of violence against emergency nurses conducted by Anderson, FitzGerald and Luck (2010) identified that the existing research was aimed at effect rather than intervention. One hundred and three studies on violence against nurses were identified but a large number of these were discounted as they were not aimed at emergency nursing in particular. Anderson et al., (2010) commented that “the paucity of research evaluating interventions demonstrates that the weight of effort, despite two decades of investigation, is still directed towards defining the phenomenon
rather than addressing solutions” (p. 2528). This was validated by other similar studies that identified that nurses remain at risk of violent and aggressive acts as a result of inaction in determining the cause and effect of aggression and violence in the ED (Lau, Magarey & McCutcheon, 2004; Pearson, Field & Jordan, 2007; Landon, 2003).

2.10 CONFLICT AND BULLYING

Conflict in the workplace is a source of stress. The life and death scenarios that occur daily in the ED often create conflict situations. The challenges of working in the ED are often heightened by poor communication and a perceived lack of managerial support (Fox & Spector, 2010). In an exposé on bullying in an emergency service organisation in the United Kingdom (UK), Owoyemi (2011) argues that this issue is becoming a substantive problem in many workplaces. Much of the discussion is based on the lack of a definition of what bullying in the workplace consists of. Owoyemi articulates the differences between conflict and bullying, although the author suggest that conflict can be deemed to be bullying if it is persistent and ongoing (Owoyemi, 2011). Furthermore, Owoyemi (2011) suggests that power imbalance is an important facet of bullying and can be deemed to be organisational as well as individual. Bullying is not necessarily confined to the lower echelons. This concept is supported by Fox and Spector (2005) who identify the relationship between positional powers held by someone in the hierarchy exerting unreasonable pressures on nurses at a lower level in the workplace. It is important to note that bullying can be deemed as being vertical where managers bully those under their supervision or horizontal where colleagues bully colleagues (Larsen, 2013). In nursing, a new generation of nurses who are well versed in information technology often intimidate and ridicule older nurses who can be challenged by technology (Larsen, 2013).

The consequences of bullying in the nursing profession are significant. Regardless of whether bullying is horizontal or vertical it contributes to a raft of psychological and physical symptoms that are destructive to the health and wellbeing of the individual. McGrath (2002) suggests that “horizontal bullying occurs between workers on the same level, (e.g. nurse-nurse) while vertical bullying is directed downward by workers in superior positions (e.g. manager-nurse) or upwards (e.g. nurses-manager)” (p. 2). Larsen (2013) details the consequences that bullying can have on individual nurses, healthcare organisations and patient safety. Larsen (2013) stated “bullying is a serious, complex
and ongoing problem in the health care workplace, which can lead to demoralization and decreased job satisfaction, as well as feelings of isolation, anxiety, sadness and depression”. Citing John Murray (2009), Larsen indicates that bullying in the workplace also has a negative consequence in terms of attrition from nursing and financial ramifications for organisation (Larsen, 2011; Murray, 2009). Yildirim (2009) suggests that poor concentration and productivity as well as decreased commitment to work and detrimental working relationships with colleagues, management and patients results if bullying is prevalent in the workplace.

It is important to understand the consequences of workplace bullying in relation to this study as much of the literature examined suggests that this has a considerable influence on the stress levels of emergency nurses (Etienne, 2014). A study by Jackson and Rea (2009) reported bullying by managers occurring amongst emergency nurses while a further study completed by Gaffney, DeMarco, Hofmeyer, Vessey, and Budin (2012) suggests that inadequate support and inaction by managers and organisations in dealing with bullying was common. Larsen (2013) states;

> The highly-stressful nature of the job could be playing a role in creating or fostering negative behaviour containment or productivity expectations, also put pressure on nurses and other health. Systemic factors of the health care environment, such as cost care personnel that may be driving disruptive behaviour.

Under reporting of bullying is also problematic. An ED surveillance report on violence undertaken by the ENA indicated that a significant proportion of those surveyed did not report any episodes of bullying which suggests that the depth of the problem is relatively unknown (ENA, 2011) . This is supported by Lewis et al. (2010) who suggests that acknowledgement of stress and anxiety amongst emergency nurses is a key component of organisational commitment to health and safety.

### 2.11 THE LITERATURE BEHIND THE HEALTH TARGETS

In 2009, a government health target aimed at SSED was introduced to combat overcrowding, waiting times and poorer outcomes for patients (Pines & Hollander, 2008; MOH, 2009). The associated link between patient mortality and increased length of stay in the ED has been well researched internationally (Richardson, 2006; Sprivulis, Da Silva, Jacobs, Frazer & Jelinek, 2006; Gilligan, Winder, Singh, Gupta, Kelly & Hegarty, 2008; Forero, Hillman, McCarthy, Fatovich & Richardson, 2010). A report by Johnston (2008)
stated “a shortage of hospital beds is killing as many as the national road toll - about 400 a year” (New Zealand Herald, 8 September 2008). This report also states “an international review of studies in the ED, done for the college, finds overcrowding and blocked access increases the risk of death 10 days later by 34 percent” (New Zealand Herald, 8 September 2008).

This triggered a parliamentary debate which instigated a government review on overcrowding in the ED which later underscored the SSED health target (Working Group for Achieving Quality in Emergency Departments, 2010). Access blocking is one of the major contributors to ED overcrowding. Jones and Olsen (2011) suggest that ED overcrowding is somewhat subjective, but balanced against occupancy can be reasonably measured. They indicate that the capacity for staff to care for patients is impeded by waiting times, assessments and discharge options. Hospital access blocking is a significant reason for extend length of stay in the ED. This study suggested that three out of four patients requiring admission waited more than eight hours. The association between overcrowding, increased length of stay, adverse outcomes and patient mortality is well documented (Richardson, 2006; Sprivulis et al., 2006; Gilligan et al., 2008; Forero et al., 2010).

Ardagh, Tonkin and Possenniskie (2011) aimed to expose the most common challenges in achieving the SSED target. Although acknowledging there are multiple causes that impact on patient flow and overcrowding it was suggested that the most common include access to hospital beds, diagnostic testing and inpatient delays as being the most significant (p. 64). The findings indicate that comprehensive changes including a whole system approach and better staffing were needed to improve acute care in the ED (Ardagh, Tonkin & Possenniskie, 2011). The need to create a whole of system approach to managing both acute ED admissions and the general problems of overcrowding in ED waiting rooms in New Zealand is supported by the New Zealand faculty of ACEM. In addition to the freeing up of the ED by addressing issues for patients being admitted, it is suggested that an improved interface with primary care would improve patient care substantially (Bonning, 2013).

A study conducted by Jelinek et al., (2013) highlights the issue where ED’s are being caught in the middle when dealing with complex care patients. This study explored the view of emergency clinicians when dealing with cancer patients with acute presentations.
The care paradigm for cancer patients in the ED is complicated. Other patients with higher acuity monopolise the care of both nurses and Drs in the ED. Widely acknowledged as a “less than ideal environment” (p. 156) admissions of cancer patients is increasing (Rosenwax, McNamara, Murray, McCabe, Aoun & Currow, 2011). This is adding to the dilemmas of appropriate patient care in the ED. The provision of a suitable care pathway for cancer patients that bypasses ED is suggested in this study. However, in the interim it appears that these patients will inevitably still end up in ED for extended timeframes and stretch the care capacity of nurses further (Jelinek et al., 2013).

According to Nugus et al., (2014), attempts to resolve the issues associated with patient flow have been relatively unsuccessful. An ethnographic study conducted in Australia by the authors, reported a conceptual construction of an ED carousel to combat overcrowding. This symbolic rotunda incorporated diagnosis, treatment and transfer of patients with the management of skill mix and destination. The initiative was designed to reduce overcrowding and improve patient flow on admission though a dynamic decision making process. With the initiation of a four hour target in Australian ED’s the methophorical carousel is designed to provide a co-ordinated response that will improve overall length of stay for patients. It is also aimed at alleviating the stress associated with achieving the imposed target (Nugus et al., 2014). Much of the literature surrounding the health targets is aimed at the known challenges of overcrowding, increased length of stay and waiting room times. There is little enquiry on the issues that emergency nurses are faced with in relation to the SSED other than workload and no nursing based studies or literature was located in this review.

2.12 SUMMARY

An extensive search revealed a wealth of literature relevant to the research question. Most of the literature bore testimony to the factors that influence occupational stress for emergency nurses. Although much of the literature focused on international studies there were common threads that could be equated to the New Zealand setting. This commonality is of value as international experience in managing occupational stress could be applied in New Zealand ED’s. Supporting literature on factors such as alcohol, aggression and violence that confront emergency nurses in New Zealand demonstrates the need for continued investigation. Literature surrounding additional influences such as
the government health targets was also identified to provide a background to the stress encountered by emergency nurses in New Zealand.

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

“Not everything that counts can be counted and not everything that can be counted counts”

(Albert Einstein, 1879-1955)

3.1 INTRODUCTION

The previous chapter examined the literature related to the occupational stress experienced by emergency nurses. This chapter discusses the research design and methods that were used in collecting and analysing the data. Any methodology merits detailed description to ensure that the research processes are clearly outlined (Creswell, 2008). This study used Healy and Tyrell’s (2011) as a framework. This is an important study that has been used in other international studies on the same topic as it is specific to the ED environment (Adrienssens, De Gucht & Maes, 2013; Adrienssens, De Gucht & Maes, 2012; Adrienssens, De Gucht, Van der Doef & Maes, 2011). Their study was a descriptive quantitative survey that examined the causes of occupational stress amongst ED staff in Ireland. Using this survey as a guide a quantitative survey was designed framed around questions used in Healy and Tyrell’s (2011) study.
Healy and Tyrell’s (2011) study was identified using Caldwell, Henshaw and Taylor’s (2005) method to critique research articles relevant to the aim of this research. This model provided a systematic and logical method with a list of questions that guided the researcher. Following the literature review it was ascertained that Healy and Tyrell (2011) investigated the attitudes, experiences and methods of coping of in the ED. The study uses a descriptive method to explore a subject that despite several international studies is relatively unanswered.

Healy and Tyrell (2011) provide an up to date and comprehensive overview of the issues contributing to stress in the ED that was clear and accurate. The use of this framework provided boundaries to the research and guided the study throughout the data collection and analysis. There were similarities in the sample population and a good description of their findings which concluded that further research into this subject was recommended. The questions used in Healy and Tyrell’s (2011) study were used to structure the questionnaire in this study.

An anonymous electronic survey using Survey Monkey ™ was adapted from Healy and Tyrell’s (2011) (Appendix 1). Questions one to eleven, fifteen and nineteen were designed to gather demographic data and closed questions eliciting a yes/no answer. These were designed to gain specific information and to establish if stress did or did not exist. The remainder of the questions followed a Likert scale approach where there was a choice of answers to the questions, and included free text boxes so that the participants could provide additional information. This allows for a richer data capture, something that is important when seeking information about a subject (Babbie, 1992, Robson 1998).

The population of ED nurses (estimated numbers being 2500), is small in relation to the overall nursing population in New Zealand (estimated numbers being 40,000). Having smaller numbers means that not only is the free text option within the survey important to add to the data being collected, but the confidentiality of the participants must be protected, when managing smaller numbers. As an ED nurse the researcher recognized that confidentiality may be an issue, and therefore the CENNZ was approached for assistance in circulating the survey to ED nurses. This removed the researcher from any possible direct interaction with potential participants. The survey was distributed via the CENNZ electronic database to registered members of the college. Consent to participate was therefore the anonymous submission, via the electronic medium, of the survey.
Ethical considerations and consent processes are described, with an acknowledgement of the demand for cultural courtesies in respect of the New Zealand context of nursing practices (Appendix One).

3.2 METHODOLOGY

The methodology is based on a descriptive survey conducted by Healy and Tyrell (2011). This study surveyed ED nurses and their responses to stressors in their work. This framework was used because the model had already been tested on a similar cohort. A descriptive survey reaches conclusions from data that is statistically manipulated but also allows for free text and the interpretation of what is also viewed as important information offers by the participants, on questions posed to them in the survey (Jackson, 2009; Keele, 2011; Polit, Beck & Hungler, 2001). This is an economical research design that allows for the collection of objective data with no influence from the researcher during the process of data collection (Burns & Grove, 2005). A descriptive method provides an opportunity to acquire simple answers to issues that are of significance, particularly in nursing research (Burns & Groves, 2005; Teddlie & Tashakkori, 2008).

The purpose of this study is to factors that influence stress levels amongst emergency nurses in New Zealand. There is little documented research about the degree of occupational stress amongst emergency nurses in this country. Much of the recent research into emergency nursing in New Zealand has investigated individual elements of stress such as violence and burnout (Rolls, 2006; Daniels, 2004). The data collected from this survey provides a platform for further research that may underpin policy and practice in the future for emergency nursing in New Zealand. A convenience sample was undertaken in order to obtain descriptions of the factors identified by nurses as contributing to stress for them, hence the use of the CENNZ for distribution of the survey.

Convenience sampling techniques offer the researcher the option of selecting the information required for the research and the number and characteristics based on the degree of experience, knowledge or skills required to provide that information (Bernard, 2002; Gillis & Jackson, 2002; Patton, 2002; Schneider et al., 2007). Inviting New Zealand emergency nurses to participate in this study engages a population whose subjective experiences of occupational stress in the ED forms the basis of this research. The
description of the comments from the online survey allows for themes to be developed and discussed in more detail. This has also provided the opportunity for ED nurses’ experiences to be compared to those from Healy & Tyrell’s (2011) Irish study which is the framework used in this research.

3.3 THE RESEARCH QUESTION

The research question asks what factors influence stress levels of ED nurses in New Zealand guided a review of the literature. As indicated in previous chapters, there is a gap in the literature regarding the exploration and examination of nursing stress in New Zealand ED’s. The objective of the research was to understand the factors that influenced the stress levels of ED nurses and to determine the degree of the issues that confront them. By allowing free text responses as well as the Likert scale questions, additional information can be provided to questions that may not fully address any particular issues that are concerning participants. So provided details as to who was involved in the research, the benefits and risks of completing the survey, what information will be used and how it will be stored and disposed of at the completion of the research. Issues of confidentiality have been negated by the use of Survey Monkey™ and the membership of CENNZ as the researcher has no prior knowledge as to who are members of this group.

3.4 SAMPLING

Sampling is acknowledged as being critical to the research (Harsh, 2011), with purposeful sampling or convenience sampling mooted as the most common methods used in nursing research (Borbasi & Jackson, 2012). The sample method is selected by the researcher on the basis of the information that is requisite for the research and the knowledge base of the people that are needed to articulate this information. The sampling method used in this research is a convenience sample. Issues related to delays in getting the link to surveys out to the target population was experienced due to the timing of the mail out being over Christmas. An alternate plan of gaining more participants was considered with the use of snowballing but ultimately this was not required. This is discussed more fully in the findings chapter.
Convenience sampling offers the researcher the opportunity to gather data from a population that has characteristics based on the degree of experience, knowledge or skills required to provide that information (Gillis & Jackson, 2002; Patton, 2002; Schneider et al., 2007). In this case, the sample population was emergency nurses who were members of the CENNZ. The use of the CENNZ database provided a means to engage nurses in this research that would have the knowledge, expertise and insight as to what factors influence their stress levels in the ED. Determining the sample size is based on the quality of the data so the number of participants was not pre-determined (Borbasi & Jackson, 2012). The response to the survey provided data beyond the expectations of the researcher. The themes that emerge from this data on the influences on stress are discussed further in chapters four and five.

3.5 THE ROLE OF THE RESEARCHER

The fundamental role of the researcher in this study is to collect the data provided by the research participants and collate into themes. The content is then analyzed and in relation to the research question (Schneider et al., 2007). The balance between critical and creative contemplation is a required attribute of the researcher whose insight and involvement in the research is considered a strength however weaknesses may be demonstrated in the exposé if there is insufficient academic discourse (Patton, 2002).

Throughout the course of the study, it is the responsibility of the researcher to maintain the integrity of the project through transparency and articulation of any bias (Sandelowski, 2004). As the researcher is an ED nurse there is an opportunity to influence the study though personal bias. To prevent bias from occurring the use of the research supervisors to audit the researcher’s work was done at all stages of the study. The discipline for the researcher was to design the questionnaire so that the validity and idiosyncrasies remains that of the research participants rather than the province of the researcher (Sandelowski, 2004). This was undertaken by collating the data into themes that emerged from the comments provided by the participants and then using the information from the literature to analyze and discuss these themes more fully.
3.6 SURVEY DESIGN

Scripting of the survey is integral to the intent of the research. Questions need to be designed to elicit responses that provide data that can be analysed in relation to the research question (Borbasi & Jackson, 2013). The format of the survey requires consideration as it will affect what data collected and how it is analysed. By using an electronic survey method such as Survey Monkey™, it can be distributed to the target population without researcher involvement. It allows for information sharing that is generic and, does not identify any source therefore ensuring transparency and confidentiality which is a significant consideration in nursing research (Borbasi & Jackson, 2012).

It is recognised that generating successful responses to surveys can be problematic (Wells et al., 2006). If the survey is not time consuming, it is simple and easy to complete and relevant to those being asked to complete the questions, then a better response can be acquired. This format is particularly useful to generate information from an extensive cohort whilst maintaining a professional focal point (Wells et al., 2006). A survey research method allows for research participants to answer a series of questions that are then discussed by the researcher (Sandelowski, 2004). It is essential that survey questions are well constructed as this provides reliability and validity to the research. The framework for this study used research questions already tested in Healy & Tyrell’s (2011) research. Because this is a tested and peer reviewed model it provided additional reliability to the structure of the questions used in determining the workplace experiences of ED nurses in New Zealand.

There was no attempt to control the variables or manipulate any part of the study. According to McNee & McCabe, (2008) this is in the best interest of any research in order to portray the realities of the participants. Addressing bias is essential; it is feasible that this study could have been subject to selection bias as the participants may have unique characteristics due to the nature of their work. Because this survey was modelled on an existing research study this was less likely (Borbasi & Jackson, 2012). Healy and Tyrell’s (2011) study was the framework for this research which can add to the integrity of this investigation as their research had underpinned other international Adrienssens, De
Gucht & Maes, 2013; Adrienssens et al., 2012; Adrienssens et al., 2011; Healy & Tyrell, 2011).

3.7 DATA COLLECTION

The collection of the data underpins the research and requires a strategy that enables the researcher to be able to present information that is complete and demonstrates an understanding of the content of the data (Schneider et al., 2007). The research questionnaire (Appendix 1) was designed to elicit information on the demographics of ED nurses and data related to the factors that influence the stress levels of ED through the use of free text options in the survey. An important facet of data collection is the confirmability, credibility and transferability of the data (Borbasi & Jackson, 2012). The transferability of the data relates to how this would fit into other situations (Guba & Lincoln, 2005). This was demonstrated throughout the study by the use of research supervisors to ensure that the information being collected from the data was accurately collated into identifiable themes.

It is acknowledged that questionnaires can distort responses through suggestion or prompts which can coerce the research participant to answer the question in a particular manner (Gillis & Jackson, 2002). For this reason the use of Healy and Tyrell’s (2011) survey was adapted for use in this study as the questions had been tested previously. As a part of the literature review information on questions and formatting was also gathered from other studies conducted by Gholamzadeh, Sharif, & Rad (2011), Ross-Adie, Leslie & Gilman (2007) Chang et al. (2006), and McFarlane, Duff & Bailey (2004), as they were also specifically related to occupational stress or emergency nursing. This was done to determine the strength of Healy and Tyrell’s (2011) study as many questions in these other surveys were similar. This added to the validity of the questions asked as they had also been previously tested and had been referenced in other international studies (Adrienssens et al., 2013; Adrienssens et al., 2012; Adrienssens et al., 2011).

Modifications were made to include questions relating to the governmental health targets initiated by the MOH (2009) so it could be determined if the participants viewed these factors contributing to ED nurses in the New Zealand context. Data refers to the findings from the survey. For this study the data was collated into themes from the
comments with other specific information such as nursing demographics gathered from selected tick box responses. Reporting of demographic includes descriptive variables such as age, gender, ethnicity and years of nursing experience. This is a limitation for this study as there was little New Zealand based research that could inform the study. This data was collected over a six week period from 14 February 2014 to 31 March 2014.

### 3.7.1 ONLINE RESEARCH QUESTIONNAIRE

Data collection via the internet has had a profound effect on research. The use of the internet as a medium for data collection has surpassed all expectations and is now a primal force in research methodologies (Couper & Miller, 2008). Although the internet is acknowledged as an effective medium for survey distribution there is little research into this phenomenon as an optimal method for data collection in nursing research (Hunter, 2012). However, online surveys have a distinct advantage as being an efficient and inexpensive means to collect data. As research is now an integral part of the academic enquiry promoted within the health profession, the use of online questionnaires continues to predominate as a viable methodology (Jones, Murphy, Edwards & James, 2008). There has also been debate as to the disadvantage of collecting data online suggesting sample bias and fears about anonymity and confidentiality recognised as key issues (Jones et al., 2008). These fears need to be acknowledged when developing a method for any study using this method for data collection.

The use of Survey Monkey™ has been selected for this online survey as not only does this method provide a high degree of functionality they also offer a wide range of formats and features to collect, analyse and report the data. In order to ensure the credibility of Survey Monkey the researcher investigated security standards. Survey Monkey™ has a privacy and security seal by TRUSTe and according to Scherer (2013) high profile companies such as Facebook and Samsung are listed as clients by Survey Monkey (Scherer, 2013).

### 3.7.2 DISADVANTAGES OF INTERNET RESEARCH

It is important to acknowledge concerns regarding the use of the internet as a research tool. While the preservation of anonymity is considered secure, there remains the
potential for persons other than the intended participants to complete the survey. This lack of control is an element that researchers need to be aware of when using on-line surveys (Williams, 2012). The researcher should be aware that they do not have control over any erroneous data and that the storage of internet acquired data is indeterminate (Canadian Federation for the Humanities and Social Sciences, 2010). Another disadvantage of using a web based survey site is the issue of ownership and jurisdiction. Survey Monkey is an American owned corporation and jurisprudence is aligned to the statues of law, in this case the U.S. Patriot Act (2001) and the subsequent US Patriots Sunsets Extension Act (2011) that allows for United States government officials to access stored on-line data (Lavende, 2011).

Survey Monkey™ does make reference to the American ownership of its company but researchers need to be aware of the implications of this. However the use of Survey Monkey™ is accepted internationally as an acceptable method collection.

“Please note that the online survey is hosted by "Survey Monkey" which is a web survey company located in the USA. All responses to the survey will be stored and accessed in the USA. This company is subject to U.S. laws, in particular, to the U.S. Patriot Act that allows authorities access to the records of internet service providers. If you choose to participate in the survey you understand that your responses to the questions will be stored and accessed in the USA”

Figure 4: Survey Monkey privacy statement (www.surveymonkey.com, 2014)

3.8 DATA ANALYSIS

The collation of the survey data and themes from the questionnaires allows for comprehensive discourse on the topic. Data analysis should ensure that the rendition is well executed and gives justice to the contributions of the research participants. The analysis of the data is executed by the software packages within Survey Monkey which reports the findings in both table and graph format. This reduced the need for in-depth statistical analysis and allows for comments and statements which constitute the raw data to be grouped into themes. This study has presented a simple statistical description of the data by the use of percentages with tables and charts to summarize the results. This method has been used to show what the data is demonstrating. Further interpretation of the results by use of inferential statistical analysis was not considered
for use in this study as more in-depth analysis of the data for other publications will be done at a later date.

Analysing the elicited information and reporting the data aims to condense the findings into a formal descriptive interpretation of the emergent themes. The credibility and confirmability of the research can be illuminated as data analysis and writing of reports can occur simultaneously (Schneider et al., 2007). Throughout the process of data analysis, any incongruence in the themes can be readily depicted through what is known as “fracturing, grouping and gluing” (Schneider et al., 2007, p. 143) whereby coding of the data occurs. The data was analysed and collated into themes from the content of comments by the research participants about the factors that contribute to stress (Schneider et al., 2007).

3.9 ETHICAL CONSIDERATIONS

Any research undertaken requires the researcher to assume a mantle of implicit trust and honesty. The intention of nursing research is to generate evidence for the betterment of the profession. It is essential that the conduct of the researcher is subject to complex ethical codes to ensure that there is no detrimental aspect of the research that may bring the nursing profession into disrepute (NZNO, 2010; NCNZ, 2012). However, nursing is not always a precise science and delineation of a code of conduct can sometimes appear obtuse if there is no clear demarcation at the outset of the research project (NCNZ, 2012). The aim in this study was to examine the factors that influence the stress levels of ED nurses in New Zealand. The ethical guidelines for research in New Zealand are closely aligned to statutory documents including the Right 4 (2) of the Code of Consumers’ Rights 1996 which legislates ethical standards in healthcare (Health and Disability Commission, 1996) and Section 32 of the Injury Prevention, Rehabilitation and Compensation Act, 2001 (ACC, 2001) which dictates that there should be no clinical component of any study that represents a risk of harm to participants. Therefore consideration of any underlying ethical considerations is an important element when structuring, designing and conducting research. Issues of informed consent, risk and potential harm, confidentiality and anonymity and the honest representation of the data by the researcher remain paramount to the veracity of the study (Resnik, 2007). By using a survey the integrity of enquiry cannot be undermined due to disclosure or any
interactions it is essential that ethical considerations are strictly adhered to during and after the research has been conducted (Fraser, Richman, Galinsky & Day, 2009).

In social theory, research is often about the lived experience of those who consent to tell their story in the name of scholastic endeavour. Researchers have an obligation to protect the contributions of the research participants as ethical considerations in research can be a conundrum. This form of enquiry is a marriage of academic responsibility and the intimacy between the researcher and research participants which demands authenticity, exactitude and rigor that can prove contradictory in maintaining confidentiality, dignity and respect for those participants who contribute to the research (Chase, 1996; Price, 1996; Smythe & Murray, 2000). Establishing how confidentiality can be maintained has resulted in the use of a descriptive survey that requires no personal detail other than demographics (Josselson, 2007). There remains an ethical duty to present the research honestly and without deception, ensuring that there is no misrepresentation or exploitation of information.

3.10 ETHICS APPROVAL

An application for ethical approval was made to the Research and Ethics Approval Committee of Eastern Institute of Technology with the submission of a research proposal and completion of a low risk application. The approval was granted (Appendix 2) before making contact with the CENNZ to request distribution of the electronic survey to their membership (Appendix 3). The content of the collected data was coded into themes using keywords that identify the factors that influence the stress levels of ED nurses. Access to the data has been confined to the researcher and research supervisors, with the online survey being closed and removed on 12 April 2014.

One of the challenges with a small survey is my own association with emergency nursing. Many of the issues identified in the survey undoubtedly resonated with me and my own personal experiences. Similarly, it is possible that a research participant could be inadvertently identified through comments they share. It was important that I declare this to my supervisors if this occurred. Any comment that would in my opinion compromise the integrity of the research would be deleted after consultation with my supervisors. On reading the comments from the online survey I state that while I can
relate too many of the statements I am not able to identify any individual participants. This is an important declaration as I currently have a nursing role in a New Zealand ED.

3.11 CULTURAL SAFETY

It is imperative that cultural consideration be given to any nursing research conducted in New Zealand (Tolich, 2002). Whilst the focus of this research is on emergency nurses, it is acknowledged that there will be amongst the research participants those whose cultural identities will impact their occupational wellbeing. Failure to include the significance of culture amongst our nursing population would be remiss and a direct contravention of the Treaty of Waitangi as well the needs to address the multi-cultural membership of the nursing community.

Tolich (2002) introduced the term “Pākehā paralysis” to nursing research where he states “Pākehā inability to distinguish between their role in Māori-centred research and their role in research in a New Zealand society, which involves Māori among other ethnic groups” (Tolich, 2002, p. 179). This graphic depiction of how Maori features in research demands the attention of researchers in this country. The cultural impact on occupational stress for nurses working in the ED has not been established and no research was located. Although this research collates demographic data that will identify the ethnic origins of the participants there is no specific question that is directed at a Maori or other cultural population. This is in no way intended to denigrate the importance that cultural considerations may have on research outcomes and this will be reported under the framework of the Treaty of Waitangi in respect of “Te Whare Tapu Wha” and the principles of partnership, protection and participation that are endemic to the nursing profession in New Zealand.

3.12 RIGOR

3.12.1 CREDIBILITY

The credibility of this research is synonymous with the subject being believable and truthful (Tobin & Begley, 2004). The notion that credibility is one of the cornerstones of rigour in qualitative research paradigms was mooted many years ago by Guba and Lincoln
(1989) who advocated that credibility, dependability and transferability underpinned trustworthiness within research (Guba & Lincoln, 1989; Bradbury-Jones, Sambrook & Irvine, 2007). This is important to the research as this research is a lived experience for me. I acknowledge that I have my own opinion on the sources of stress for nurses in the ED. I was able to maintain credibility by having my supervisors edit my thesis and checking the raw data from the survey.

Further credibility is gained by the conduction of a literature review that lasted for the duration of the study and substantiated the need for research into the factors that influence the stress levels of ED nurses in New Zealand. This review requires the researcher to critique the available literature in order to promote a balanced viewpoint of current research that is both primary and empirical in origin and endorse the aims and objectives of the study (Coughlan, Cronin & Ryan, 2007). Corroboration of information garnered from the literature review can add validity to the research by substantiating the data collected from the study though robust data analysis (Mcnee & McCabe, 2008). As themes emerged from the data new information from the literature was introduced where it was relevant to the analysis.

3.12.2 TRUSTWORTHINESS

The honesty of data collected during research is paramount to the study (Mcnee & McCabe, 2008). The contributions of the research participants communicate information, attitudes and experiences that are insightful and personal. The phenomenon that is being deliberated requires a judicious framework to safeguard rigour, particularly in qualitative research (Mcnee & McCabe, 2008). This requires respect from the researcher to present the information collated from the data in a manner that elicits trust. The data collection process requires the implementation of a strategy that supports a consistent protocol. Guba (1981) depicted a strategy that utilised four criteria to satisfy the pundits who have historically challenged the trustworthiness of qualitative research. Trustworthiness was demonstrated with the content of the free text contributions being collated into the emerging themes. The raw data was accessible to my supervisors at all times who oversaw the process of data collection throughout the study. No other person was involved in the raw data exploration, and all data is maintained on a password protected computer.
3.12.3 TRANSFERABILITY

Transferability is a term that refers to the “fit” of the study data and how elements of the research can be transferred to other studies with alternative populations or settings. A process of external checking assist with determining transferability whereby themes from the collected data can be compared to other studies (Macnee & McCabe, 2008). The aim of this research is to allow readers to assess if research findings have similarities that could be deployed elsewhere (Lincoln & Guba, 1985).

This study engaged emergency nurses who have affiliation to the College of Emergency Nurses New Zealand (CENNZ). The expectation was that this group of nurses would provide honest and succinct information however; the size of the study is limited to the membership of the CENNZ. Comparison to international studies such as Healy and Tyrell’s (2011) Irish study suggests that the data will be similar and though the responses are restricted to the research participants there is an expectation that the findings could be replicated amongst nurses or health professionals in other health dimensions.

3.12.4 CONFIRMABILITY

The neutrality of the researcher is imperative in order to preserve the integrity and objectivity of the themes that emerge from the data. Validation of confirmability is achieved by demonstrating a structured process of data collection, analysis and discussion that is both auditable and trustworthy (Gillis & Jackson, 2002). Personal biases of the researcher should be declared as should any notion that this may influence the conclusions garnered from the research. The use of research supervisors is the primary control to manage any bias. The research supervisors have access to the online survey to ensure credibility in the analysis of the data. Exclusion of bias from research is problematic as there is always a determinant of bias within the inquiry (Cutcliffe & McKenna, 2004). Deliberate bias exists throughout the literature search as the selection of the literature is that of the researcher while there are elements of purposeful bias that may be endemic due to the relationship of the researcher to the topic (Cutcliffe & McKenna, 2002). The aim of this research is to explore what factors influence the stress levels of ED nurses in New Zealand and the researcher is an emergency nurse so there is an implicit knowledge and academic enterprise that is a declared bias for this study.
Cutcliffe and McKenna (2004) debate the usefulness of acknowledged tools such as audit trails, suggesting that “using audit trails as a means to achieve confirmability of qualitative research findings is an exaggeration of the case for method, and may do little to establish the credibility of the findings” (Cutcliffe & McKenna, 2004, p. 125). A research journal was maintained throughout the study. The reliance on this by the researcher did not necessitate that this journal provided an audit trail but was a manuscript of the research journey based on the experiences of the researcher.

However, confirmability of the research is ascertained though analysis of the data and comparison of the research findings with other relevant studies including Healy & Tyrell’s (2011) research which guided the research questionnaire that was distributed to a similar population. This concept aligns with Cutcliffe and McKenna’s suggestion that “the criteria for judging the quality of qualitative research are not ‘set in concrete’, and huge advances in method and findings have occurred as a result of researchers moving away from established norms and challenging hegemonies (Cutcliffe & McKenna, 2004, p. 132).

3.13 SUMMARY

This chapter has discussed the research methodology and process related to this research project. This included the data collection from the online survey and made reference to disadvantages of web based survey techniques. Further discussion centred on the credibility and validity of this descriptive enquiry with the aim of enhancing the reliability of the findings. The importance surrounding the recruitment of the research participants from the CENNZ database was deliberated. This was particularly relevant as it was important to establish a clearly defined boundary that separated the researcher from the participants due to their closeness to the targeted research population. Ethical considerations are clearly detailed so that the integrity of the research is not breeched. Involvement of the research supervisors was the primary control to ensure ethical standards were maintained. The research question which links to all parts of the study has guided the design and methodology. This provides a necessary connection to the intent of the research project which was to gain insight and understanding into the factors that are sources of stress amongst ED in New Zealand.
CHAPTER FOUR

RESULTS

4.1 INTRODUCTION

This chapter examines the data collected from the online survey. Demographic data and simple statistical calculations based on the number of respondents have been presented to provide information that was gained from the data. This includes a brief commentary and a report in table and graph format to provide demonstrate the percentage of responses to specific questions. The information provided in this chapter compliments further analysis that includes qualitative descriptions of the content which is presented in Chapter Five. Questions were designed to collect data that included demographics of the research participants, relevant nursing information related to professional practice, and information that focused on stress related aspects of daily work.

4.2 PARTICIPANTS INFORMATION

A total of 178 who are members of CENNZ answered the survey. As indicated previously, the membership of CENNZ is not representative of the total number of nurses registered with NCNZ as emergency or trauma nurses which is 2625 at the time of data collection. Based on this information the research participants equate to approximately which makes 6.78% (n=2625) of the total emergency and trauma nursing population (NCNZ, 2013).

4.3 DEMOGRAPHIC DATA
4.3.1 AGE

Table 1 Age Distribution

In New Zealand the average age range for all emergency and trauma nurses registered with the NCNZ in 2011 was between 35 – 50 years of age. This is comparable with the age range of survey participants with 66% of participants aged between 36 years and 55 years. Importantly 12% of participants are over 56 years of age. This is consistent with NCNZ statistical information presented in their nursing workforce report that states that “the nursing workforce is ageing it is predicted that over 50% of our present workforce will retire by 2035” (NCNZ, 2012, p. 4).

4. 3.2 GENDER

Table 2 Gender

In the NCNZ workforce survey (2011) the number of emergency / trauma nurses registered in New Zealand totalled 2625. The gender ratio in this study equates to 93.2% female (n= 124) and 6.8% male (n= 9). This ratio is similar to that of data relating to gender for the overall nursing workforce in New Zealand whereby 90.08% identified as female and 9.92% male (NCNZ, 2011).

4.3.3 ETHNICITY
The ethnic composition of nurses in New Zealand is predominantly New Zealand European / Pākehā which is equivalent to 66% (n=29539) of the total nurses registered. The Māori nursing workforce equates to 6.7% (n=2984) of nursing registrations (NCNZ, 2013). By comparison the NCNZ (2013) registrations of emergency and trauma nurses by ethnicity were similarly represented with 66.88% (n=1789) described as New Zealand European / Pākehā and New Zealand Māori equating to 7.43% (n=193). This is comparable to the ethnic composition of participants in this study with 83.3% (n=110) identified as New Zealand European and just 3% (n=4) identifying themselves as New Zealand Māori. Other ethnicities are also represented in this study and consist of nurses of Australian, Asian, Pacific Island, American, Canadian, English and European origins with 17.5% (n=23) which is similar to NCNZ (2013) workforce data that details other ethnicities as being 23.3% (n=606) of the emergency nursing workforce.

4.4 NURSING DEMOGRAPHICS

4.4.1 Number of years as a Registered Nurse
Data collected from this survey reveal that the majority of participants have been Registered Nurses (RN) for over ten years with 72.7% (n= 93) in this category. Those participants registered between five and ten years equalled 21.1% (n= 27) of the respondents. A further 6.3% (n= 8) were registered for less than five years. Several respondents did not provide an answer to this question (n= 38). Statistics from NCNZ (2013) indicate that of all RN’s registered in New Zealand, 58% (n=39785) had been working for more than 15 years (NCNZ, 2013, p. 16).

4.4.2 NUMBER OF YEARS NURSING IN THE ED
The number of years working as an RN is replicated in the years worked in the ED with 45.1% (n=60) of participants employed for over ten years in this field of practice, 24.1% (n=32) from five to ten years, 23.3% (n=31) two to five years and just 7.5% (n=10) less than two years.

### 4.4.3 Employment Status

The demographic between full time and part time emergency nurses is minimal. There was a small response from casual nursing staff who work in the ED that equated to 5.4% (n=7), a further 44.6% (n=58) indicated that they work part-time with a total of 50% (n=65) indicating that they were employed fulltime. This is comparable with statistics from NCNZ’s (2013) workforce survey that report 48% (n=21496) as indicating that they were employed part-time, although this is not reported by setting (p. 7).

### 4.4.4 Nursing Roles
Table 7 Nursing roles

Thirty eight respondents skipped this question. The variables between nursing roles in the emergency department were identified for demographic purposes only. The responses suggest a comparable mix of RN’s who have been registered for between one and five years with 56.4% (n=55) of participants within this category. A further 28.6% (n=40) indicated that they were senior nurses, although it is acknowledged that the criteria to be categorised as a senior nurse may differ from DHB to DHB. The data reveals that 9% of respondents are Clinical Nurses Specialists (CNS), while a further 2.3% (n=3) are Nurse Practitioners (NP) and 3.8% (n=5) were CNM’s. There were no responses from new graduate nurses. This is consistent with New Zealand practices as graduate nurses are not often employed by ED services.

4.4.5 ROLE STRESS

A question in the survey asked participants if they experienced stress in their current position and required a yes or no answer. A total of 97.7% (n=130) indicated that stress was a prevalent factor.

Table 8 Nursing roles and stress

4.5 OCCUPATIONAL STRESS IN THE EMERGENCY DEPARTMENT
The relationship between stress and emergency nursing is reflected in the response of the participants, with 99.2% (n=132) of participants identifying that they experienced stress in their work in the ED. Only 0.8% (n=1) indicated that no stress occurred. There was no attempt to identify what the source of this stress was in this question which required a yes or no indication as to whether stress was experienced.

### Table 9 Stress in the ED

- **Have you ever experienced stress due to your work as an emergency nurse?**
  - Yes: 99.2%
  - No: 0.8%

### Table 10 Stress when going to work

- **Do you feel stressed or anxious when going to work in the Emergency Department?**
  - Yes: 60.9%
  - No: 18.0%
  - Other (please specify): 21.1%

The results from the survey suggest that there is a small proportion (18.0% - n= 24) of participants that feel stressed when going to work. Determining why some nurses feel stressed going to work as against when they are at work is difficult to establish without further enquiry.
It is apparent from the survey results that emergency nurses are encountering stress on a regular basis in the ED. A small percentage of nurses (7.5% - n=10) indicate they experienced no stress. A further 36.8% (n=49) experience moderate stress with a further 18.8% (n=25) specify that they are experiencing stress very often. In response to the question that enquired if this stress had occurred in the last twelve months 94.7% (n=125) responded yes. There were a total of one hundred and seventeen comments made which listed factors that contribute to the stress levels of nurses in the ED. These are discussed further in the following chapters.

Table 11 Weekly stress

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extremely often</td>
<td></td>
</tr>
<tr>
<td>Very often</td>
<td></td>
</tr>
<tr>
<td>Moderately often</td>
<td></td>
</tr>
<tr>
<td>Slightly often</td>
<td></td>
</tr>
<tr>
<td>Not at all often</td>
<td></td>
</tr>
<tr>
<td>Other (please specify)</td>
<td></td>
</tr>
</tbody>
</table>

In a typical week, how often did you feel stressed at work?

- Extremely often: 8.3%
- Very often: 36.8%
- Moderately often: 26.3%
- Slightly often: 7.5%
- Not at all often: 2.3%
- Other (please specify)

Table 12 Stress in the last twelve months

<table>
<thead>
<tr>
<th>Has this stress occurred in the last 12 months and if so please describe what has contributed to this stress</th>
</tr>
</thead>
<tbody>
<tr>
<td>94.7%                                                                                          Yes</td>
</tr>
<tr>
<td>5.3%                                                                                           No</td>
</tr>
</tbody>
</table>

[Diagram of survey results]

Table 12 Stress in the last twelve months
Stressful events are common in the ED. The factors that nurses find the most stressful include sudden or traumatic deaths with 24.8% (n=33) of respondents indicating that this is of concern. The incidents that contribute the most to stress levels are identified as the death of a child or young person with 38.3% (n=51) signifying this as an issue. The largest response centred on aggression and violence with 39.8% (n=53) alluding to this as a factor in stress. Sixty six comments were posted in the free text boxes identifying factors that influence the stress levels of nurses in the ED.

<table>
<thead>
<tr>
<th>Most stressful event[s] experienced whilst working in the emergency department?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Aggression and violence from patients</td>
<td>39.8%</td>
</tr>
<tr>
<td>Death or resuscitation of a child or young person</td>
<td>38.3%</td>
</tr>
<tr>
<td>Critical illness</td>
<td>11.3%</td>
</tr>
<tr>
<td>Sudden of traumatic death</td>
<td>24.8%</td>
</tr>
<tr>
<td>Major incident</td>
<td>13.5%</td>
</tr>
</tbody>
</table>

*Table 13 Most stressful events*

Violence is highlighted as being an issue with the comments from participants suggesting this factor is an ongoing influence on the stress levels of ED nurses. The results from this study highlight that the issue of violence. 96.2% (n=128) of respondents indicated that they have experienced either physical or verbal violence in their workplace.

*Table 14 Violence and aggression in ED*
4.6 ALCOHOL
The concerns around alcohol related presentations as being a source of stress for nurses in the ED were well represented in the free text section. Survey participants provided extensive commentary on the impact of intoxicated patients on nursing workload with 77% (N=128) of responses indicating this is a significant problem confronting staff in New Zealand ED’s.

![Pie chart showing impact of alcohol in the ED]

Table 15 the impact of alcohol related presentations in ED

4.7 ORGANISATIONAL SUPPORT

![Bar chart showing employer support]

Table 16 Employer Support

There were mixed responses about employer support. A total of 61.1% (n=80) indicate that they do receive support while 38.9% (n=38) suggest there is no support given. A total of thirty five participants skipped this question so the results can only be used in the context of highlighting the issues.
A question requiring a yes, no or occasionally response was used to determine if this was a factor. The results imply that support to reduce stress amongst nurses in the ED is either occasionally sufficient or inadequate. Although 20.3% (n=25) of respondents have indicated that the level of support is sufficient to decrease their individual stress, 40.7% (n=50) disagree suggesting the level of support is insufficient. A further 39.0% (n=48) have identified that support is occasionally satisfactory. As 43 participants skipped this question the results may be inconclusive but they do offer insight into issues around the level of support within the DHB’s.

![Has this support been sufficient to reduce your stress?](image)

*Table 17 Effects of employer support on reducing stress*

The following table provides an outline of the structure and processes that are perceived as contributing to workplace stress for emergency nurses. A total of forty one nurses did not answer this question so the data is not conclusive in terms of the actual issues that have been recorded. This does assist in providing insight and a greater understanding of the issues that these nurses are confronted with in the ED. There were thirty one comments that relate directly to the structures and processes of organisations which were collated into themes for analysis and discussion in the following chapters. Key issues were staffing with 82.6% (n=114) identifying that inadequate staff numbers were a problem while lack of management support was also ranked highly with 65.9% (n=91) of respondents indication that this was a concern. There were thirty one comments made which were similar to themes that emerged from other questions.
4.8 CONFLICT

Conflict is an aspect of nursing that contributes to stress. The research participants indicate that a common cause of conflict was with the public however conflict with patients ranked highly with 74.4% (n=99) of respondents noting this as having an influence on stress. The most stressful interactions are highlighted as being between colleagues with 76.7% (n=102) of research participants indicating the occurrence of collegial conflict.

Table 18 Organisational determinants that contribute to stress

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of support from senior management</td>
<td>65.9%</td>
<td>91</td>
</tr>
<tr>
<td>Relationships with your immediate colleagues and</td>
<td>13.0%</td>
<td>18</td>
</tr>
<tr>
<td>Lack of communication and information at work</td>
<td>39.1%</td>
<td>54</td>
</tr>
<tr>
<td>Poor management and supervisor</td>
<td>31.2%</td>
<td>43</td>
</tr>
<tr>
<td>Lack of ways that conflicts are resolved in the</td>
<td>39.9%</td>
<td>55</td>
</tr>
<tr>
<td>Poor organisational structure and policies</td>
<td>21.0%</td>
<td>29</td>
</tr>
<tr>
<td>Lack of adequate staffing</td>
<td>82.6%</td>
<td>114</td>
</tr>
<tr>
<td>Lack of financial resources for training course and</td>
<td>42.0%</td>
<td>58</td>
</tr>
<tr>
<td>Lack of equipment and supplied</td>
<td>34.8%</td>
<td>48</td>
</tr>
<tr>
<td>Inadequate clerical / technical backup</td>
<td>23.2%</td>
<td>32</td>
</tr>
<tr>
<td>Poor physical working environment</td>
<td>21.7%</td>
<td>30</td>
</tr>
<tr>
<td>Lack of protection in potential dangerous environment</td>
<td>26.1%</td>
<td>36</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>22.5%</td>
<td>31</td>
</tr>
</tbody>
</table>

Table 19 Stressful experiences

A question that specifically asked about the most common cause of conflict at work suggest that conflict between colleagues was an issue with 70.2% (n=87) indicating as a factor that causes stress. This result is contradicted with only 29.8% (n=37) suggesting
that they lacked emotional support by colleagues. Conflict between different departments also ranked highly with 60.5% (n=75) of respondents suggesting this was a problem. There were twenty six specific free text comments on conflict as a factor that influences stress levels amongst ED nurses.

Table 20 Conflict

4.9 BULLYING

The question on bullying required a yes or no answer with an option for free text comments. Although 41.2% (n=54) have indicated that they have not experienced bullying behaviour, a further 58.8% (n=77) have specified that they are being bullied. There were seventy free text comments made on the subject of bullying and forty five participants skipped this question.

Table 21 Bullying
4.10 HEALTH TARGETS

Response to participants opinions on the influence of government health targets varies, with many commenting that though they are a necessary part of emergency nursing they do impact on workload. A total of 89.3% (n=100) indicate that the SSED target creates additional stress in the workplace. The smoking cessation target attracted a response of 25.0% (n=28), with a similar result in relation to the reporting of family violence with 25.0% (n=28) of respondents indicating this was of concern. Child abuse reporting had a response rate of 19.6% (n=22) that denote this as being a contributing factor to occupational stress. There thirty nine comments with the majority indicating that the health targets are a factor that influence stress levels.

![Graph showing response rates for health targets]

Table 22 Health targets

4.11 PERSONAL FACTORS

Results identified issues around the balance between work and home life.
Table 23 Work life balance

Time with family and friends was the most significant factor with 52.9% (n=64) responding that this was an issue. There was a higher response regarding social relationships and occasions with 62.0% (n=75) highlighting this as a factor. Taking work home was common with 47.9% (n=58) identifying that this was a regular occurrence. Personal relationships with partners or spouses was not as significant although 20.7% (n=25) pinpointed this as a concern.

Personal anxieties, feelings and concerns are factors that contribute to individual stress levels for ED nurses. The most commonly identified personal factor was regarding the provision of care for patients with 87.2% (n=109) of participants indicating that this was a concern. There was also an interesting response about the fear of making mistake with 51.2% (n=64) denoting this as an issue. The results also signified that the maintenance of knowledge and skills is a factor for 42.4% (n=53) of participants while feelings about inadequacies in managing the emotional needs of patients was noted with 44.0% (n=55) of participants responding to this query.

Table 23 Work life balance

The balance between home and work can be difficult to manage at times. Have you ever felt

<table>
<thead>
<tr>
<th>Factor</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>You don’t have enough time with family and friends</td>
<td>52.9%</td>
</tr>
<tr>
<td>Inability to separate personal from professional roles</td>
<td>17.4%</td>
</tr>
<tr>
<td>Taking work home</td>
<td>47.9%</td>
</tr>
<tr>
<td>Relationship with spouse / partner affects work</td>
<td>20.7%</td>
</tr>
<tr>
<td>Inadequate time for social relationships and occasions</td>
<td>62.0%</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>30.6%</td>
</tr>
</tbody>
</table>
A question was asked about how nurses cope with the stress of working in the ED. There were a total of one hundred and twenty three free text comments made in answer to this question which will be discussed further in Chapter Six.

4.12 SUMMARY

In this chapter the findings from the online survey have been presented. Demographic data has been presented to describe the relatively small population of nurses engaged in emergency nursing in this country. The volume of content from the free text comments provided by the research participants throughout the survey suggest that there are many factors that influence the stress levels of ED nurses in New Zealand. The data was compiled into themes with analysis of the content and selected comments relative to the themes presented in Chapter Five. Inclusion of all the comments in this chapter was not possible due to the number of responses. Discussion of the findings in relation to the aims of the research is presented in the Chapter Six.
CHAPTER FIVE

CONTENT ANALYSIS

“The value of an idea lies in the using of it”

(Edison 1847 – 1931)

5.1 INTRODUCTION

Chapter five will examine the data collected from the online survey in conjunction with the free text responses offered. Analysis of this data was based on the content of comments from the research participants and collated into themes and discussed with reference to the results provided in Chapter Four. The themes were collated under the headings that they related to. The survey comments have been included in the analysis to illustrate the opinions of the research participants. Responses from the participants have provided some insight as to what factors influence the stress levels of ED nurses in New Zealand. Included in this analysis is an examination of the demographic information...
as this assumes relevance to the aims of the research based on issues such as age and experience.

5.2 DATA ANALYSIS

The use of content analysis is a recognised quantitative method that analyses words or statements by allocating a code and then grouping this data into themes in a systematic manner (Stemler, 2001). This is a useful technique that allows for a description of the characteristics of the data. A six step method was used to analyse the content of the comments made by the research participants.

Step one involved assembling all of the comments into groups by coding the data according to the contents of the text. This step also identified if there were links between the groups that could strengthen the predominant themes that had emerged from the data.

Step two involved reading all of the comments within each group to gain understanding and familiarity with the data to assist with analysing the information. This was done several times.

Step three comprised removing anything from the comments that might be identifiable such as comments that alluded to an area of practice within the ED.

Step four included consideration of the aims of the research in relation to the comments of the research participants.

Step five identified comments that were representative of identified themes for inclusion in the analysis and compared against factors emerging within the statistical data presented in the previous chapter.

Step six involved a qualitative analysis of the themes.

Analysis of the content of the data follows under the headings that are consistent with those used in the previous chapter. A substantive amount of data was collected and it should be noted that the volume of information that emerged from the comments is beyond the scope of this thesis. The data which has been collated into themes will be used in further articles that will follow on from this dissertation. The following sections
analyses the demographic information to provide insight into the population of ED nurses in New Zealand.

5.3 DEMOGRAPHICS

5.3.1 AGE

It was apparent from the data that the age of ED nurses in New Zealand tends to be older. Hallin and Danielson (2007), Laposa et al., (2003) and Potter (2006) suggest that emergency nursing is an area of nursing that is more commonly staffed by experienced nurses. The predominant age group in this survey was aged between forty six and fifty five years. This was matched by data from the nursing demographics which indicate that the majority of nurses having been registered and working in the ED for over ten years.

The age distribution in Healy and Tyrell’s (2011) study was reported as an average with the mean age being 33.4 years (p. 32) however, the age range that was reported in Gholamzadeh, Sharif and Rad (2011), study differed with 37.8% (n=34) being below twenty five years of age, 44.4% (n=40) aged between twenty five and thirty five years and the remainder of respondents 17.8% (n=16) being over thirty five years (p. 44). It was difficult to ascertain if the age distribution for the Iranian study is relevant for this study as there was no data available on the age of nurses practicing in Iran.

5.3.2 GENDER

Nursing in New Zealand is a female dominated profession. The ratio of male to female emergency nurses is reflective of a similar ratio of nurses registered to practice in this country. Demographic data on gender from Healy and Tyrell’s (2011) study was similar to this study with 87% (n=90) female and 9% (n=8) being male nurses (p. 32). This is comparative with data from Gholamzadeh et al. (2011) whose study of Iranian emergency nurses also had a similar gender ratio with 86.7% (n=78) being female and 13.3% (n=12) male (p. 44). Loughery (2008) suggests that females are more likely to be engaged in caring roles than males. No further analysis of gender issues amongst ED nurses was done as this was not the primary focus of the research; however the researcher acknowledges that this may be a factor that influences stress levels for some nurses.

5.3.3 ETHNICITY

Ethnicity is an important factor in provide equitable and culturally appropriate healthcare. Anderson, Scrimshaw, Fullilove, Fielding, Normand and the Task Force on Community
Preventative Services (2003) suggest that cultural competence in health care should include a nursing workforce that not only reflects the communities they serve but is able to converse in a language that is understood by the healthcare consumer. A study conducted by Jansen, Bacal and Crengle (2008) identified organisational, community and human resource barriers for Māori patients in New Zealand. This included a lack of Māori health professionals and the perceptions and attitudes of non-Māori staff towards their Māori patients. The concept of health disparities is important for emergency nurses to understand. This is because research indicates that the community level barriers such as access and affordability of healthcare are often the drivers for Māori patients to present to the ED for less serious conditions which would normally be dealt with in primary care (p. 8). This is supported by comments from participants in Jansen et al.’s (2008) survey that states “hui participants’ experiences at hospital, including A&E, were largely connected with the behaviour and attitudes of hospital staff” (p. 49). While this aspect of emergency nursing has not been examined in this study it is relevant as one of the determinants of culturally appropriate healthcare includes the ethnic composition of the nursing workforce (Durie, 2001; McPherson, Harwood & McNaughton, 2002; MOH, 2004).

5.4 NURSING DEMOGRAPHICS

Nana, Stokes, Molano & Dixon (2013), in a nursing workforce report commissioned by NCNZ, states that;

By 2035 it is estimated there will be 5.26 million people living in New Zealand and a predicted increase in demand for health care based on an ageing population and lifestyle disease. As the nursing workforce is ageing it is predicted that over 50% of our present workforce will retire by 2035. Therefore the supply of nurses must replace the increasing numbers of nurses who are retiring and meet the extra demand for nurses as a result of population changes (p. 3).

This has important ramifications for nursing including ED where a level of expertise and experience is recommended in this field of practice (McQuillan et al., 2002).

As previously mentioned the data suggests that the emergency nursing workforce in New Zealand has considerable nursing experience. There is no regulation that excludes new nurses from working in the field of emergency nursing in New Zealand; however regulatory bodies recommend that new graduate nurses should not work independently.
in the ED (CENNZ, 2006; MOH, 2002). While there is limited reference in the literature as to what constitutes experience there is considerable debate about skill mix. Staffing recommendations in the ED are aligned to the positions statements of emergency nursing groups who act as advisors to NCZN and the DHB’s (CENA, 2007; CENNZ, 2006; ENA, 2003). Cloughnessy and Martin (2008) and Paw (2007) discuss skill mix as being an issue for emergency nurses as there is considerable impact on senior staff in the direction, delegation and supervision of less experienced nurses in the ED. The issues surround skill mix emerged as a factor that influences the stress levels of nurses and is discussed further in the next chapter.

5.4.1 EMPLOYMENT STATUS

The study does not investigate hours worked or roster status but research indicates that there is an increase in the stress levels of nurses that is relative to poor rostering and long shifts (Aiken et al., 2002). It is difficult to determine if there is a correlation between fulltime and part time work and stress levels in the ED. However, comments from participants indicate that working hours have been changed as a mechanism that is directly related to coping with the stress levels encountered at work. The literature suggests that many nurses work part time in response to burnout and overwork (Aiken et al., 2001). This is supported by Burke, Dolan and Firkensenbaum (2013) who also indicate that there are several reasons for opting to work part time.

Burke et al. (2013) suggests that the common reasons for working part-time were due to provide care for children or others, personal issues, alternative careers or opportunities and significantly the lack of available fulltime work. This was supported by a comparable study with similar findings (Maynard, Thorsteinson & Parfyonova, 2006). The demographic profile in a study by Burke et al. (2013) study demonstrated that that nurses were younger, less engaged and had fewer employment options which may be a characteristic of the generation Y factor or an indictment on the nursing profession to provide sufficient opportunities for new young nurses (Clendon & Walker, 2011; Weingarten, 2009; Young & Twinn, 2006). There are limited New Zealand based studies on the generation factor in nursing but research from other industries suggest that the generational factors are important considerations for organisations and managers to consider (Jamieson, 2012).
The decision to work full time or part time is supported by Burke and Greenglass (2000a) who propose that this is an individual choice by nurses. In a second article Burke and Greenglass (2000b) make reference to organisational factors that imposed working hours by the reduction of resources and restructuring which is an organisational factor that may be of significance. Jamieson, Williams, Lauder and Dwyer (2008) indicate that there are some negative connotations related to part-time work for nurses, for example rostering and less engagement with colleagues and leaders. Dwyer and Ryan (2008), state that;

There is little research that looks holistically at the experiences of these part-time workers (e.g.; job satisfaction, wages and conditions, factors influencing options and choices). Nor is there very much research at all on other groups working part-time (e.g.; young workers, older workers, workers with other caring responsibilities)...... there is virtually no research that considers the use of part-time work from an employer’s point of view; these include the extent to which they see it as beneficial to accommodate people’s wish to work part-time, even in management positions, the reasons why they create part-time jobs, the way in which part-timers are used, and any issues that employers face in managing part-time workers or a largely part-time labour force (p. 33).

Comments made by research participants reflect this.

“Work part time by choice to achieve work life balance - to allow me time for family relationships and relaxation”.

“Working part time - Doing something joyful outside of work”.

“Working only part time, and quite honestly starting to look around at another career. This one does not feel sustainable into my 60’s!”

It is difficult to determine if there is a correlation between fulltime and part time work and stress levels in the ED. However, comments from participants indicate that working hours have been changed as a mechanism that is directly related to coping with stress levels. This is supported by international studies that suggest working part time has been identified as a means to coping with stress levels (Aiken et al., 2002; Burke et al., 2013; Maynard et al., 2006).

5.4.2 NURSING ROLES
The nursing roles identified in the data are consistent with recommendations from international professional bodies such as CENA (2008) with whom the New Zealand has a collegial relationship. The Australian regulatory body CENA detailed nursing roles in the ED as being a mix of RN’s with a range of experience and skills that includes novice nurses to expert nurses. In New Zealand, ED nursing roles are covered in the CENNZ (2006) position statement although this is does not include senior nursing roles or positions such as clinical nurse managers as a part of the calculation for clinical requirements for safe staffing and optimising patient outcomes. Nurse Practitioners (NP), who are able to work independently without immediate supervision of a medical doctor were included in this staffing profile as they are becoming more common in the ED. Registered Nurses (RN) under the NCNZ (CENA, 2008). An NP is a “senior nurse clinician who is recognised by the relevant Registering Authority as an expert in the field of emergency health care, who practices in accordance with relevant legislation” (p. 3).

Ray et al., (2003) suggests that primary considerations should be given to essential components that will influence staffing levels in the ED such as:

- Patient census
- Patient acuity
- Patient length of stay
- Nursing time for interventions and activities by patient acuity
- Skill mix for providing patient care based on nursing interventions that can be delegated to a non-Registered Nurse (RN)
- Adjustment for the non-patient care time included in each full-time equivalent position (p. 246).

5.4.3 ROLE STRESS

The data indicates that stress is a factor for ED nurses in New Zealand. Information from the statistical data noted that 97.7% of the research participants indicated they experienced stress in their current nursing roles in the ED. There are acknowledged differences between nursing roles and the factors that may influence the stress levels of nurses that may be experienced commensurate with the level of skill and knowledge. For instance organisational demands and financial pressures may be factors that are more likely to impact on a CNM’s levels of stress than a junior RN who is not required to co-
ordinate the clinical and services demands (Shirey, 2006). Chang et al. (2006) regards role stress as being related to excessive workloads and increased job requirements with less resources. Environmental factors such as difficulties with patients and members of the public, the demands of shift work and inadequate organisational or collegial support are also factors that add to tension within nursing roles (Chang et al., 2006). This premise is supported by Lambert and Lambert (2001) and Lambert et al., (2004) who made the connection between nursing roles and levels of stress within the workplace. There is also a link between role stress and issues such as increased exposure to aggression and violence, shortages in nursing staff, organisational structures and positions within the nursing hierarchy for instance being a new graduate nurse (Aiken et al., 2001; Chang & Hancock, 2003; Jackson, Clarem & Mannix, 2002).

Chang and Hancock (2003), suggest that increased levels of stress are not uncommon for new graduate or junior nurses as they have had neither the experience nor exposure to the challenges and issues of nursing and are often uncertain of their role. This may also apply to experienced nurses working in the ED who have never been engaged in this area of practice previously. Lambert and Lambert (2001) note that this has an important implication for organisations and managers who may need to ensure mentoring, orientation and ongoing support for nurses who are new to the specialty to reduce the impact of this factor on stress levels. Hooper, Craig, Janvin, Wetsel, and Reimels (2010) argue that role stress is caused by the constantly changing demands of a chaotic and unpredictable working environment rather than a specific nursing role. This premise that the unpredictable nature of work in the ED is a significant factor influencing stress levels of nurses is supported by Healy and Tyrell (2011), Kilcoyne and Dowling (2007) and Potter (2006) who all reached similar conclusions. A factor that concerns some ED nurses relates to junior nurses in the ED with several comments that made reference to inexperienced staff contributing to the stress of other nurses, for instance;

“Higher patient presentation rates, decreased staffing levels, very junior staffing”.

“Also staff on floor not educated in simple things so get taken away from own pts to do simple things like plaster and picc/port access”.

“Inexperienced medical staff not able to make critical decisions or having to direct them to make the right calls”.
Much of the literature focuses on the RN and occupational stress rather than the different experiences nurses in specific roles may be subjected to. There were no specific comments that identified managers stating that they were stressed. Laschinger, Almost, Purdy and Kim’s (2004) Canadian study of nurse managers determined the levels of stress being experienced was disproportionate to the support they received from the organisation, which in turn influenced how they managed their own behaviours towards others in the department. Johansson et al. (2013) stated;

Today, work life in health-care organizations is characterized by a fast work pace combined with an excessive amount of work, increased demands for efficiency and stringent requirements for quality of care and patient safety. These factors have resulted in increased risk of work-related stress for front line Nurse Managers and their subordinates” (p. 450).

Wilson, Goettmoeller, Bevan and McCord (2013) report that;

Working in the acute care hospital setting can lend itself to an environment that result in nurses being presented with difficult and challenging situations. These situations are such that if encountered on a daily basis could result in a painful, psychological disequilibrium (p. 1455).

ED nurses have a high exposure to ethical and moral dilemmas which, when combined with a horde of other factors can be stressful and damaging (McCledon & Buckner, 2007; Meltzer & Huckabay, 2004; Rice, Rady, Hamrick, Verheijde & Prendergast, 2008; Wilson et al., 2013). The lack of literature that relates directly to stress within specific nursing roles in the ED indicates that this is an under explored aspect of nursing and would warrant further investigation however this is not discussed further in this thesis. It is difficult to ascertain from the data the influence that a particular nursing role has on individual stress levels, however 97.7% of participants indicated that they experienced stress on regular basis.

5.5 NURSING STRESS IN THE EMERGENCY DEPARTMENT

The statistical data indicated that ED nurses have increased stress levels on a consistent basis. This stress occurred weekly with 81.9% of respondents indicating that they experienced increased stress levels on a weekly basis. Josland (2008) proposes that it is important to gain insight in how often this stress is occurring so that this can be recognised as a significant dynamic in emergency nursing. Determining why some nurses experience stress when going to work as against when they are at work is difficult to
establish without further enquiry. There was no literature found that examined this variable, although studies into part time work did suggest that difficulties in retaining skills and collegial relationships may impact on negative emotions (Jamieson et al., 2008). Comments included;

“Last year when staffing was reduced, despite our attempts to halt it...I worried every day going to work, that something bad was going to happen”

“Not stressed as such, but sometimes I think, as I'm going in the doors “is this going to be the day that I lose my registration?” (Due to events transpiring from impossible working conditions”

Alternatively the shift an individual is on or who they may be on with influences the level of stress encountered by some individuals.

“Not all the time - afternoon duties are usually the worst as they seem to be consistently the busiest shifts of late”

A study by Rogers, Hwang, Scott, Aiken, & Dinges (2004) suggested that there is a correlation between fatigue from working long shifts in high acuity departments and job stress. Much of this was due to extended shift patterns to combat nursing shortages but this had a detrimental effect on both staff morale and patient care. Gillespie and Melby (2003) also proposed that rostering and shift patterns were factors that influence the stress levels amongst nurses. Muecke (2005) reported evidence that changing shift patterns and night shifts had had an adverse effect on patient care and is a factor in nurses’ ability to provide quality care when they are sleep deprived and excessively fatigued. In contrast, there were several responses that reflected ED nursing in a positive light.

“I love going to work each day and seeing what new and exciting things will happen, I love the challenge of not know what’s going to happen”

“No. I have learnt to deal with my stress, I’m not anxious coming to work, if anything I’m excited to see what will happen in my day”

Healy and Tyrell’s (2011) study reported similar results with fifty one percent reporting frequent stress (p. 34). This is indicative that cumulative stress is present amongst ED nurses so determining what factors influence stress levels of ED nurses is an important element in managing this stress.
“I only work one day a week now due to kids plus masters study but feel stressed every single shift”

“About once a week”.

“Every shift”

“Stress related to inadequate resourcing and department capacity”.

“The biggest stress is the pressure from management to meet ED stay target times; this is compromising patient cares and putting my own practise at risk.

“High turnover of patients for an individual nurse is unsafe. Excess night shifts is unhealthy”.

The majority of comments cited workload as a contributor to increased stress levels.

5.6. STAFFING

There are multiple factors that influence nursing workloads including staffing issues. Lack of adequate staffing was a concern with 82.6% of participants indicating that this was a factor that impacted on their stress levels. The statistical data suggests staffing was a consistent theme with many comments about poor staffing levels being a significant factor in contributing to workplace stress. Aiken, Clarke, Sloane, Sochalski & Silber (2002), suggest that unsafe staffing has a direct relationship with patient mortality, while other studies demonstrate the link between job stress and decreased quality of care for patients (Kane, Shamliyan, Mueller, Duval & Wilt, 2007). Staffing is also linked to increased workload, patient and staff safety and inadequate resourcing of the ED (Adams & Bond, 2003; Hwang & Chang, 2007; Lyneham et al., 2008). This is concurrent with findings from Healy and Tyrell (2011) who reported that the workload and staffing were factors that influenced the stress levels of ED nurses. Comments that support this premise include;

“Great team, but let down when staffing is inadequate for the day. It feels dangerous”.

“Some staff excellent team players, others are not, and are lazy-so you do your own work and theirs too”.

“Insufficient staffing levels to cope with 'surge' events".
“Busy and constantly increasing workloads; sick patients and not enough time to look after them adequately”.

“short staffing; junior staffing; large presentation numbers within a short time frame; inability to move patient to appropriate areas; lack of space to safely and appropriately place patients”.

“Expectations from other disciplines/areas that all the work will be completed by the ED nurse prior to moving pts”.

“Busy workload, understaffed reduced care to patients”.

“Bed blocks, other departments closing when full meaning a backlog of their pts in ED, No help staff wise when in overload. DM being rude and abrupt.

“Staff shortages. Drs from other departments changing the agreed processes for warding their pts, making pts wait in ED longer. Other area DRs not wanting their pts to move from ED because they are too sick for the wards”.

“Trying to manage nursing 4 critically ill patients with only 2 nurses in resus. Lack of support from the Charge Nurse. We (the ED nurses have met many times with the service manager, DON and CEO and expressed our concerns regarding the high nurse to patient ratio to no avail”.

“Cumulative stress of working day in, day out with a department that is almost always working beyond capacity”.

“Understaffing, heavy patient work load, unsafe staffing levels, lack of breaks”.

“Workload poor rosters junior unsupported staff increasing tasks for nurses”.

“Work load, overseeing large numbers of patients to cover breaks, intoxicated and aggressive patients”.

“High patient flow and acuity, tiredness, patient anxiety/stress”.

“Management and bullying by these people, the lack of support from anyone, the roster (it’s unsafe for staff - such as multiple short changes etc.) and the high/heavy workload”.

“Seeing the impossible workload that staff are expected to deal with and being unable to assist them with this - constantly being stretched too thin to cope with demands, relentless and increasing workload leading to continuously 'prioritising' care - i.e. not providing a high standard of care”.

These comments are centred on workload which was clearly identified as a central theme during analysis of the content.
5.7 WORKLOAD

Nursing workload was one of the most commonly listed factors that influenced stress levels amongst ED nurses. Throughout the study ‘workload’ was mentioned in response to the majority of the questions. Winters and Neville (2012) suggest that care rationing occurs when the workload is excessive which results in sub-optimal patient care. Similar results were discovered by McCloskey & Diers (2005) while Schubert, Glass, Clarke, Aiken, Schaffert-Wityliet et al. (2008) conclude that adverse events such as medication errors are linked to increased workloads.

“Large patient workload”
“Volume of work”
“High workload”
“Busy workload, understaffed, reduced care to patients”
“Poor staffing, increased workload”

The underlying issues that contributed to workload were extremely similar. Comments on safe staffing levels and reduced patient care were commonplace.

“Understaffing, heavy patient workload, unsafe staffing levels, lack of breaks”
“Inadequate staff to cope with patient numbers or acuity”
“Not enough time to give the level of care you want too”
“Lack of staff”
“Decrease in fte in department. Overloaded with patients not enough nurses. A lot of roster gaps due to sickness and staff resigning”.

Increasing workload has a correlation with staffing levels that was identified as a significant factor that contributed to stress amongst ED nurses. The increase in violence and aggression by the public and patients in the ED is another factor that was noted as being a cause of stress.

5.8 VIOLENCE AND AGGRESSION

Violence is highlighted as being an issue with the comments from participants suggesting this factor is an ongoing influence on the stress levels of ED nurses in New Zealand. A total of 96.2% of respondents cited violence and aggression as a concern. This situational stressor is becoming a predictable cause of workplace stress and is seen by some ED
nurses as significant in the erosion of their confidence (Rolls, 2006). Violence and aggression were commented on frequently.

“Aggression / threats verbally”
“Aggression from patients”
“Angry patient communication”

Anderson et al. (2010) suggests that violence and aggression are becoming more commonplace in the ED. This is supported by Rolls (2006) and Healy and Tyrell (2011) whose research indicates that this is an ongoing source of stress for nurses in the ED. Managing violence in the ED is an organisational issue that requires considerable attention. This factor requires ongoing investigation but is not described further in this thesis other than as an organisational issue that contributes to the stress levels of ED nurses in New Zealand.

5.9 ALCOHOL

The concerns that surround violence and aggression experienced by emergency nurses is matched by the issues that surround alcohol related presentations to the ED. Survey participants provided extensive commentary on the impact of intoxicated patients on nursing workload. The statistical data revealed that 77% of participants saw alcohol as a factor that contributed to workload and to increased stress levels. The range of comments are indicative of the impact of alcohol related presentations on nursing practice in the ED.

“Every weekend more and more people come to the ED drunk and drugged, they are violent aggressive. Older people are having more falls which means they break bones and lose their independence, children are exposed to violence drugs and alcohol that causes them harm, pregnant women drinking causing harm to their unborn baby but don’t want your help car accidents trauma and death. Drunk patients are often difficult and time consuming and use a lot of our resources, it is becoming a real problem for all of us in hospitals but especially ED’s and nurses have to deal with most of the drunks”.

“Patients under the influence of alcohol and/or drugs almost without exception require more nursing input to maintain their safety. In addition one requires more time to assess and treat them as their intoxication can mask or mimic symptoms, time for patients to sober up”.
A study in Wellington Hospital reinforced the problems associated with alcohol related admissions to the ED. Gunasekara et al. (2011), suggests that nursing workload increases significantly, safety becomes an issues and other patients have reduced care as nurses are managing intoxicated patients. These findings are comparable to international studies where alcohol has become a significant burden to health care (McKenzie, Harrison & McClure, 2010). Connor et al. (2005) links alcohol to a raft of social problems that are common presentations to the ED, particularly family violence and assaults on partners and children. This connection to domestic violence is supported by Devries et al. (2013), while Room and Rossow (2001) have also made the association between violence, injury and alcohol. Connor, Kypri, Bell and Cousins (2011) conducted a cross-sectional study in New Zealand to determine the incidence and gravity of partner violence and alcohol related consumption with findings indicating that the association between alcohol and intimate partner violence is compelling with increased consumption associated with an increased severity of the assault (p. 7).

Citing a New Zealand Herald article dated 3 June 2006, Schafer (2011) remarked that “hospital emergency departments estimate that 10 to 30% of their work is alcohol related” (p. 135). A search of other New Zealand media publications are even more indicating of the contributions that alcohol is making to ED workloads. O’Sullivan (2014) cites comments from ED staff;

What frustrates our staff is people who abuse alcohol and harm each other......we see far too many people for injuries in which alcohol is a contributing factor.....an Otago University study found almost a third of those seeking emergency hospital treatment on Saturday nights in Christchurch Hospital were drunk. The study found almost 7 per cent of alcohol-affected patients were abusive when dealing with staff. Drunk patients took longer to process because they cannot relay their symptoms reliably, so extra precautions and resources are put in place.....another study, which took a snapshot of 14 emergency departments found one in five patients was admitted due to harmful alcohol use”.

Articles from other media sources also highlight the effect that alcohol related presentations are having on workload in the ED. An article in the Bay of Plenty Times (2013) comments;

From 11pm on December 31, 2012, to 8am January 1, 2013, 95 per cent of patients arrived with acute alcohol-related problems.....patient flow was predictable, with early
presentations being binge-drinking young adults with injuries caused by alcohol-related clumsiness or assault......during this period ED staff have to forfeit their usual leave allowance and double up staffing numbers to provide care (December 18, 2013).

Hawkes Bay Today (2009) reported;

A quarter of the people who are presenting with injuries at the region's emergency department need treatment because of alcohol-related injuries, usually after a fight, a fall, or self-harming.....between May and December last year, department nurses assessed patients for the likelihood that alcohol had contributed to their injury and found drinking was likely to be the cause of 18.2 per cent of injury presentations in May and 24.6 per cent in December...between midnight and 6am, those numbers increased to about two thirds of injury admissions, 67 per cent in May and 64 per cent in December.....the figures also showed the role of violence in alcohol-related injuries. Forty-six per cent of alcohol-related injuries were caused by assaults at this time last year.....falls accounted for 20 per cent and self-harm for 14 per cent (May 14, 2009).

Alcohol misuse is a far wider issue for society than just the ED but there is a real sense of fatigue amongst emergency nurses at the constant weekend barrage of intoxicated and unruly patients that impact on the care of others (Connor et al., 2005; Gunasekara et al., 2011; Mackenzie et al., 2010; Schafer, 2011). These patients present huge challenges in terms of time and constantly marginalise the safety of staff. Many comments expose the depth of feeling about these patients.

“Majority of presentations especially night shifts and weekends. Take extra time and staff to look after them, and ensure their safety, often to detriment of other more deserving patients”.

“Pts who are intoxicated or impaired due to drug related presentations take up a vast amount of scarce resources. It is hard to suppress frustration at these patients whom consume such huge resources and have such a huge impact on the department”.

“Patients under the influence of alcohol and/or drugs almost without exception require more nursing input to maintain their safety. In addition one requires more time to assess and treat them as their intoxication can mask or mimic symptoms, time for patients to sober up”.

“Adds to violence and security needs in the ED. Feels like there is nobody prosecuted for this despite lots of signs up saying that this will not be tolerated”.

“Alcohol related injuries and intoxicated pts are time consuming, often argumentative or verbally/physically abusive. Their injuries also mask head injuries so are often scanned which is more often than not and unnecessary
expense to the unit. All in all, such patients increase stress in the unit due to increase use of units’ resources”.

A burning issue amongst emergency nurses is the constant exposure to aggression, violence and verbal abuse by intoxicated patients and their friends and family. This destructive behaviour is concerning as despite the efforts of many agencies to combat the insidious effect of alcohol. There were length comments that contain a lot of separate issues for ED nurses. These comments require in-depth analysis to ‘unpack’ the detail that is contained in the statements. Participant comments that allude to this includes;

“Patients are coming to ED intoxicated and they seem to feel that is ok to treat us like this! There is a big deal made about we won’t accept violence or verbal abuse but actually nobody will stand up for you. I have had cases where a drunk pt has threatened me verbally and physically and i have reported it to my boss and have been told "oh well, he is drunk and he has said sorry so you will just have to let it go!!" If you walked into a shop drunk and threatened to punch the check-out lady you would be arrested, but in ED we are just expected to "let it go". Also the police are very unsupportive of us when we have had to ring them”.

“Patients under the influence of alcohol and/or drugs almost without exception require more nursing input to maintain their safety. In addition one requires more time to assess and treat them as their intoxication can mask or mimic symptoms, time for patients to sober up”.

“I get frustrated when I get caught up looking after an intoxicated or drugged patient when I have other patients who require my time and care also, yet their position often not self-inflicted”.

“To sum up-alcohol and drug related presentations have a real risk of impacting the effective care health professionals are giving in our ED’s – so much of our time and resources are wasted. People presenting with etoh-related problems are often mostly well but time hungry in that they need constant observation, cajoling back to their beds, dealing with equally drunk friend / relatives who think it’s all a big joke. These people often distress other patients with their lude / aggressive behaviour. There has been a lot of societal change since I have worked in the ED. People are drinking more but also younger and hard liquor and are less responsible for their actions while under the influence”.

“Huge impact since these patients needs close monitoring particularly if trauma related + ETOH + drug induced, this exhaust most of ED resources & time. Stressful since these patients mostly were verbally & sometimes physically abusive”.

“They tie up staff, some so drunk need frequent/close monitoring to ensure adequate airway....some need intubation....they vomit, meander/stagger around department-will not listen to requests to stay in their own cubicle-so you are policing them as well, usually accompanied by similarly inebriated friends with
similar disruptive behaviour. Drug related presentations the same—but with an unknown measure of unpredictability in their behaviour....When you are busy with all your other patients—these 2 groups are a black hole of time wasted....limitless. Watching and treating them directly impacts on the quality of care other patients get. Also—abusive swearing patients make it unpleasant for unwell patients, the elderly, and children”.

“Majority of presentations especially night shifts and weekends. Take extra time and staff to look after them, and ensure their safety, often to detriment of other more deserving patients”.

“Pts who are intoxicated or impaired due to drug related presentations take up a vast amount of scarce resources. It is hard to suppress frustration at these patients whom consume such huge resources and have such a huge impact on the department”.

“Adds to violence and security needs in the ED. Feels like there is nobody prosecuted for this despite lots of signs up saying that this will not be tolerated”.

“Huge impact since these patients needs close monitoring particularly if trauma related + ETOH + drug induced, this exhaust most of ED resources & time. Stressful since these patients mostly were verbally & sometimes physically abusive”.

“Stretches capacity. Time consuming when other patients require more immediate care. Unsafe”.

There was so much commentary from participants on the impact that alcohol related presentations has on workload and workplace stress which is beyond the realms of this thesis. The information from this data needs to be separated further and analysis of these comments suggests that this may be examined more fully in subsidiary articles to this dissertation. The imposition that alcohol has on nursing workload is significant. There is also a risk of harm from abusive and intoxicated patients and their families which causes angst amongst nursing staff. One comment stood out which epitomises this issue and challenges the continued acceptance of alcohol misuses as the status quo.

“It annoys me immensely that there appears to be an historical acceptance that the intoxicated patient and “their mates” are a normal fixture of an ED. If/when we as a nursing profession accept this it will never improve”.

5.10 ORGANISATIONAL FACTORS
The factors that influence the stress levels of nurses in the ED are multifactorial. Lack of support from senior management and poor management and supervision were cited as contributing to stress in the ED. It appears that this is an important issue to address. Dubois and Singh (2009) suggest that ineffective responses by management to inadequate staffing and poor skill mix are endemic in nursing. Dracup & Bryan-Brown (2005) and Schriver, Talmadge, Chuong & Hedges (2003) also make reference to leadership being a crucial element in reducing stress amongst emergency nurses. One participant commented;

“"ED I believe has a culture of get on with it or get out". This is ongoing stress - constantly faced which wears you down. The 'stressful' events are much easier to deal with than this pervasive chipping away at your reserves”.

Other comments that allude to lack of management support include;

“Upper management think restricting finances are okay and staff can do a perfect job without the proper structure behind them!! The bean counters have no idea what is happening because of their money cuts. We are expected to pick up the slack & work late with no extra pay & they think it is because we are not doing our job properly!”

“Ongoing. Never resolved. Also management don't often consult us on the shop floor. They don't appreciate or value our cumulative wealth of knowledge and experience”.

“Lack of understanding of workplace realities in management. They have either been out of it for so long they don’t get it or the snapshot they witness is not real or adequate”.

“We are not allowed to drink while on the "flight deck" at work. This leads to being in a constant state of dehydration”.

“I feel management here makes staffing decisions that should be the Clinical nurse managers' decisions to make”.

The nursing management roles in the ED are of fundamental importance (Raup, 2005). This study did not seek to examine the roles of managers or nursing leaders in the ED. The volume of comments that refer to issues surrounding management suggests that there is disquiet amongst emergency nurses as to the part that nurse managers play in the
organisational culture. It is not suggested that CNM’s are necessarily protagonists of negative organisational structures. Nevertheless, they are in a unique position to influence professional nursing standards and legitimise a positive environment by containing and managing issues such as bullying and violence that seems to be so profound in this environment (Raup, 2005). While detailed comments specifically about management were often limited to single word statements simply saying ‘managers’ other comments alluded to managers demonstrating a lack of understanding or consultation as the main issue.

“Lack of understanding of workplace realities in management. They have either been out of it for so long they don’t get it or the snapshot they witness is not real or adequate”.

“No management consultation with floor staff”.

“Poor management”.

“When you work as a clinician, and often managers are not out on the ‘floor’, there is definitely a perceived lack of support sometimes”.

There were some encouraging comments about management with comments such as;

“Boss tries to ensure adequate staffing levels”.

“My immediate manager does her best, but management appears to be blind and deaf to the situation, offering no support”.

There are many comments that made reference to the fiscal constraints and budgetary measures that are having a profound influence in the ED, with particular reference to resources such as staffing and equipment.

“I feel that the drive for budgetary constraints overshadow patient needs”.

“Large organisation decision making, the never ending money vs care argument”.

“Upper management think restricting finances are okay and staff can do a perfect Job without the proper structure behind them!! The bean counters have no idea what is happening because of their money cuts. We are expected to pick up the slack & work late with no extra pay & they think it is because we are not doing our job properly!!”

“last year when staffing was reduced, despite our attempts to halt it...I worried every day going to work, that something bad was going to happen”.

“Usually under-resourced on shift, or have to Rob Peter to pay Paul”.

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Throughout the survey comments on staffing and skill provide compelling commentary on how inadequate staffing affects workload, patient and staff safety and patient outcomes.

“General stressors such as high volumes of patients during traditionally 'quiet' months which means high workloads with fewer staff and greater expectations on what can be done in ED (e.g. Ketamine sedations late into the night) and emphasis from management on meeting 6 hour rule”.

“Staffing issues- i.e. Lack of staffing”.

“Too many patients. Not enough nurses. Not enough beds”.

“Huge workloads, no back up, lack of support”.

“Poor staffing, increased workload”.

“Staff shortages with increased workload and demands from management”.

“Understaffing, heavy patient work load, unsafe staffing levels, lack of breaks”.

The link between cost reduction strategies in hospitals and the impact that this has on patient care and nursing morale is under investigated (Sovie & Jawad, 2001). This was reiterated by Cho, Ketefian, Barkauskas & Smith (2003) who made the association between decreased staffing levels and the impact on nursing care, suggesting that this a false economy as this often results in increased length of hospital stay, poor patient outcomes and increased costs. Similar findings were made by Sasichay-Akkadechanunt, Scalzi & Jawad (2003) who examined the relationship between nursing staff levels and patient mortality suggesting that the findings should be considered by organisations when undertaking restructuring of the nursing workforce as there is evidence of detrimental clinical outcomes when the nurse numbers are reduced.

Resourcing and budgetary constraints exert a stressful influence with participants suggesting this was an issue. Fiscal restrictions are a reality for all areas of healthcare however, balancing the health dollar comes at a cost to the ED who is facing an increase demand on their service with less staff and resources (Armstrong, 2009; Mays, 2013). This was identified as having an influence on the stress levels of nurses in the ED with comments such as;
“We have resorted to having cake stalls and raffles to raise funds for basic medical equipment!”

“Lack of work time to do available courses. Lack of provided time to check email communications vital to work. Amount of work taken home to complete or staying unpaid to complete documentation such as incident reports because there is no time to complete in work hours”.

The concerns around the organisational structure have a close association with leadership within the ED. Attree (2007) proposes that ineffectual relationships between CNM’s and the hospital hierarchy can contribute to workplace stress as nurses are often excluded from decisions about issues such as staffing levels. The comments from the research participants suggests that organisational factors impact on the stress levels of ED nurses. Another element of stress is conflict which is analysed in the next section.

5.11 CONFLICT

Conflict is another aspect of emergency nursing that is a factor that influences the stress levels of nurses in the ED. The most common cause is with members of the public over extended waiting times and their perception of what takes priority. Unfortunately when this occurs emergency nurses often bear the brunt of these reactive episodes (Finlayson, 2011; Gillespie, Gates & Berry, 2013; Kato, 2014; Nelson, 2014). Interpersonal conflict at work can be damaging and this is evident in the respondents’ free text responses. The responses identify that this collegial conflict causes barriers in communication and contributes to tension in the environment. Issues such as access blocking of in-patient beds, availability of diagnostic testing are contributors to occupationally related stress in the ED. These are all aspects of a dysfunctional culture where issues that contribute to stress and tensions within an organisation fail to be addressed (Nugus et al., 2014).

Following on from this, respondents were asked if conflict at work was a common cause of occupational stress with 76.7% noting collegial conflict as an issue. Conflict with patients was also a factor with 74.4% having a stressful experience with a client. Comments suggest that the conflict is more to with systemic issues that impact on the stress levels of staff, which in turn leads to conflict, rather than actual personality or professional issues between staff.

“Short staffing on wards mean they are stressed and complaining about taking patients”
Other comments also support this observation;

“yet I let it go by as when we work with 120 staff we can’t expect everyone to like one other, I say we come to work to work not to make friends and thus we have to find a way to have effective work relations”.

Interdepartmental conflict creates additional tensions that are experienced by emergency nurses, particularly in relation to health targets such as SSED, where other specialties become barriers to patient flow as they do not see the SSED as a priority for them (Ardagh, 2010; Bonning, 2013; Jones & Olsen, 2011; Nugus et al., 2014).

Interdepartmental issues were highlighted as an issue as these comments suggest;

“Lack of awareness of ward staff re transferring patients out of ED in a timely manner, the need to work within the 6 hour target”.

“We have a deadline to handover patients. Often the wards want a great deal of unnecessary information for their handover and often want to delay transfer of the patient to them. Meanwhile, the CCN is pressuring you to get the patient out and accept the new one”.

“Have experienced all the above but the conflict is always related to being stressed and overloaded and under staffed i.e. ask physio to come review a pt. but they are busy and snap because it’s going to put them behind on their other work. Doctors needing bloods on a pt. too busy to do it themselves so falls on nurses to sort it out when really its doctors role”.

The most commented on cause of conflict was interpersonal, with many participants making reference to bullying behaviours causing anxiety and pressure amongst emergency nurses and doctors. In a similar context there were several comments that indicate that while conflict is present it remains manageable.

“The roster nurse who is a known bully. She is also a charge nurse. It does not matter how often I go to the manager to sort this cleanly nothing really happens. Common problem getting a six week roster two weeks before it is due to start!!!”.

“Senior staff one especially a bully”.

“Some staff uncooperative and lazy. Issues in the dept not addressed by NUM”.

“Personality clashes”.

“1-2 difficult, overconfident, inexperienced staff members”.

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“Some staff nurses aren’t interested or being encouraged to work as a team and make working with them very difficult and unsafe”.

“All of these i have ticked has contributed, my conflict with a doctor resulted in myself writing a formal complaint”.

“Don’t have too much trouble thank goodness. Most of the time we get only pretty well and work collaboratively. As long as we stay focused on the patient & the best outcomes for that patient, it doesn’t get personal”.

“All of these are common and predictable but not insurmountable”.

“We have a great ED team of doctors and nurses, most conflict is with patients and families, ward staff not wanting to take patients even when you state that we are being hammered. Also some conflict with specialty doctors who don’t come down to see their patients or take hours to come back to complete paperwork”.

Interpersonal conflict can cause considerable angst in the workplace. It is difficult to determine if conflict with management decisions may be construed as bullying or if it is simply a manager implementing organisational and governmental demands. This facet of conflict is beyond the scope of this thesis and warrants further investigation as this can contribute to the breakdown of interdepartmental relationships. The challenging environment of the ED can foster conflict due to the nature of the work, however this is an extremely important aspect of stress for emergency nurses and does require attention to alleviate the issues that underpin conflict.

5.12 BULLYING

Bullying was noted as a cause of stress for 58.8% of research participants. The prevalence of bullying is a significant concern with the effects infiltrating all spheres of the healthcare workforce (Lutgen-Sandvik, Tracy & Alberts, 2007). The negative consequences of bullying can result in staff turnover, increased sick leave and occupational stress (Hogh, Mikkelsen & Hansen, 2011). Salin and Hoel (2011) suggest that the working environment can foster bullying through inattention to the dynamics that surround this behaviour, particularly if the organisational support does little to curtail this conduct. Identifying the existence of a bullying culture is imperative so that tactics can be employed to deal with this destructive influence in the nursing workforce (Woelfle & McCaffrey, 2007). The comments from the research participants highlight a range of issues that suggests that the degree of intimidation and bullying in New Zealand ED’s exists in many differing forms, for example;
“From a junior Registrar doctor and by some older senior nursing staff”.

“Bullying is big in the nursing profession, and sadly still happening now after 17 years of nursing, I don’t experience it now because I’m a senior nurse, but when I was a new graduate it was awful”.

Bullying has emerged as a theme that is a contributing factor in occupational stress amongst nurses in New Zealand (Huntington et al., 2008). The significance of this is corroborated by research that infers that a culture of bullying is not only symptomatic of flaws in organisational culture but also poorly dealt with despite policies and conduct codes (Etienne, 2014; Gaffney, DeMarco, Hofmeyer, Vessey & Budin, 2012). According to Simons and Mawn (2004) an environment where problems and issues prevail fosters activities that are detrimental to the health and wellbeing of staff and compounds stress. While this is largely an organisational issue, nurses themselves contribute to their own stress by participating and condoning these behaviours (Atabay et al., 2010, Gaffney et al., 2012). Reporting of bullying behaviours often seen as difficult and may lead to reprisals or conflict with other nurses which can contribute to emotional stress and ill health (Jackson et al., 2010). The impact of widespread bullying is substantial and the consequences both harmful and destructive and the degree of bullying behaviours that is alluded to by the research participants is disturbing. This is discussed further in the next chapter.

Comments from the research participants are levelled at colleagues, peers and managers which is suggestive of a detrimental organisational climate in New Zealand ED’s.

“The management in my ED as well at the educators are bullies. They deliberately attack and insult people they don’t like. They intimidate people and generally make the lives of some people very difficult/unpleasant. Some people are even stopped from attending study days so they cannot further themselves in their education and careers”.

“Several staff in my ED are Bullies. Out of 40+ staff, you just learn to remove yourself from the situations where they can bully”.

“The culture of the DHB I work for is one of bullying until upper level management their practise this will continue to flow down to the shop floor”.

“There are at least two low level bullies in the nursing team, who will make your life a misery - snide comments, undermining your decisions, assigning difficult workloads and setting you up to failure. As is common this is not addressed by
management as these bullies are in senior roles. The insidious nature of bullying makes it very difficult to provide factual evidence of these behaviours”.

“Current CNM exhibits bullying behaviour towards other if he/she does not like the decision/ feels threatened/ or if others do not agree with him. Rn staff often take “shots” at senior nursing team some persistent and purposeful”.

“Negative and disruptive behaviour directed towards me by a colleague. Staff member who I was direct line report, talking behind my back to other staff members about me, making up stories to badly reflect on me”.

“By a Senior Nurse who has her own problems and takes it out on her ‘juniors.’ Being an EN who retrained, she has brought all her hang-ups from those days with her”.

“Senior staff one in particular even pushed me”.

There is evidence from participant’s comments that indicate that rostering is a common form of bullying. A rostering guideline developed by Nursing and Midwifery Office, Queensland (2012) states “equity and fairness in the treatment of employees are important goals in the development of a roster (p. 14). Daly, Speedy and Jackson (2004) suggest that inequitable rostering is often perceived as a bullying behaviour (p. 61). The suggestion that the roster is used as a mechanism that causes stress for some emergency nurses is concerning. Comments include;

“The roster nurse place nasty games with the rostering. It is truly ghastly”.

“A previous CNM manipulating staff through withholding leave, not allowing requested days off, 'tellings-off' in front of other staff”.

“Colleague with a difficult personality who targeted nurses she did not like. Poor rostering for nurses who was not in favour with the nurse in charge of rostering”.

“Issues not handled by management. Other forms of less overt bullying e.g. favouritism with rostering”.

Budin, Brewer, Chao and Kovner’s (2013) study of young nurses, found that verbal abuse from colleagues was prevalent in negative working environments which were also linked to poor organisational structures. A survey conducted by Rowe and Sherlock (2005) discusses the consequences of verbal abuse by nursing colleagues as having a significant influence on the stress levels of ED nurses. ENA (2011a) suggests that the incidence of verbal abuse amongst colleagues is under reported as victims are often intimidated by
the behaviour of the perpetrators of bullying. Verbal reprimands and disparaging language appears prevalent with comments including;

“Been shouted at in front of others”.

“Made to feel stupid at times”.

“Moving a patient to an area considered safer when deteriorating. Verbally publically reprimanded for doing so by the nurse in charge of that shift. The other patients asked me if I was OK”.

The government health targets are also perceived as having an influence on the stress levels of nurses. This is an organisational issue as the determinants that contribute to problems in achieving the SSED target impact on all staff in the ED including managers who become pressured to meet these targets. This may be misconstrued as bullying when it is an enforced performance measure by the DHB, however this is difficult to determine in this context.

“From managers when health targets aren't met”.

“Bullying from senior staff to conform and lower standard of care to meet targets e.g. 6 hour target, moving/dx people who aren't ready or stable”.

“Pressure to compromise my standards of care and personal beliefs and the dignity of my patients just to get patients to the ward”.

Regardless of the source, bullying appears to be problematic in the ED. It appears that the origins of bullying behaviours in the ED are seated in an organisational climate that perpetuates the cycle though inadequately applied processes and a reluctance of nursing leaders to confront and challenge the attitudes and conduct of bullies.

5.13 HEALTH TARGETS

The government health targets were identified as a factor that has an influence on the stress levels of ED nurses. A total of 89.3% of participants indicated that the SSED target was a cause of stress for them. The literature supports the comments by acknowledging
that although the targets have been inititated to improve patient outcomes, there is less evidence to suggest that they have not added to the workload for emergency nurses.

“They all are important but just add to our workload and it never appears as though this extra work is acknowledged in staffing levels”.

“While I agree that these are all good initiatives, the added administration paperwork that these targets incur further reduce the ‘patient care’ time”.

“The targets themselves don’t create stress. They just contribute to time pressure when too busy for basics”.

There were several good comments that demonstrate support of the targets.

“No I think these are good targets and don’t create stress”.

“I think that these targets have helped us focus on the complete loop of care and prevention - I think this is a good approach”.

5.13.1 SHORTER STAYS IN ED

The target that impacts the most on emergency nurses is the SSED target. Initiated by the government in an attempt to address issues such as overcrowding and poor patient outcomes in ED, the agreed time of six hours was aimed at reducing waiting times and improving the quality of acute care. Endorsed by the ACEM and CENNZ the target is now under some scrutiny as there is a continual to mee the agreed 95% target rate (Bonning, 2013). The survey results indicate the SSED target commonly known as ED6 has the most significant influence the stress levels of ED nurses in New Zealand. Ardagh, Tonkin & Possenniskie (2011) suggest that the issues confronting the SSED target is an organisational problem, while Jones and Olsen (2011) propose that the 6 hour target is having a negative effect on patients and staff. Although opinions varied most participants agree with the principles behind the target however it is acknowledged that this is becoming an issue for nurses in the ED as the pressure to achieve the target continues to cause significant stress (Nugus et al., 2014).

“They shouldn't be there to put stress on folk as are only a target and there are times when that target is unable to be met”.

“6 hour target dies cause stress but it is also positive in fact the specialties see pts quicker and they are out of the department faster. Also ED doctors’ maker faster decisions and get people discharged quicker so faster movement in the department”.
“The 6 hour target is the single biggest improvement in reducing stress in my workplace, but it does not always lead to better patient care”.

“I whole heartedly agree with this target, HOWEVER, it often feels as though the department's commitment to this target overrides patient safety and we are pushed to get patients out of the department so that they don't breach - even at times when the patient may have been incontinent and you explain that they need a wash and change of linen first”.

“There is always pressure to get patients out of ED inside 6 hours - just not enough time to care sometimes so don't feel that I am doing the job well”.

“Busy workloads, the 6 hour target, the hospital is full etc.”.

“6 hour target - has been so good for both staff & patients. No more languishing in ED waiting for ward beds. Meeting the target is challenging at times, but is a whole hospital problem / solution, not just seen as an ED problem”.

“The 6 hour target is a good thing but should not supersede the needs of the patient”.

“The 6 hour targets can sometimes reduce the thoroughness of care for pts, in the pressure of getting them to wards”.

The SSED target is designed to improve patient flow from the ED in a timely manner. ED nurses indicate that they feel pressured to meet the target which is causing increasing stress. This issue is discussed further in chapter six. Other targets which include smoking cessation and family violence are outlined in the next sections.

5.13.2 SMOKING CESSATION

There is a fundamental agreement by all emergency nurses that smoking cessation advice is important to the long term health of patients. Comments were generally favourable although there appears to be some negativity against “asking the question” versus priority of care.

“Smoking screen questions in triage area for tiny things like small lacerations or stubbed toes which are mainly done across the desk due to sheer volume of patients. Adds time to assessment in this area (I wonder if they should cut some slack in auditing waiting room patients.)”.

“I am the link nurse for the smoking cessation. It has been a hard road trying to get
the nurses (and others) to ask the question and offer the quit pack. Most of the patients in our Obs area are trying to end their lives with ODs so seems a bit crazy to ask them if they want to stop smoking! Just another thing to be absorbed by nurses”.

Smoking cessation targets were included in the survey to determine if this was a factor that influenced the stress levels of ED nurses. Although this links to the themes of workload and health targets this is not discussed further in this thesis.

5.13.3 FAMILY VIOLENCE AND CHILD ABUSE

An emotional aspect of emergency nursing is dealing with family violence and child abuse. Comments include;

“Family violence & child abuse reporting is so important, but sometimes just being the one that has heard the disclosure can cause stress depending on the content”.

“I 100% agree with the family violence and child abuse reporting but it is incredibly time consuming and if disclosed you need time to discuss these issue and there isn’t the time or the correct environment for this and this is hugely stressful”.

“Family violence - we know it is so important but finding the right time & place to have a conversation about family violence is not always possible in ED”.

“These are important but to these things properly requires a lot of additional nursing time and in an ED time constraints on clinical staff are a huge issue. Particularly these often occur outside normal working hours so there are no support services e.g. social workers available to assist”

“Non-accidental injuries of children are hard to justify”.

“They all do we need another staff member just to go and ask these questions due to response time if a pt. discloses about family violence we really don’t have the time to listen”.

Family violence and child abuse are factors that have an emotional influence on the stress levels of ED nurses. This is an important facet to understand as exposure to family violence and child abuse is an element that nurses working in the ED often have to deal with. There is an opportunity for further research into this important topic which is beyond the realms of this study. The inclusion of family violence as a health target is linked to other government initiatives but no further enquiry is undertaken in this thesis.
It would appear from the responses from the research participants that the targets themselves are not an issue. However, the remarks are suggestive that there are contributing factors such as inadequate staffing and workload that impact on emergency nurses ability to achieve the targets. This has wider implications for the DHB’s which the subject of a nationwide quality improvement campaign is now (National Emergency Departments Advisory Group, 2014).

5.14 PERSONAL FACTORS

The stress experience by emergency nurses affects all aspects of their lives. The balance between home, work and personal relationships is challenging. The participant’s comments reflect how this impacts on their personal lives.

“Having a bad roster can impact on home life”.

“Non-shift workers don’t understand the demands of shift work i.e. just because I’m working tonight doesn’t mean I can hang out all day because at some point I need some sleep”.

“22 years of shift work, juggling to get birthdays and Xmas off is a struggle. I love my job but have dropped to part time in order to have a better work life balance”.

“Feeling tired and worn out following work”.

Time with family and friends, an inability to maintain social relationships and attend functions are common themes. It was also noticeable that some respondents had an inability to separate work from home, while inadequate time with family and friends and the impact of work on spousal relationships indicate that this is a factor that can cause increased pressure and stress. In contrast there were several comments that indicate that nurses have managed to establish a suitable work life balance that enable them to function well.

“I have a healthy work / life balance which has enabled me to work as a nurse for 42 years and in ED for 24 years”.

Time off for nurses is a crucial element in mitigating the effects of stress. Fritz and Sonnentag (2005) propose that rest and recreation is an important facet of nurses being able to recover from the constant pressures of caring for others. This premise is supported by Ragsdale, Beehr, Grebner & Han (2011) who discusses the positive effect that having weekends off has on recovery. As the majority of nurses work rostered shifts,
their days off are can vary and there is little research that compares the difference between time of at the weekend or during the week (Drach-Zahavy & Marzuq, 2012). It is difficult to determine if time off or the pursuit of other activities promotes recovery in nurses. If time off is stressful then recovery is less likely and the cycle of stress will continue. Drach-Zahavy and Marzuq (2012) make reference to a decrease in emotional exhaustion as fundamental to recovery (p. 579). However, Ramsey, Denny, Szirintynak, Thomas, Corneliuson and Paxton(2006) and Maslach, Schaufeli and Leiter (2001) suggest that ongoing emotional exhaustion can result in physical symptoms of stress but can also impact on performance with nurses less caring and disgruntled.

Drach-Zahavy & Marzuq’s (2012) research is important as their findings demonstrated that time off at weekends resulted in better family relationships stating;

Research has shown that having to work at non-standard times (i.e. weekends) was associated with lower levels of family satisfaction, less participation in family activities, increased marital instability, greater work family conflict, and enhanced fatigue and physical health problems.... nurses often choose to work weekends thinking that they can better use weekdays off to catch up on various commitments, but are unaware of the detrimental effects of their decision on their potential recovery from work stress (p. 585).

Although this has an implication for nurse managers who need to balance the demands of the roster against the health and wellbeing of nurses, Drach-Zahavy and Marzuq (2012) suggest that nurses themselves need to recognize the consequences that time off has on their ability to deal with stress;

“All of the above, wonder why we do this job sometimes”.

“Often feel that I have not delivered excellent care because of heavy workload. Frequently lie awake at night a stress over my inadequacies”.

“Time constraints are the main issue, can’t deliver the care I want. Some stress around coming back to the resus room or monitoring area only to find there is new equipment which i have not been orientated to”.

“Concerns about the level or care and attention that you are able to offer to relatives/significant others for sick pts”.

“It is very difficult to provide grieving families... miscarriages, deaths, poor prognoses appropriate emotional support when you are running just to keep up. This often leads to feelings that you haven’t nursed this patient & family in the way you would expect of yourself”.
5.14.1 COPING STRATEGIES

Healy and Tyrell (2011) and Lim et al. (2010) suggest that ED nursing is a profession that is synonymous with stress and it is important for nurses to learn to develop strategies so that they can take care of themselves. There are many ways to cope and how a person copes varies from person to person. Lazarus & Folkman (1987) suggests that coping employs two different strategies with coping mechanisms driven by a problem focused approach that manages issues in a direct manner and emotionally focused reactions which generates an emotive response to a situation (p. 179). Healy and McKay (2000) investigated the connections between stress and coping in a study of Australian nurses from a variety of settings. This study suggests there is that job stress and mood disturbances co-exist with findings giving credence to Lazarus and Folkman’s theory that factors that influence coping are determined by different situations (p. 688).

The correlation between workplace stress and coping as well as the impact that this has on the psychological and physical health of nurses has been the subject of academic attention in recent years. A study by Chang et al. (2007) examined the association of stress and coping in nurses from New Zealand and Australia, determining that this has negative effect on health and wellbeing if there is frequent exposure to stress in the workplace. Significantly this study revealed that the effects of workplace stress primarily impacted on the psychological health of nurses with emotionally charged responses more likely to engender a negative outcome than those who cope with stress by using a problem solving approach. Similar results were found in other studies where nurses were more likely to be symptomatic of psychological ill health as a result of workplace stress than physically unwell (Lambert et al., 2004b; Lambert, Lambert & Ito, 2004; Lambert, Lambert, Petrini, Li & Zhang).

Social support is an important factor in being able to cope with workplace stress. Inadequate support networks either in the workplace or via family and friends can have a mitigating effect on stress and burnout amongst emergency nurses (Diong et al., 2005). While a comprehensive support network will ameliorate the effects of stress and reduce the likelihood of burnout (Ersoy-Kart, 2009). Lambert and Lambert (2008) advocates the use of family and friends as support for nurses with emotional stress related to the working environment and situations that are emotionally stressful such as the death of a
patient. Cheng, Kawachi, Coakley, Schartz, & Colditz (2000) also places an emphasis on the need for social support as coping strategy for nurses from across the Asian pacific region including New Zealand. Social support is an important factor in being able to cope with workplace stress. Inadequate support networks either in the workplace or via family and friends can have a mitigating effect on stress and burnout amongst emergency nurses (Diong et al., 2005). Lack of familial or social support is a factor that can further influence the stress levels of ED nurses. Participant responses with comments including;

“Use my team members for support (we have a great team with plenty of social events)”. 

“Discuss with friends and family”. 

“Only with the support of my colleagues/friends. We debrief and support each other”. 

“Talking with workmate laughter debriefing with workmates is a great de stressor”. 

“Talk/share with colleagues, informally debrief”. 

“Talk about it with colleagues and family”. 

“Debrief/vent with trusted colleagues”. 

There were several comments that allude to ‘leaving it behind’ at the end of the shift or not taking their work home with them. 

“Try and put it all behind me as I leave at the end of a shift. Start each new shift feeling positive and optimistic. Nurses are a committed, hard working group of people, it is the nursing colleagues at my work that give each other support and keep us coming back for more”. 

“I make sure that any issues that I come across are dealt with immediately and appropriately prior to mu going home. There is always someone who will listen even if our department is heaving there is someone somewhere”. 

“Make sure I keep work/social life separate”. 

“Try to walk away after each shift and "let it all go". Take plenty of deep breaths. Know that I have done my best in all situations & the problems are not of my making”. 

“When I walk out the door I turn work off and go home to my family, friends and the occasional beer”.
Plante, Coscarelli and Ford (2001) make the link between physical exercise as a way to reduce stress, adding that as there is often a social element associated with exercise this can have the additional benefit of support in a manner that creates a positive atmosphere and induces calm. Murray (2005) in a stress guide produced by the Royal College of Nursing states “exercise is another key to managing the stress response….exercise will burn up the excess adrenaline and release endorphins – the feel good hormones” (p. 6). It is apparent from comments by the research participants that exercise is a common coping strategy.

“Ensure adequate sleep, eat well and stay active, regular walking and tramping trips, holidays. Debrief as required with colleagues”.

“Exercise regularly. Talk to friends and colleagues that understand the environment, try not to think about work at home, be aware when you are stressed and reflect on it. Have other hobbies and activities outside of work, oh and of course have a wine, bath........ Anything to relax”.

“Take the dogs for a long walk, play with my children that puts things in perspective. Keep fit and eat healthily”.

“Go surfing or relax with family”.

Healy and McKay (2000) describe humour as a positive mechanism for coping with stress. This was ascertained by Moran and Massam (1997) in their investigation into the use of humour as a coping mechanism for emergency workers while Bennett (2003) identified the use of humour as a means to manage stress and burnout and suggesting that ED physicians and their colleagues display good coping skills when they have the ability to laugh. This is evident in comments about coping such as;

“Running, eating, laughing”.

“Resorting to laughter”.

“Talking with workmate laughter”.

The use of reflection has always been of value in gaining perspective on nursing practices; however it is also a useful strategy for dealing with stress. Brunero, Cowan, Grochulski & Garvey (2006) write “by identifying and then modifying those thoughts which produce negative feelings, you are then able to reach your goals and make changes in the way that you perceive and feel about life situations” (p. 17). While Asselin and Cullen (2011) promote the use of reflection to analyse experiences and gain insight that can have a
positive impact on practice and dealing with stress. The use of reflection was indicated in comments such as;

“Reflection, time out, asking for help and not feeling inadequate if you do”.

“Use time at the end of a shift to reflect on practise”.

“I reflect on my/our practice to see how things may be done differently or better in future”.

Kato (2014) suggests that those nurses who cope by distancing themselves from the workplace may experience increased stress as there is a positive association with avoidance strategies and psychological dysfunction and a lack of collegiately in the workplace. There is some evidence of negative practices that suggest that avoidance and distancing may be a reality for some participants with comments;

“Don’t get involved just do my job and collect pay on payday”.

“I read novels, watch TV and do crosswords - basically isolate and vegetate whenever I can”.

The most frequent comment is compelling evidence about the importance of debriefing as a means of support. Hanna and Romana (2007) states that “research shows that nurses who experience moral distress in their work setting without receiving situational support aren't able to easily process the experience” (p. 39). They also state;

If no one debriefs after a distressing situation occurs? Staff members could process their responses individually in silence, which is depersonalizing, fails to acknowledge their dignity as workers who are suffering, and ultimately alienate themselves from each other. The resulting fragmentation of the workgroup reduces morale and makes it more difficult for workers to work with each other (p. 45).

There were numerous comments on informal debriefing as a coping mechanism which suggest that emergency nurses use debriefing to manage workplace stress.

“I do believe that we need to cope w/ stress ad accepting that stress is part of work and daily living. Coping with these includes talking with colleagues, friend and family members, going out, and unwinding self”.

“We have a very close-knit department, we do not have a formal social club but we regularly socialize together. The whole department has drinks every 2 weeks, we go camping together, and often go out for breakfast post night shift. “Talking with workmate laughter debriefing with workmates is a great de stressor”.
“Debriefing with select colleagues - often over a wine”.

“There is a great team of nurses and doctors in this department, and the work is incredibly interesting. Without the support of fellow staff I would leave”.

The level of response and comments that describe the coping mechanisms are suggestive that many emergency nurses have worked out ways that help them cope best. Recognising that coping is an important factor in managing the stress levels of ED makes this relevant for inclusion in this study. The comments are reflective of the positive outlook that ED nurses have despite the negative connotations that some factors that influence their stress levels may have. Ways of coping is another component of this study that warrants further investigation in future articles that will unpack this data further.

5.15 SUMMARY

In this chapter the findings and some discussion relating to the content analysis from the free text comments from the online survey have been presented. Inclusion of some comments from throughout the survey has been used to illustrate factors that influence the stress levels of ED nurses in New Zealand. Demographic data has been presented to describe factors that are relative to population of nurses engaged in emergency nursing as there is some evidence that this has an influence on stress. Common themes such as workload, violence and alcohol related presentations became apparent. Organisational demands, bullying and the added pressure of government health targets were also identified as aspects of emergency nursing that contribute to occupational stress in the ED common themes. The considerable commentary from the research participants throughout the survey suggest that the degree of occupational stress is of concern. Discussion of the three themes and sub themes that were analysed as being the most significant are discussed in the next chapter.
CHAPTER SIX

DISCUSSION

Education is an ornament in prosperity and a refuge in adversity.

(Aristotle 384 BC - 322 BC)

6.1 INTRODUCTION

The objective of this study was to determine what factors influenced the stress levels of ED nurses in New Zealand. Comments made by the participants were grouped into themes and analysed using key words and phrases. This discussion is based on three themes that emerged from the data. These factors attracted the most comments from the research participants them as having the most impact on stress in the workplace. The central themes include organisational culture, workload and the SSED target. The government health targets featured as a common factor that influenced the stress levels of ED nurses in New Zealand, with particular reference to the SSED target. Workload was also identified as predominant theme, with participants commenting on the cumulative pressures of other factors all contributing to their workload. One of the principle themes that emerged alluded to prevailing organisational cultures within the ED. This included the structure, processes and issues surrounding safe staffing levels, skill mix, violence and a reported culture of dysfunctional collegial relationships and bullying in the ED.

6.2 ORGANISATIONAL CULTURE

The basic premise of providing a workplace that is both physically and psychologically safe is not only integral to the health and wellbeing of emergency nurses but also essential in the provision of optimal patient care (Leape et al., 2012). Any demonstrated lack of respect by either colleagues, managers or the wider organisation is conducive to widespread occupational stress. In a commissioned report on work and workplace safety the Lucian Leape Institute (2013) states;

Many health care workers are suffering harm—emotional and physical in the course of providing care. Many are subjected to being bullied, harassed, demeaned, ignored, and in the most extreme cases, physically assaulted ......they are also being physically injured, working in conditions of known and preventable environmental risk (p. 5).
There is no easy solution to changing the culture of an ED. Challenging the established order requires dynamic leadership, a strong quality framework and most importantly a culture of respect. Leape et al. (2012) suggests that

Disrespectful behaviour is at the core of the dysfunctional culture prevalent in health care systems. It is a ‘root cause’ of the difficulties encountered in developing team-based approaches to improving patient safety and implementing safe practices. The most extreme forms of disrespect, disruptive and humiliating behaviours induce errors. Disrespect underlies the tensions and dissatisfactions that diminish joy and fulfilment in work for many types of health care workers “(p. 857).

The presence of nursing subcultures in the ED can be a dynamic that is not recognised as the organisational culture of the hospital often predominates (Khokher, Bourgeault & Sainsaulieu, 2009; Mallidou, Cummings, Estabrooks & Giovannetti, 2010). There is an inference that emergency nurses believe they are neither respected nor supported by management and the hierarchy (Eisenberg, Baglia & Pynes, 2006; Keough, Schlomer & Bollenberg, 2003; Khokher et al., 2010). High turnover amongst nursing leaders in the ED has contributed to a culture that suggests that if management is not important to the hierarchy then the staff can adopt a do as I please attitude (Eisenberg et al., 2006). The inference is that if there is no support for management and the hierarchy does not deal with, then respect for the organisation is eroded (Etienne, 2014). The consequence of poor leadership either by management or the wider organisation is job dissatisfaction, nursing burnout as pressures and stress become endemic (Aiken et al., 2002). Inattention to the issues that contribute to stress amongst emergency nurses also contributes to a culture of bullying and interpersonal conflicts.

6.2.1 BULLYING

Bullying has been represented in this study as a significant concern. There are numerous comments that allude to oppressive behaviours, intimidation and discriminatory practices amongst emergency nurses in New Zealand. Research suggests that this largely unreported and poorly dealt with and this aspect of these behaviours has significant consequences in terms of occupational stress, staff turnover and the quality of patient care (Etienne, 2014; Gaffney, DeMarco, Hofmeyer, Vessey & Budin, 2012). Simons and Mawn (2010) suggest that inadequacies in staffing and occupational stress are conducive to creating an environment where bullying becomes more prevalent. The advent that ‘nurses eat their young’ is commonly associated with the ED where nurses not only have
strong personalities but are generally older and more experienced (Bartholomew, 2006). This concept of aggressive criticism of performance or skill can promote a negative experience particularly for new graduate or junior nurses and lead to stress, hostility and ultimately attrition from nursing (Clarke, Kane, Rajacich & Lefreniere, 2012; Einarsen, Hoel & Notelaer, 2009; Yildirim, 2009). Historical indifference to bullying behaviours and a culture of silence alludes to inadequate support, lack of organisational structures, policies and process and more commonly unresponsive or weak leadership (Atabay, Gunay & Cangarli, 2010; Gaffney et al., 2012).

It is of concern that 58.8 % of participants in this survey state that they have experienced bullying in the workplace. Furthermore, 72.2% of participants also state interpersonal conflict with colleagues as a cause of stress. This is an indictment on the state of the organisational cultures that prevails in the ED. Similar results were identified in an international study by Etienne (2014) with 48% of survey participants indicating that they had experienced bullying in the workplace with 35% reporting bullying weekly and 28% stating that this occurred on a daily basis (p. 8). Bullying and interpersonal conflict has widespread implications for the health and wellbeing of nursing staff in the ED. Implementation of zero tolerance strategies requires a commitment by both the organisation and management to nullify poor behaviour. While it is clear that constructive and positive leadership is essential, nursing managers are also subjected to bullying behaviours from both nursing staff and the hierarchy and are often unsupported or lack the skill, knowledge or resources to deal with these difficult situations (Jackson & Rea, 2009).

6.2.2 SAFE STAFFING AND SKILL MIX

Also closely linked to both organisational structure and cultural dynamics is staffing. In the ED, staffing is a constant source of stress for both nurses and managers (Kroning, 2014). Establishing correct levels for nursing staff in the ED is important as research has demonstrated that the levels of nursing staff has “a significant effect on preventable hospital deaths…..according to researchers the odds of patient mortality rose 7% for every additional patient added to the average nurse’s workload” (Aiken, Clarke, Sloane, Sochalski & Silber, 2002, p. 1991). This is supported by research completed in Californian hospitals where the impact of reduced staffing is closely linked to patient outcomes (Cho, Ketefian, Barkauskas & Smith, 2003). Cho et al. (2003) revealed that there was a direct
association between events such as prolonged length of stay and mortality in hospitals with decreased staffing. A similar study by Kane, Shamiyan, Mueller, Duval and Wilt (2007) scrutinized the relationship of staffing and patient outcomes determined that an increase in nursing staff resulted in reduction of adverse events such as respiratory or cardiac arrest.

Establishing correct levels of nursing staff in the ED is problematic. Mandated nurse staff ratios in the ED is a challenge. There is no uniformity as to how many nurses are required for a single event such as a resuscitation although CENNZ (2006) has issued a position statement on recommended levels as a means to guide staffing in the ED. The reality however, is often different from the recommendation and the mismatch of staffing in the ED is complicated by issues such as skill mix and availability (Adams & Bond, 2003; Lyneham et al., 2008). Safe staffing is the responsibility of managers and the wider organisation to ensure the mitigation of any risk to both patients and staff. The premise of safe staffing for nurses in the ED is clearly outlined by the CENNZ (2006) who state;

The College of Emergency Nurses believes that Emergency Departments must have appropriate infrastructure and staffing requirements so emergency nurses have the environment to provide safe quality patient and family centred care ensuring optimum patient outcomes …..managers and administrators have the responsibility to ensure effective, efficient emergency care delivery systems” (p. 1).

Concerns regarding skill mix were expressed in the study. Participants suggest that although there is no perfect model, senior nurses are continually confronted with the need to support, guide and direct inexperienced nurses while maintaining their own workload. The need to maintain adequate staff and a suitable skill mix is a pre-requisite for quality patient care and outcomes (CENNZ, 2006). There has been a suggestion that healthcare organisations subscribe to practices of substituting less qualified nurses for senior staff as a way to cope with staff shortages and improve cost saving (Dubois & Singh, 2009). This practice is a factor that concerns ED nurses. Research suggests that this can have an adverse effect on patient outcomes and subscribe to increased absenteeism due to work related stress (Dubois & Singh, 2009). Establishing appropriate staff distribution and skill-mix in the ED is extremely important if occupationally related stressors are to be diluted in the ED (Adam & Bond, 2003; Hwang & Chang, 2007; Lyneham et al. 2008). The role of the management team who oversees rostering and staff distribution in line with robust organisational structures and guidelines is cortical to
ensure there is no unnecessary duress amongst emergency nurses who are already faced with stressful events and heavy workloads on a daily basis (Dracup & Bryan-Brown, 2005; Schriven, Talmadge, Chuong & Hedges, 2003).

The organisational factors that influence the stress levels of ED nurses in New Zealand requires further investigation. Issues such as bullying as well as poor leadership and management have been noted by the research participants as being a concern for them. The depth of enquiry is beyond the scope of this thesis and has been identified as a topic for further research.

There is a close correlation between organisational culture and the instigation of the government mandated health targets as achieving this target and is linked to the wider health network particularly in the hospital environment. These targets have been identified as significant contributors to workplace stress for emergency nurses. There was significant reference throughout the study to the SSED target commonly known as “ED 6” which materialised as a major theme.

6.3 HEALTH TARGETS

The SSED health target attracted a high response. In answer to the question regarding the contribution of government health targets to workplace stress, 89.3% of those surveyed indicated yes. Comments by participants have an underlying acceptance of the health target but feel that this impacts on patient care and is a definite pressure point in the ED. There are so many contributing factors to patient flow within the ED. The constant pressure to achieve ‘the target’ is having a sub-optimal effect on patients and nursing staff and is contributing to conflict with the wider hospital system (Jones & Olsen, 2011).

The ED is a critical department that filters patients in and out of the hospital system. Issues within the ED are symptoms of inadequacies within the healthcare system which can ultimately manifest in reduced access to care and diminished quality of care. As an example overcrowding in the ED is a longstanding problem that signifies a systemic organisational problem that requires solutions from the wider health network (Ardagh, Tonkin & Possenniskie, 2011). The ascription of congested waiting rooms, insufficient beds and lengthy stays is often aimed at inefficiencies in the ED. However, there is no simple answer to these issues as the cause of overcrowding are complicated and systemic (Jones
& Olsen, 2011). For example the patient that presents to the ED with pneumonia can linger for hours as an in-patient bed is sought. The reality is that this in-patient bed is already occupied but as the pressure to admit intensifies an early discharge sees the occupying patient returned to the community with a high probability of representing to the ED (Ardagh, 2010).

The establishment of a quality framework is integral to both compliance with the health targets and removing the barriers that currently prevail (Ardagh, 2010). This is essential if nursing staff are to be motivated to provide quality patient centered care without duress. The complexities of the ED environment require comprehensive resourcing and supportive process to improve care and reduce risk to both staff and patients. The culture of doing more with less is indicative of a wider problem within health but is a contributing factor to workplace stress in the ED. From the comments generated in the survey it appears that there is low morale which is in danger of leading to a subculture of apathy and disengagement that is directly related to achieving the ED6 target if there is no buy in from other hospital departments and specialties (Nugus et al., 2014). However, acceptance and achievement of the ED 6 target requires both leadership from within the ED and an investment by the organisational hierarchy to provide the structure, resources and systemic support that endorses quality nursing practices and optimal patient care in the ED (Jones, Tonkin & Olsen, 2011). Workload is another predominant theme that included issues such as aging patients and alcohol. It is recognised that the components of a nurses workload are difficult to determine and multifactorial. The next section provides discussion on two aspects of workload.

6.4 WORKLOAD

Workload emerged as one of the most predominant themes. Factors that influence workload are recognised as being a constant source of stress. Alcohol related presentations are both challenging and time consuming and often place additional pressure on nursing workload. The aging population with complex acute exacerbations of chronic health conditions and high incidences of injury events are becoming significant contributors to the workload of nurses in the ED. It is also recognised that organisational influences such as budgetary constraints that impact on safe staffing levels and resources within the ED can add to workload and cause additional stress for ED nurses (Armstrong, 2009; May, 2013).
The rising cost of health care which has resulted in hospital restructuring in recent decades is a factor that impacts on nursing workload (Gower & Finlayson, 2002). This is a global phenomenon and New Zealand has followed suit in an attempt to provide a more efficient health care model. The demands of the aging population and the expectations of consumers for better and more expedient healthcare is a conundrum. Emergency nurses are not alone in experiencing the demands for fewer nurses to deliver care to an increasing population (Aitken, Clarke & Sloane, 2002; Gower & Finlayson, 2002). The effects of tightened health budgets are widespread. Care rationing is implemented with basic nursing cares being skipped in order to complete other tasks or attend to other priorities (Winters & Steven, 2012). Nursing care in the ED can be driven by patient acuity and this can result in diminished opportunities to establish rapport with patients (Duffy, 2009). While completion of nursing tasks is often generated by the demands of the medical staff with the need for clinical assessment and diagnostic testing often outweighing the fundamentals of nursing practice to the detriment of the emotional needs of the patient (Duffy, 2009; Kalish, 2006).

Although unsupportive nursing management does not rank highly amongst the participants, it is mentioned as being an issue for some emergency nurses. The need to provide a supportive working environment for emergency nurses is important. The relationship between hospital management, clinical nurse managers and nursing staff can reflect the tone the workplace (Attree, 2007). Failure by managers to provide honest feedback on reported issues such as safe staffing and skill mix is problematic. Complaining by emergency nurses about staffing issues is often ignored by management. This causes nurses to revert to non-reporting of difficulties with staffing as there is no faith in the system to address these issues (Attree, 2007). This is an important issue as research has demonstrated that common nursing tasks such as medication administration can be adversely affected (McDowell, Ferner & Ferner, 2009; Dean, Schachter, Vincent & Barber, 2002).

The delivery of patient care is highlighted in the text as being a source of frustration. The imposition of care rationing due to workload is damaging, not only to the patient but also to nursing morale (Winters & Neville, 2012). The inability to deliver quality care to patients can be detrimental to health outcomes (McCloskey & Diers, 2005). Adverse events such as medication errors and falls are more likely to occur if there is sub optimal
nursing staff levels and an increased workload (Schubert, Glass, Clarke, Aiken, Schaffert-Witylilet et al., 2008). Organisational support is essential when care delivery is compromised. In order to match patient demand and care capacity DHB’s in New Zealand have collaborated with Safe Staffing Healthy Workplaces (SSHW) Unit, NZNO and Public Service Authority (PSA). This initiative is imperative if patient safety is to be maintained with the DHB’s providing support to ensure that there is adequately skilled staff with sufficient resources to meet the demands of the department (Safe Staffing/Healthy Workplaces Committee of Inquiry, 2006). Application of the care model in the ED should provide an organisational response to any variance experienced due to acuity or patient numbers. The mantra associated with variance response management is levelled at the provision of safe and effective patient outcomes and an improved working environment for staff. The difficulty lies in DHB’s ability to respond. This is reflected in comments by research participants who do not appear to have faith in either managerial or organisational response strategies.

6.4.1 THE AGING POPULATION

It is important to recognize the impact that the aging population in New Zealand is having on ED services (MOH, 2002). As people age they are more likely to experience an escalation in chronic diseases with acute exacerbations that require hospitalisation, particularly amongst those over 85 years of age (Evans, McGrail, Morgan, Barer & Hertzman, 2001). In their report on the impact of the aging population in New Zealand, Cornwall and Davey (2004) indicate that there will be 1.18 million people over the age of 65 years by 2051. This represents a 165% increase since 1999, with older persons making up 26% of the population. This demand is being seen now with the older population being one of the highest users of the ED (MOH, 2013a).

This anomaly of aging is an important issue for emergency nurses (Samaras, Chevalley, Samaras & Gold, 2010). The older age group frequent the ED with a variety of conditions. As a cohort, the elderly are contributing to ED overcrowding for many differing reasons. Atypical presentations with confusing clinical pictures are common. The likelihood of multiple co-morbidities complicates diagnosis and treatment which causes delays. The ability of nurses to provide high levels of care that meets the needs of the older patient is often marginalised by the length of stay in the ED (Samaras, Chevalley, Samaras & Gold, 2010).
The elderly are also overly represented in ED attendances related to falls. This has become a factor in nursing workloads in the ED as these are the leading cause of hospitalisation in New Zealand with all of these injury related events presenting to the ED (Accident Compensation Commission (ACC), 2001). Disabling injuries and serious fractures are commonplace, while mortality associated with falls is significant. These patients require careful assessment as they often have co-morbidities that cannot be excluded as the cause of the fall and require frequent observation and nursing interventions (Burns, 2001). Alcohol consumption is also a factor in falls and injury in the older adult and often not considered in presentations to the ED (Mehta, Moriarty, Proctor, Bird & Darling, 2005). Nursing staff endeavour to spend time providing quality care for older persons but this care is often compromised and patient care diminished by the volume of work nurses are experiencing particularly when this care is affected by issues such as the increase alcohol related attendances to the ED.

6.4.2 ALCOHOL

The influence that alcohol related presentations has on nursing workload in the ED suggests that this is becoming a significant challenge (Gunasekara et al., 2011). A large amount of research has been conducted into alcohol consumption and the healthcare sector and a recent study that examined the impact of intoxicated patients on staff in the ED recommends more research is needed to accentuate this societal epidemic (Gunasekara et al., 2011). The consequences of alcohol misuse result in accident, injury, psychological insults, and self-harm events. Alcohol also features as an increasing factor in chronic disease pathologies. ED nurses often bear the brunt with increased exposure to verbal and physical abuse as they are usually the primary caregivers in ED.

In New Zealand, it is estimated that between 600 and 1000 people die each year from alcohol related causes (Berl 2009; Connor et al., 2013). More than half of alcohol-related deaths are due to injuries, one-quarter to cancer and one-quarter to other chronic diseases. Between 18 and 35\% of injury-based ED presentations are estimated to be alcohol-related, rising to between 60 and 70\% during the weekend. One fifth of all deaths for males and one-tenth for females aged between 20 and 24 years are attributable to alcohol (Law Commission, 2009, p. 72). Alcohol is involved in 50\% of the patients presenting to ED with facial fractures (Lee and Snape, 2008), and in 2008, there were
10,290 primary alcohol diagnosis admissions to New Zealand hospitals. The risk taking behaviours of New Zealand youth is also contributing to alcohol related presentations at ED. The binge drinking culture has contributed to an increase in physical, mental health and social problems. Accidental injury in this cohort is also problematic, while acts of aggression and violence are common (MOH, 2013).

One of the most common effects of alcohol relates to falls. The connections between falls and alcohol are often missed as these ED attendances are usually registered against the injury type rather than the contributing factors (Rehm et al., 2010). Inaccuracies in the quantities consumed is common when drinking at home as drink size and amount is not measured or monitored as it might be in a licensed facility. The associated cognitive impairment leads to decreased balance and mobility and increase the risk of a fall causing injury. Older persons also underestimate the amount of alcohol consumed and if this is a contributing factor in a fall it is less likely to be detected by ED staff as this mechanism of injury are more common in the elderly (Mehta et al., 2005). The physiological effect of aging is a concern when associated with alcohol consumption due to less efficient metabolism. Coupled with the probability of poly pharmacy amongst older persons, alcohol can enhance the sedating effect of some medications causing falls and collapse.

The contribution of alcohol related presentations to stress amongst emergency nurses is considerable. There is a correlation between alcohol and the increased of violence and aggression events experienced by nurses in the ED and an increasing sense of disregard for these time consuming drunk patients (Gunasekara et al., 2011). Survey participants provided extensive comments on the impact that alcohol has on their practice, the care of other patients and the time and stress associated with dealing with this considerable problem. There is no easy answer to the issues associated with alcohol. The data collected during this study suggest that this is a factor that influences the stress levels of ED nurses and requires further enquiry.

6.5 SUMMARY
The discussion of the three main themes that have emerged from the finding in this chapter completes the research project. The aim of the study was to establish what factors influenced the stress levels of ED nurses in New Zealand. Healy and Tyrell’s (2011)
study was used as the framework for this study as there is limited New Zealand based research into the factors that contribute to the stress for emergency nurses. The sample size is small and is an acknowledged limitation of the study, but has given valuable insight into factors that influence the stress levels emergency nurses in New Zealand. Understanding these factors is important as it provides a starting point to addressing some of the issues through further research and investigation. Other themes that became apparent throughout the data collection were not scrutinised but will be used in peer reviewed articles at a later time.
CHAPTER SEVEN

RECOMMENDATIONS, LIMITATIONS AND CONCLUSION

“We cannot solve our problems with the same thinking we used when we created them”.

Albert Einstein

7.1 INTRODUCTION

This study set out to identify the factors that influence the stress levels of emergency nurses working in New Zealand. The online survey was remarkable and comments from the research participants provide rich data that was collated into themes. Providing analysis and discussion on all the themes was beyond the scope of this thesis however, this data will be examined in detail for other writings. The predominant themes of organisational culture, workload bullying and the SSED health target were identified as being the most significant factors that influenced the stress levels of nurses in the ED. These were discussed further in chapter five. This, the final chapter outlines recommendations to address issues that impact on the stress levels of ED nurses and to identify strategies that will assist them to manage their stress levels and improve their health and wellbeing. Limitations associated with this study will also be outlined.

7.2 RECOMMENDATIONS

There is a siege mentality that prevails in many nursing specialties that is contributing to stress, burnout and attrition from the nursing profession (Jackson, Firtko & Edenborough, 2007). As an industry there is little doubt that emergency nurses are subjected to a wide range of stressors in the ED (Gillespie & Melby, 2003). Some of this stress is due to the nature of emergency work, as ED nurses balance life and death situations with a host of minor injury and illnesses. This is mixed with the constant barrage of societal issues such as alcohol and violence. These and a raft of other presentations both tax and challenge the physical, emotional and psychological health and wellbeing of emergency nurses. However, Jackson et al. (2007) suggested that attrition from emergency nursing is more likely to be associated with issues such as the aging experienced workforce, excessive
workload and organisational cultures such as bullying, conflict and aggression rather than the actual work of emergency nurses.

Regardless of the issues, the adversities of working in the ED needs to be countered by the promotion of an organisational culture that is proactive in assisting emergency nurses to develop robust coping mechanisms and build resilience and emotional insight to counter stressful experiences (Jackson et al., 2007). The construct of a positive and supportive working environment is imperative if the problems that confront emergency nurses are to be resolved. In addition, an organisational culture that allows and by default subscribes to behaviours such as bullying, conflict and poor professional demeanour needs to be challenged and confronted if the nursing workforce is to be maintained (Cline, Reilly & Moore, 2003; Jackson et al., 2007; Jackson, Mannix & Daly, 2001; Strachota, Normandin, O’Brien, Clary & Krukow, 2003).

Emergency nurses experience the anguish, distress and tragedy of those in their care on an almost daily basis (Tusaie & Dyer, 2004). In order to endure the constant exposure to tragedy and suffering emergency nurses develop a range of coping mechanisms that provides them with the resilience and aptitude that allows them to continue working in the ED. It would be prudent for healthcare organisations to develop strategies that foster personal and professional growth amongst nurses. Within the ED, it is important that there is an organisational commitment that engages staff in reflective practices such as incident debriefing and professional networks that are collegial and supportive (Jackson et al., 2007; McGhee, 2006; Tugade & Fredrikson, 2004). Similarly, encouraging nurses to engender concepts such as emotional intelligence to develop insight into their own emotional needs is growing in value as a means to build resilience and manage stress (Daly, Speedy & Jackson, 2004).

The manifestation of stress amongst nurses in the ED often has a domino effect (Kroning, 2014). Understaffing, skill mix and quality of patient care are commonly attributed to nursing stress in the ED. While it is impossible to gauge the exact nature or severity of ED presentations, hospital administrators have attempted to impose staffing formulas that match historic patterns of use (Kroning, 2014). Unfortunately, this is an inexact science as it fails to predict those major events that requires three nurses instead of one, or the volume of patients that appear in the waiting room who ultimately need hospital admission (Rossetti et al., 2013). This is not a slight on the administrative process but an
unfortunate reality that reflects the unpredictability of the ED (Rossetti et al., 2013). To counterbalance this hospital managers require the ability to ressource the ED if there is a mismatch in capacity and demand particularly, if it jeopardizes patient and staff safety. Nursing staff have the greatest contact with patients in the ED, so any pressures such as a sudden change in acuity or the arrival of a major trauma can profoundly influence the outcomes for patients, as well as the stress levels of the nurses (Kroning, 2014). Mitigating this risk is the responsibility of management and the wider organisation. There is a need for a solid infrastructure to ensure that there is no compromise to patient outcomes or staff safety.

The introduction of a quality framework and suite of measures for the ED have been adopted nationally (National Emergency Departments Advisory Group, 2014). The premise behind this framework is linked to the SSED target and while there is consensus that this target has been the impetus to improving acute care services in New Zealand compliance has occurred without a nationally mandated quality framework (p. 1). International frameworks have been fundamental in influencing the quality measures that were implemented into practice in New Zealand in July 2014 (ACEM, 2011, Lecky, Mason, Benger, Cameron & Walsh, 2012). The incorporation of the quality measures may address many of the issues that are causing stress in the ED however, without the whole of hospital approach to address patient flow this could be a lost opportunity. A commitment is needed by emergency staff, in-patient services, allied health and primary healthcare to adopt a multi-disciplinary model of care that centres on the patient’s journey.

Emergency nurses in New Zealand will experience significant challenges and changes in the upcoming decades. The aging patient population, nursing shortages brought about by the aging workforce and the constant changes brought about by financial pressures and regulatory measures will impact on nurses (Benner, Stephen, Leonard & Day, 2010; Institute of Medicine, 2011). However, there is also opportunity for nurses who are the largest group of health professionals in New Zealand to be more involved in the development of future healthcare policy (Buresh, Gordon & Benner, 2006). Transformative leadership that can energise the nursing workforce and counteract the negative effects that institutional cultures tend to accumulate is imperative. It is also important that nursing leaders and managers in the ED receive the support from both the
hierarchy and the nursing teams so that they can function effectively and efficiently as advocates for nurses in the ED.

The comments from the research participants have detailed a large amount of information that is difficult to ‘unpack’ and interpret within the confines of this thesis. It is a recommendation that the data from the central themes be analysed using a statistical software programme. These results will form the basis of further research as the issues highlighted are compelling and would add to nursing knowledge in New Zealand.

7.3 LIMITATIONS

As an emergency nurse currently working in ED, assuming the role of researcher from a distinctly clinical background was a quantum shift. The importance of self-determination, personal insight and acknowledging the significance of how the researchers own clinical involvement in emergency nursing has formulated the research has been revealing. The use of supervisors as a sounding board was used to maintain objectivity. Their guidance of the research process has ensured the separation of personal ideals and opinion from the context of the research. This supervision has safeguarded the validity of the research.

As the research process has evolved, it was a struggle to contain the boundaries of the investigation in relation to the research question. This was due to the volume of research into occupational stress, as this is a genre that commands research throughout the realms of human endeavor let alone nursing (Sandelowski, 2009). In New Zealand, there is a wealth of investigation into individual influences such as violence, alcohol and government health targets that contribute to workplace stress relative to emergency nursing. The lack of research into the occupational stress in emergency nursing in New Zealand was a limiting factor. The use of an international study (Health & Tyrell, 2011) was the framework for this study, however although this study has many similarities it does not allow for true comparison. Healy & Tyrell (2011) examined stress amongst nurses and doctors in the ED. Participants in this study are all emergency nurses and it is acknowledged the cause of stress may differ between emergency nurses and doctors.

An additional limitation has been the time taken to acquire permission to use the CENNZ database for distribution of the online survey link. This was due to the timing of the
request which was in December 2013. The request was not received by CENNZ until mid-January 2014 with further delays due to the absence of the college executive who were on leave and no meeting scheduled until February 2014. The CENNZ executive met in February 2014 and distribution was done the same day. It was important to the validity and confidentiality of the research to engage participants that the researcher had no part in selecting the sample. Delays in obtaining consent to use the database limited the undertaking and the time of the survey in order to meet the requirements of this thesis but the questionnaire is aimed at acquiring sufficient information to present themes for discussion. The response in such a short time was overwhelming and a wealth of data was collected over the time that the questionnaire was available online. The study sample was emergency nurses who were members of the CENNZ and distribution was via the electronic database. The size of the sample is small and potentially limiting. It is acknowledged that the sample group does not necessarily reflect the thoughts or opinions of other nurses engaged in the field of emergency nursing in New Zealand. Similarly, the structure and format of the research questionnaire could have been improved by ensuring that the participants could elaborate further on their chosen answer.

It is also important to recognise that this study was aimed at the emergency nurse population of New Zealand and the comments of the participants are related to their perception of occupational stress in the ED. The perceptions and opinions of healthcare organisations and clinical nurse managers have not been portrayed, although it is feasible that managers have contributed to this study as members of the CENNZ. This may be a limitation in terms of how occupational stress amongst nurse in the ED is perceived and managed and would require further study which is beyond the scope of this research project.

The use of descriptive statistics to summarize the data is acknowledged as a limitation in this study. The study may have been better served with the use of inferential statistical analysis of the data (Westlake, Pozza & Buelow, 2012). Further interpretation of data relevant to the central themes will be undertaken in subsequent publications and is a recommendation that has emerged from this research. Similarly, the large amount of data was also a limitation given the scope of this thesis. Managing the volume of information proved daunting and difficult to analyse and discuss. Reducing the discourse
to the principle themes and sub themes identified in the content analysis gave structure
to this dissertation. However, there remains a wealth of data that could be further
unravelled to give justice to the contributions of the research participants. This data is
compelling and will be used in future articles.

7.4 PERSONAL REFLECTION

During the research and writing of this thesis I changed my role in the ED from emergency
nurse to clinical nurse manager (CNM). The discovery of the depth of stress and the
implications this has for both nurses working in the ED and patients is somewhat
disturbing. As an emergency nurse I was aware at the outset that there were multi-
dimensional aspects of working in the ED that both caused and contributed to workplace
stress amongst ED nurses. Much of what has been examined has made me reflect on my
own practices and interactions with the nursing team and I have become more aware of
the factors that influence stress levels of ED nurses in New Zealand. This study has been a
personal challenge for me to remain objective. The contributions of the research
participants have served as inspiration to become a better leader and to continue
working towards negating the impact that stress has on emergency nurses in the ED.

7.5 CONCLUSION

The intent and purpose of this thesis is to identify factors that influence the stress levels
of ED nurses in New Zealand. The findings of this research are indicative of a nursing
specialty that appears to be under duress and the factors that influence stress levels of Ed
nurses are substantial and challenging. There is no doubt that addressing some of these
issues require intervention at the highest level with robust and effective policies and
directives to cope with social problems such as alcohol and violence. Similarly, a whole of
health approach is needed to cope with the challenges that the aging population and the
increasing chronicity that will place considerable demands on acute care environments
such as the ED.

Although the factors that influence the stress levels of emergency nurses was my main
focus, it is important to note that these factors cannot be viewed in isolation. The
combined influence that issues such as overcrowding in the ED, reduced time for patient
care and the imposition of government health targets has on the levels of stress
experienced by ED nurses are closely linked. Organisational dynamics also feature as a factor that influences stress levels and it is imperative that these are addressed in order to preserve the health and wellbeing of emergency nurses in the ED. It would be impossible to remove all of the factors that cause stress, however minimizing the effects these have would be welcomed. The understanding I have gained from this study has empowered me to ignite change and improve awareness of how stress can impact on our attitude, professional demeanor and practice as nurses in the ED and how well emergency nurses cope in the face of adversity.
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APPENDIX 1: OCCUPATIONAL STRESS IN THE EMERGENCY DEPARTMENT
<table>
<thead>
<tr>
<th>Occupational Stress in the Emergency Department</th>
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<tr>
<td><strong>Participant Information and Consent</strong></td>
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</table>

My name is Jaki Boyle and this research is being undertaken as part of my thesis to complete my Masters of Nursing at Eastern Institute of Technology (EIT).

Instructions: This electronic survey is completely anonymous and will take about 15 minutes to complete. Please click on the box(es) you wish to answer or that applies to you. There are boxes provided for comments for many of the questions if you would like to provide additional comments or items.

The aim of the research: The aim of the questionnaire is to determine the levels and types of stress that emergency nurses in New Zealand are experiencing and the coping strategies that nurses use to deal with this stress. I am also interested in examining the factors that contribute to occupational stress in the emergency department and how this is recognized and managed.

The participants: This electronic survey is being distributed to emergency nurses in New Zealand hospitals although there will be no identifying questions to determine which hospital you are employed in.

What will participants be asked to do: Participants will be asked to complete an online questionnaire via Survey Monkey which comprises of 27 questions with the option to make comments and should take approximately 15 minutes.

Benefits and risks of participation: One of the main benefits of this project is that it will help identify issues that emergency nurses in New Zealand are experiencing and ascertain what coping mechanisms are being employed to deal with this stress. If it is hoped that it will also highlight which nurses are experiencing the most stress and how this might be addressed. This research is important because it has the potential to provide insight into issues in emergency nurses and form the basis for further research. There are no risks associated with participating.

What data or information will be collected and what use will be made of it? This questionnaire will help collect information on the occupational stress issues that emergency nurses experience in New Zealand. It will include demographic information that seeks to situate your nursing experience. The questionnaire is completely anonymous, so there will be no information that links you to the questionnaire in any way. The data collected will be securely stored and only myself and my supervisors will have access to it. At the end of the research all questionnaires will be deleted and destroyed. The results of the project will be published in the thesis that this research pertains to and may be published in other articles.

If you have any questions: If participants have any questions about this research, either now or in the future, they can contact:

Jaki Boyle (Researcher); jakb@itrc.co.nz Tel: 027 326 5506,
Dr Clare Harvey (EIT Supervisor); CHarvey@eit.ac.nz - Tel: +64 6 9748000 Ext 5174
Dorothy Isaac (EIT Associate Supervisor); disaac@eit.ac.nz - Tel: +64 6 8690810

1. Please click either “accept” or “decline” to indicate you agree to participate in this survey. By accepting you indicate that you have read the information provided above and are over 18 years of age.

- Accept
- Decline
## Occupational Stress in the Emergency Department

### 2. Please indicate your age group
- [ ] < 25 years
- [ ] 26 - 35 years
- [ ] 36 - 45 years
- [ ] 46 - 55 years
- [ ] ≥ 56 years

### 3. What is your gender?
- [ ] Female
- [ ] Male

### 4. What is your ethnicity? (Please select all that apply.)
- [ ] NZ European
- [ ] NZ Māori
- [ ] Australian
- [ ] Pacific Islander
- [ ] Asian
- [ ] Other [please state]  

Other (please specify):  

### 5. Number of years as a Registered Nurse
- [ ] < 5 years
- [ ] 5 - 10 years
- [ ] ≥ 10 years

### 6. Number of years in the Emergency Department
- [ ] < 2 years
- [ ] 2 - 5 years
- [ ] 5 - 10 years
- [ ] ≥ 10 years
Occupational Stress in the Emergency Department

7. What is your employment status?
   - Full time
   - Part time
   - Casual

8. What is your current role?
   - New graduate nurse
   - Registered Nurse Level 1 - 3
   - Registered Nurse Level 4 - 5
   - Senior Nurse
   - Clinical Nurse Specialist
   - Nurse Practitioner
   - Clinical Nurse Manager

9. Have you ever experienced stress due to your work as an emergency nurse?
   - Yes
   - No
   - Other (please specify)

10. In a typical week, how often did you feel stressed at work?
    - Extremely often
    - Very often
    - Moderately often
    - Slightly often
    - Not at all often
    - Other (please specify)

11. Has this stress occurred in your current role?
    - Yes
    - No
12. Has this stress occurred in the last 12 months and if so please describe what has contributed to this stress
   - Yes
   - No

   Please comment

13. What is the most stressful event[s] that you have experienced whilst working in the emergency department?
   - Aggression and violence from patients
   - Death or resuscitation of a child or young person
   - Critical illness
   - Sudden or traumatic death
   - Major incident
   - Other – please describe

   Other (please specify):

14. Does your employer provide you with support when you are stressed at work?
   - Yes
   - No

   Please describe what support you have received if you have answered yes

15. Has this support been sufficient to reduce your stress?
   - Yes
   - Occasionally
   - No
16. Do you feel stressed or anxious when going to work in the Emergency Department?

- Yes
- No
- Other (please specify)

17. Has your stressful experience involved interactions with (you may tick more than one);

- Colleagues
- Patient
- Members of the public
- Other

Other (please specify)

18. Describe stressful situations you have experienced when dealing with colleagues, patients or members of the public

19. Have you ever experienced verbal or physical violence in dealing with patients or members of the public in your workplace?

- Yes
- No

20. It is well publicised that there is an increase in alcohol and drug related presentations to emergency departments. Describe how this is impacting on your workload and time and how it contributes to stress in the emergency department.
### Occupational Stress in the Emergency Department

21. Have you ever experienced bullying in your workplace? If you have answered yes please comment

- [ ] Yes
- [ ] No

Other (please specify)

22. Conflict at work is a common cause of occupational stress. Have any of the following caused you stress?

- [ ] Conflict with other professionals (e.g., doctors)
- [ ] Conflicting roles with other health professionals
- [ ] Conflict with other departments
- [ ] Criticism by other professionals (e.g., doctors)
- [ ] Lack of emotional support by colleagues
- [ ] Difficulty working with your colleagues

Other (please specify)

23. Have you ever experienced any of the following when caring for patients in the Emergency Department?

- [ ] Feeling uncertain about skill and knowledge
- [ ] Feeling inadequate to deal with patients’ emotional needs
- [ ] Fear of making a mistake in a patient’s treatment
- [ ] Difficulty in maintaining clinical/technical skills and knowledge up-to-date
- [ ] Concerns about the level of care and attention that you are able to provide your patient

Other (please specify)
24. The balance between home and work can be difficult to manage at times. Have you ever felt

☐ You don’t have enough time with family and friends
☐ Difficulty separating personal from professional roles
☐ Taking work home
☐ Relationship with spouse/partner affects work
☐ Inadequate time for social relationships and occasions
☐ Other (please specify)

25. Does the structure, processes, policies and resources of your organisation contribute to stress?

☐ Lack of support from senior management
☐ Relationships with junior colleagues and peers
☐ Lack of communication and information at work
☐ Poor management and supervision
☐ Lack of ways that conflicts are resolved in the organisation
☐ Poor organisational structure and policies
☐ Lack of adequate staffing
☐ Lack of financial resources for training courses and workshops
☐ Lack of equipment and supplies
☐ Inadequate clerical/technical backup
☐ Poor physical working environment
☐ Lack of protection in potential dangerous environment/situations
☐ Other (please specify)
26. Do government health targets create increased pressures that contribute to stress at work and if so which targets cause the most concern

☐ Smoking cessation
☐ Family violence intervention
☐ Child Abuse reporting
☐ ED 6 hour target

Other (please specify)

27. Please describe your how you cope with the stress associated with working in the emergency department


APPENDIX 2: EIT ETHICS APPROVAL

Reference Number 19/13

5 December 2013

Jaki Boyle
C/- Faculty of Health Sciences
EIT

Dear Jaki

I am pleased to inform you that your research project “What’s going on? How do New Zealand emergency nurses cope with the occupational stress that is associated working in the emergency department?” was approved by the Research Ethics & Approvals Committee at their meeting held on 29 November 2013 for a period of 2 years.

You are reminded that should the proposal change in any significant way, then you must inform the Committee. Please quote the above reference number of all correspondence to the Committee.

Please provide the Committee with a progress report after one year of the project and a brief summary at the conclusion.

The Committee wish you well for the project.

Yours sincerely

Jeanette Fifield
Secretary – Research Ethics & Approvals Committee
APPENDIX 3: LETTER TO CENNZ REGARDING DISTRIBUTION OF SURVEY

Jaki Boyle
PO Box 767
Gisborne 4040

12 January 2014

College of Emergency Nurses New Zealand
Po Box 2128
Wellington
New Zealand

Dear Committee members

Re: Research Project — “How do New Zealand emergency nurses cope with the occupational stress that is associated with working in the emergency department?”

I would like make application to the college to distribute a research project that utilizes an electronic survey method [Survey Monkey: https://www.surveymonkey.com/s/162VV61] to the membership of the College of Emergency Nurses. I am a financial member of the college and believe that this method of distribution would preserve the anonymity of both individuals and organisations and maintain the integrity of the research.

This research is to complete the academic requirements of my Masters of Nursing at the Eastern Institute of Technology, where I am being supervised by Dr Clare Harvey and Dorothy Isaac, but is driven by a passion to understand the dynamics of emergency nursing and make a contribution to my chosen profession in New Zealand.

I have attached the information sheet and copy of the questionnaire for your consideration. I am aware that this is a significant research topic so have limited the survey questions to ensure that the research does not become side-tracked by other extensive issues such as bullying and burnout which warrant independent investigation and research.

I propose that I would supply the link to the survey for distribution electronically if this is acceptable but I am aware that should there be an associated distribution cost that this would be met by me. Subsequent to the conclusion and acceptance of my thesis I would be delighted to share the findings with the college.

Thank you for your consideration of my request and I look forward to your reply

Yours truly

Jaki Boyle
MN candidate
Eastern Institute of Technology