Emergency Department Mental Health Nurses' Perceptions of Occupational Stressors and Utilization of Coping Strategies

By

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A Thesis Submitted to the Faculty of Graduate Studies
In partial fulfillment of the requirements for the degree of
Master of Psychiatric Nursing

Faculty of Graduate Studies
Faculty of Health Studies
Brandon University
Brandon, Manitoba
September 2019

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Abstract

Individuals in mental health crises can present to an emergency department 24 hours a day, seven days a week. Yet there is minimal literature discussing the function and importance of emergency department mental health services. This investigation seeks to answer the question: what is the lived experience of dealing with occupational stress as a mental health nurse working on an emergency department mental health team? This research is based on a qualitative descriptive approach where a narrative is derived from the lived experiences of several individuals involved with a common phenomenon. Eight participants from two emergency department mental health teams were interviewed to explore their perceptions of occupational stressors and resulting coping strategies. Findings were divided into two categories: stressors and coping strategies. The main themes of stressors were: feeling morally distressed, working in an acute and uncertain environment, and incivility in the workplace. The main themes of coping strategies were: learning to work together, a shift in perspective, and personal coping strategies. These findings are discussed alongside current literature and suggestions are made for future research, continuing education, and practice improvement.

Acknowledgements

I would like to begin by thanking Dr. Dean Care, my thesis advisor, who has been a continuous source of guidance, reassurance and encouragement throughout this graduate program. Thank you to Dr. Sonia Udod for your countless hours combing through my work and mentoring me through this process. I have learned an incredible amount from you during this time. To Kimberly Poong, thank you for taking me under your wing for my preceptorship placements as well as serving as a committee member. You have been such an influential role-model to me in my career and your knowledge as a healthcare leader has been invaluable to this work. Words cannot express the gratitude I feel towards all of you as my committee members.

Thank you to the management group who granted me access to their amazing nursing teams and a special thank you to the participants who chose to share their stories and experiences with me. Without you, this thesis would not have been possible.

Thank you to my classmate John, for supporting me over the course of this degree. You've been a great school husband and have made this mountain a little easier to climb.

I've encountered some amazing women over the course of my education and career who have supported me in pursuing this degree. June Clark, Pamela Coulson, and Melissa Watkins. I am so lucky to know you all and to have had your support.

Thank you to my parents, Norma and Larry Pratt. You have always encouraged me to pursue a higher level of education and I am so thankful for all your love and support over the years.

A special thank you to my mother in law, Helen Vermeulen, for your babysitting services over the last 4 years. It would have been incredibly difficult to get through this program without you. I will be forever grateful for your time, care, and love. I would like to acknowledge my late father in law, Henry Vermeulen, for lending his wife to me so frequently.

To my beautiful girls Nora and Estelle. You girls were my motivation to get through this degree. I hope that someday you will know that you can have it all, you just have to work extra hard for it.

And finally to my husband Peter Vermeulen. I have always been in awe of you, especially as a nurse. You inspire me to do more for our 'people' and to advocate for what really matters for them. I think it was a terrible idea for both of us to do a masters degree at the same time while working, having children, and trying to survive life in general. But we get to do it together. Thank you for cheering me on and being my biggest source of support, love and encouragement.

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Chapter 1: Introduction

Nursing represents one third of the healthcare work force and attributes an absenteeism rate that is twice that of other professional groups (Canadian Federation of Nurses Unions [CFNU], 2017). Previously published literature indicated that heavy workloads, repeated exposure to traumatic events, and ongoing staffing shortages were among the occupational stressors that contributed to turnover and absenteeism in the nursing profession (Browning, Ryan, Thomas, Greenburg, & Rolniak, 2007; Garcia-Izquierdo & Rios-Rizquez, 2012; Healy & Tyrrell, 2011; Hu, Chen, Chiu, Shen, & Chang, 2010; O'Brien-Pallas, Murphy, Shamian, & Hays, 2010; Ross-Adjie, Leslie, & Gillman, 2007; Sawatzky & Enns, 2012; Wolf, Perhats, Delao, Moon, Clark, & Zavotsky, 2016). The price of recruitment efforts and overtime hours reflected direct costs while indirect costs related to attrition included the loss of organizational knowledge and productivity (Jones & Gates, 2007). In 2016, the total cost of overtime and absenteeism for regulated Canadian nurses (see Appendix A) was almost $2 billion dollars (CFNU, 2017). O'Brien-Pallas et al., (2010) examined nurse turnover in Canadian hospitals and estimated turnover cost at approximately $25,000 per nurse. Increased overtime and nurse turnover results in decreased productivity, an increased occurrence of medical errors, and decreased quality of patient care (CFNU, 2017; O'Brien-Pallas et al., 2010).

This research project explored emergency department mental health nurses' perceptions of occupational stressors and utilization of coping strategies. It is hoped that findings will increase the understanding of the unique occupational challenges present in this environment, assist management teams in knowing how to better support their

nursing teams, and improve nursing turnover and absenteeism in this high acuity area of healthcare.

The Emergency Department and Psychiatric Nursing

The Emergency Department (ED) is often the first point of contact for individuals seeking urgent medical and mental health services (McArthur & Montgomery, 2004). Several uncontrollable stressors exist in the ED due to the unpredictable, time-sensitive nature of this environment (Browning et al., 2007). Capacity levels rapidly fluctuate throughout the day resulting in overcrowding and irregular patient assignment loads (Hooper, Craig, Janvrin, Wetsel, & Reimels, 2010; Sawatzky & Enns, 2012). Nurses working in the ED are regularly involved in high-stress situations where patients have been victims of trauma, pose a risk to themselves and others, and require emergent assessment and treatment (Healy & Tyrrell, 2011; Hooper et al., 2010). The psychological and physical effects of ongoing exposure to stressful workplace situations are noted to include: emotional exhaustion, depression, anxiety, irritability, mental health concerns, lashing out at one's spouse and family members, relationship problems, increased likelihood of substance abuse, weight gain or loss, stomach issues, generalized aches and pains, and difficulties sleeping (Armstrong, 2001; Edwards, Guppy, & Cockerton, 2007; Gillespie & Melby, 2003; Healy & Tyrrell, 2011; Udod, Cummings, Care, & Jenkins, 2017). McArthur and Montgomery (2004) indicated that emergency psychiatric nurses felt powerless and were distracted from standards of practice when faced with role conflict and ongoing stressors in the ED.

Canadian healthcare organizations have recognized the need for psychiatric services embedded within EDs (McArthur & Montgomery, 2004). The balance between patient

care needs and available institutional resources has led to a variety of emergency psychiatric nursing services, ranging from a single psychiatric nurse providing consultation to an entire specialized psychiatric nursing team providing direct patient care (Clarke, Hughes, Brown, & Motluk, 2005; McArthur & Montgomery, 2004). A psychiatrist working on one of the emergency mental health teams (EMHT) included in this study indicated their team had grown from a single nurse consultant into a specialized nursing team in response to increased volume of mental health presentations to the ED (J. Doe*, personal communication, May 1, 2018). The idea of this concept was that nurses would complete the mental health assessment while also providing bedside support and care. Psychiatric nurses within the ED assess patients, collect pertinent data, provide care for admitted patients requiring inpatient care, and assist with discharge planning (Clarke et al., 2005). Nurses employed on the EMHTs included in this investigation are responsible for these duties as well as medication administration, behavioural and medical management of patient care, providing support and short term solution focused therapy as well as any other duties included in patient care. EMHT nurse designations include both Registered Nurses and Registered Psychiatric Nurses. It should be noted that while Registered Nurses and Registered Psychiatric Nurses have very similar education and scopes of practice in terms of medical training, specific skills can only be done in appropriate practice settings as governed by their respective governing colleges. Therefore there is some difference in skillsets between general ED and EMHT nursing staff.

The psychiatrist and several participants described the pathway taken by patients in the ED when seeking and accessing EMHT services. Patients presenting to the ED in

need of addictions and mental health services were first triaged by the ED triage nurse. Depending on the circumstances of the presentation, the patient was seen on the medical side of the ED for medical clearance and then moved to the EMHT, or was sent directly to the EMHT. Patients seen and assessed by the EMHT nursing staff, and ED casualty officer, would make a recommendation for either a referral to psychiatry or discharged with follow-up and support. If the patient was seen by psychiatry they could either be discharged or admitted to an inpatient psychiatric unit.

One of the cost saving benefits to this model of ED mental health services was that the EMHT was able to filter patients requiring consultation to the psychiatrist on call. According to the psychiatrist and several participants from site A in this study, only about 13% of addictions and mental health presentations to the ED were referred to the psychiatric team by the EMHT. Therefore psychiatrists were able to spend their time assessing patients who truly required psychiatric consult and patients that did not were still given mental health supports and connected with appropriate resources.

In conclusion, there are many ways that ED mental health services exist in various EDs across the country. This study focused on two sites that had developed highly specialized, multi-disciplinary services to best meet the needs of individuals seeking to access addictions and mental health services in a highly acute and challenging workplace environment. These nursing teams, comprised of both Registered Nurses and Registered Psychiatric Nurses were approached to further understand the unique perspective of what it was like to work in this setting.

*name has been changed to protect the identity of the individual.

Chapter 2: Literature Review

This chapter includes a literature review that was completed prior to the initiation of this investigation in regards to turnover and absenteeism within emergency department and acute mental health care settings. A review of the factors affecting turnover and absenteeism will be discussed along with previously documented occupational stressors and associated coping strategies.

Factors affecting Turnover and Absenteeism

Several themes emerged from the literature search regarding factors that contributed to turnover and absenteeism of nurses working in emergency departments (EDs) and acute care mental health care settings. These included compassion satisfaction, compassion fatigue, burnout, and moral distress. This overview will describe how these themes influence the desire to leave nursing positions and how occupational stressors impacted the development of these themes. It should be noted that the majority of the literature addressed general nurses working in an ED setting not in mental health nursing roles, or addressed mental health nurses working in acute care inpatient environments. This evident gap in the literature further encourages this investigation regarding ED mental health nurses experiences.

Compassion Satisfaction and Compassion Fatigue. Compassion satisfaction (CS) was the positive aspect and underlying foundation of nurse caring (Hooper et al., 2010; Sawatzky & Enns, 2012), where caregivers feel fulfillment from providing care to others (Simon, Pryce, Roff, & Klemmack, 2005). Hooper et al., (2010) identified that ED nurses had lower scores for CS than nurses working in other inpatient specialties. This finding may be attributed to nurses feeling less emotionally connected with their patients due to

the quick turnaround time for ED services (Garcia-Izquierdo & Rios-Risquez, 2012). Low levels of CS had been linked with nurse turnover in the ED (Sawatzky & Enns, 2012). Older nurses, or nurses with more years of experience in the ED, were shown to have higher CS scores and lower compassion fatigue (CF) scores than their younger counterparts (Burtson & Stichler, 2010; Hunsaker et al., 2015). Established nurses had learned to cope with the effects of frequent exposure to trauma, whereas novice nurses face challenges such as gaining practical experience, learning new information, and keeping up in a stressful work environment where promptness and proficiency is integral (Burtson & Stichler, 2010; Hunsaker et al., 2015).

CF was defined by Joinson (1992) to describe disconnect between care providers and their feelings, as a result of being witness to suffering from illness or trauma. Individuals working in caring professions were at greater risk of developing CF due to their increased ability for expressing empathy, and exposure to patients who had experienced trauma (Figley, 1995; Hooper et al., 2010). Burtson and Stichler (2010) found a correlation in acute care settings between CF and burnout, and that these factors may impact nurse caring.

Burnout. Lazarus and Folkman (1984) identified burnout as a consequence of prolonged exposure to emotionally demanding circumstances and inability to cope. When participating in a study investigating the lived experiences of the time preceding burnout, nurse participants reported being caught between motivating challenges and unlimited demands (Ekstedt & Fagerberg, 2005). The participants' desire to do well increased their focus on responsibilities and coping, but eventually led to disappointment and exhaustion as they continued to deal with persisting pressure (Ekstedt & Fagerberg, 2005). The

participants in the aforementioned study described self-neglect of their own self-care activities and unmet basic needs resulting in emotional exhaustion and lack of professional accomplishment (Ekstedt & Fagerberg, 2005).

The Maslach Burnout Inventory (Maslach, Jackson, & Leiter, 1996) consists of three stress response outcomes that include emotional exhaustion, feelings of cynicism or detachment from the job, and lack of professional accomplishment. Workplace stressors and environmental factors such as workload and lack of supervisor or colleague support were noted to impact these three dimensions of burnout (Ersoy-Kart, 2009; Escriba-Aguir & Perez-Hoyos, 2007; Flarity, Gentry, & Mesnikoff, 2013; Jenkins & Elliott, 2004; Rios-Risquez & Garcia-Izquierdo, 2016; Yoder, 2010). The decreased occurrence of emotional exhaustion and depersonalization was influenced by positive nurse-physician relationships (Li, Bruyneel, Sermeus, Van den Heed, Matawie, & Aiken et al., 2013; O'Mahony, 2011). Emotionally exhausted nurses were less likely to participate in organizational affairs, contributing to feelings of low job control (O'Mahony, 2011). Findings by Browning et al., (2007) determined that ED nurses experienced a greater loss of job control, burnout symptoms, hostility, stress and depressive symptoms when compared to nurse practitioners and nurse managers. Changes in job demands, loss of job control and social support are noted to influence long-term job satisfaction, engagement, emotional exhaustion and desire to leave the profession (Adriaensenns, De Gucht, & Maes, 2015; Browning et al., 2007).

Moral Distress. Moral distress (MD) reflects being restricted from pursuing what is believed to be the right action by limitations of the environment, and was noted to contribute to nurses' desire to leave their jobs, or the profession altogether (Austin,

Bergum, & Goldberg, 2003; Jameton, 1984; Wolf, Perhats, Delao, Moon, Clark & Zavotsky, 2016). Austin et al., (2003) explored the experiences of MD in nurses working in Canadian mental health settings and noted that the role of a healthcare provider comes with great responsibility but not great power or control. The reported emotional consequences of morally distressing situations had been described as systemic and included feelings of decreased self-worth, depression, helplessness, despair and physical symptoms of stress (Wolf et al., 2016; Wilkinson, 1987/1988). ED nurses were found to generally report low levels of MD, however those considering leaving their positions reported high levels of MD (Fernandez-Parsons, Rodriguez, & Goyal, 2013).

Occupational Stressors in the ED and Acute Care Mental Health Settings

ED nurses are faced with higher job demands and less decisional authority due to the unpredictable nature of their work (Adriaenssens, De Gucht, Van Der Doef, & Maes, 2011; Basu, Yap, & Mason, 2016). Nurses identified heavy workload, overtime, staffing shortages, and repeated exposure to traumatic events as continuous stressors in the ED (Browning et al., 2007; Garcia-Izquierdo & Rios-Rizquez, 2012; Healy & Tyrrell, 2011; Hu, Chen, Chiu, Shen, & Chang, 2010; O'Brien-Pallas et al., 2010; Ross-Adjie, Leslie, & Gillman, 2007; Sawatzky & Enns, 2012; Wolf et al., 2016). Additional factors included overcrowding, lengthy wait times for admitted patients requiring an inpatient bed, time pressures, frequent users, violence and aggression towards healthcare staff, poor managerial support and shift work (Adriaenssens et al., 2015; Browning et al., 2007; Fernandez-Parsons et al., 2013; Flarity et al., 2013; Garcia-Izquierdo & Rios-Risquez, 2012; Healy & Tyrrell, 2011; O'Brien-Pallas et al., 2010; Ross-Adjie et al., 2007; Sawatzky & Enns, 2012; Wolf et al., 2016).

A unique aspect to patient care in the ED was turnaround time. Patient turnaround time was categorized as the ability for staff to quickly treat care needs and move patients out of the ED either into an inpatient bed, or discharge home. This pressure was present in medical nursing in the ED but also presented unique challenges for nursing staff attempting to address psychiatric care needs due to the systematic pressure to decrease patient turnaround time (Marynowski-Traczyk & Broadbent, 2011). Additionally, role ambiguity and conflict have been shown to be a factor in nurse turnover where nurses experience opposing demands and unclear expectations (O'Brien-Pallas et al., 2010; Wolf et al., 2016).

Psychiatric nurses (PNs) working in a Winnipeg, Manitoba ED reported that triaging, interdisciplinary functioning, safety concerns, and workload were the most concerning stressors of their work environment (Clarke et al., 2005). Specific to acute mental health care settings, the challenges of heavy workloads, managing patient aggression, and limited resources were discussed in the literature (Edward, Ousey, Warelow, & Luis, 2014; Jackson & Morrissette, 2014; Jenkins & Elliott, 2004; Humble & Cross, 2010; McArthur & Montgomery, 2004). Happell (2008) noted that stressors within psychiatric nursing was related to working with individuals who pose a threat to themselves or others, and frustration related to role overload, role conflict, and issues with the physical environment.

A theme of role confusion regarding the PN emerged from the literature (Clarke et al., 2005; Humble & Cross, 2010; Jackson & Morrissette, 2014; Jenkins & Elliott, 2004; McArthur & Montgomery, 2004). Humble and Cross (2010) described the experiences of PNs in mental healthcare settings as being different from other healthcare professionals.

Misconceptions about psychiatric nursing were noted by participants who described that "psychiatric nurses wear the stigma of their patients" (Jackson & Morrissette, 2014, p. 140). McArthur and Montgomery (2004) described role conflict when ED staff perceived the PN as a gatekeeper to inpatient beds when they had no control over patient flow.

Coping Strategies

Lazarus and Folkman (1984) defined coping as the dynamic cognitive and behavioral attempts to deal with outward or inward stressors that may be perceived by the individual to be exhausting their own resources. Coping was seen as process-oriented, where the individual thinks and then acts based on their appraisal of the perceived demands and available resources of the encounter (Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986). There were no assumptions about what was right or wrong when exploring how an individual copes with a situation, but rather whether or not that individuals efforts to cope were successful (Folkman et al., 1986). Regulating stressful emotions and changing the upset person-environment relationship causing the distress are the two major functions associated with coping strategies (Folkman et al., 1986).

Udod and Care (2012) explored the stress experiences and coping strategies of nurse managers in acute care settings and found a variation in coping strategies identified and utilized by participants. The primary strategies used included peer and superior support, cognitive coping strategies, and social and personal strategies (Udod & Care, 2012). Udod, Cummings, Care and Jenkins (2017) identified that nurse managers utilized planful problem solving, reframing of stressful situations, and having social support to cope with ongoing exposure to stressful situations.

Riberio, Pompeo, Pinto, and Riberio (2015) also identified that nurse participants working in hospital emergency services used more than one coping strategy when dealing with stressful situations. Commonly used functional strategies included problem solving, positive reappraisal, and social support (Riberio et al., 2015). Less commonly used were confrontation, distancing, and acceptance of responsibility (Riberio et al., 2015). Healy and Tyrrell (2011) noted that nurses often sought assistance to reflect and debrief informally with peers or colleagues as a positive way to cope with demanding circumstances. Nurses who perceived more social support from peers reported being more able to express their feelings, while those less able suffered more commonly from feelings of depersonalization (Ersoy-Kart, 2009).

Summary

Factors affecting nurse turnover and absenteeism impact the quality of patient care, escalating health care costs, and the stability of the work environment (Sawatzky & Enns, 2012). Gaining the unique perspective of mental health nurses working in the ED would provide meaningful understanding of the perceived stressors and coping strategies employed by nurses in this setting. This information may aide nurse supervisors to develop resilient and engaged psychiatric nursing teams within the ED and contribute to the body of nursing literature specific to psychiatric nursing. Acting to minimize the direct and indirect losses and expenditure associated with nurse turnover and absenteeism should be a priority for healthcare organizations, where clinical outcomes are affected.

Chapter 3: The Research Design

A qualitative descriptive approach was chosen to explore the topic of how mental health nurses working on an emergency mental health team perceived occupational stressors and how they utilized coping strategies. This chapter provides an outline of the theoretical framework and methodology utilized and includes sampling, data generation and analysis. Also discussed is the researchers' engagement in self-reflection, trustworthiness, limitations, and ethical considerations.

Theoretical Framework

The Theory of Stress and Coping was used as a structure for this investigation as it accounted for an individualized cognitive approach to stress and coping. This framework addressed "two processes, cognitive appraisal and coping, as critical mediators of stressful person-environment relations and their immediate and long-range outcomes" (Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986, p. 992). Cognitive appraisal is the process where an individual determines if a situation is relevant to their wellbeing, while coping is the individuals' cognitive and behavioral approach to manage internal and external environmental demands (Folkman et al., 1986; Lazarus & Folkman, 1984). The congruency between the individuals' appraisal of the situation and reality, as well as the appraisal of coping options determines whether or not strategies employed to manage stressful events are functional or dysfunctional (Lazarus & Folkman, 1987). This framework has proven useful in previous investigations where the relationship between the nurse and their work environment, stressful situations, coping strategies, and perceptions on one's health are being explored.

Emotion-focused coping and problem-focused coping are two identified mediating processes that individuals use to attempt to control stressful emotions and change the person-environment interaction causing the distress, respectively (Folkman et al., 1986). Short-term outcomes are concerned with the resolution and quality of the consequence, whereas long-term outcomes include the physical health, subjective wellbeing, and social functioning of the individual (Lazarus & Folkman, 1987). Gaining an understanding of the context of environmental stressors is critical in the process-oriented approach where "coping is assessed as a response to the psychological and environmental demands of specific stressful encounters (Folkman et al., 1986, p. 992)."

Research Purpose and Question

The purpose of this descriptive study was to describe how emergency department (ED) nurses working on an Emergency Mental Health Team (EMHT) in an urban setting, experience and cope with occupational stress. This investigation seeks to answer the question: what is the lived experience of dealing with occupational stress as a mental health nurse working on an emergency department mental health team?

Research Methods

This investigation was based on the qualitative descriptive approach where participants describe how a particular phenomenon was experienced (Polit & Beck, 2012). This approach was developed from constructivist inquiry where the objective of research is meant to understand an individuals' experience while acknowledging the multiple ways an event can be perceived (Polit & Beck, 2012). A content analysis was used to examine participant narratives as it required a low level of interpretation and is a well-suited approach to the complex phenomena of nursing (Vaismoradi, Turunen, &

Bondas, 2013). In this research study, participants described their experiences working as a mental health nurse in an ED on an EMHT.

Sampling

In a descriptive study, it is important all participants have experienced the phenomenon under investigation; therefore, purposeful sampling was utilized (Creswell, 2013). A homogenous sample of 8 participants was obtained by establishing inclusion criteria (Patton, 2015) that included: 1) Registered Psychiatric Nurses and Registered Nurses, 2) who had worked in a regular full or part-time position for a minimum of one year on an EMHT in one of two designated urban settings, and 3) were willing to discuss their experiences. For the remainder of this paper, EMHT nurses will collectively be referred to as mental health nurses.

Recruiting was initiated March 5, 2018. Invitation letters (Appendix B) were distributed in designated staff common areas and via work email to potential participants once approval was obtained from the Brandon University Research Ethics Board, the University of Alberta Health Research Ethics Board, and from Alberta Health Services. Interested potential participants contacted the researcher through confidential email or telephone. Interviewing commenced between the period of March 19 through April 30, 2018.

Six participants were recruited from site A and two participants were recruited from site B. Two participants were male and six participants were female. Six participants were full time while only two participants were part time. The average age of participants was 35. The average length of time participants had been working as nurses averaged 8.75 years while the average length of time participants had been working on a

mental health team in an ED setting was 4.8 years. The EMHT at site A had been established approximately nine years ago while the team at site B had been established approximately five years ago. Many of these nurses had been immersed in this setting since graduation, since the inception of the EMHTs, or had come from other highly acute psychiatric settings. As these nurses had been working in part-time or full-time lines in the ED for greater than one year, they were deemed to have been exposed to a wide range of patient presentations and scenarios. Interviews ranged between 26-63 minutes with an average length of time of 49.5 minutes.

Data Generation

Research data was generated through digitally recorded, open-ended interviews guided by open-ended questions (Appendix D). Moustakas (1994) indicated that participants are asked two general broad questions followed by several other open-ended probing questions to gather data that would describe the phenomenon as an understanding of the shared experience among participants (Creswell, 2013). In this investigation, participants were asked three general broad questions that were then followed by other open-ended probing questions. Interviews were conducted in a setting that was preferable to each participant. In this particular study, all participants were interviewed via telephone. The first participant requested this data collection method of being interviewed therefore it was offered as an option to all participants interested in the study. Most participants indicated they worked long hours in either their full time lines or picked up extra if they were part-time. Days off were busy with juggling other responsibilities and managing young children. Participants indicated that being interviewed by telephone was most convenient at the time the research was being conducted.

The researcher ensured to incorporate good interviewing techniques as described by Creswell (2013) that included sticking to the interview questions, completing the interview within the time previously specified and being respectful and courteous to participants. The researcher did not offer advice during the interview and was mindful that being a good listener was preferable to being a frequent speaker (Creswell, 2013). Throughout the interview the researcher made quickly inscribed notes of the content of the participant's description of experiences. These notes were referenced during the interview to ensure all questions had been answered and to also relay information back to participants to seek clarification of the meaning of participants' experiences.

Data Analysis

Elo and Kyngas (2008) described the process of content analysis in a qualitative investigation that begins with immersing oneself in the data content to obtain a sense of participant experiences as a whole. Vaismoradi et al. (2013) and Polit and Beck (2012) identified that this includes transcribing participant narratives and re-reading them multiple times. The researcher transcribed audio-recorded interviews by hand into a locked word document within three days of the interview. The researcher then listened to each interview once during transcription, a second time to ensure accuracy of the transcription, and a third time to reflect and focus on the content of each interview and its prominent themes and meanings. The researcher originally planned on using NVIVO software, however after careful consideration with the researcher's thesis committee it was determined that due to the small sample size, processing the data by hand was a more meaningful way to immerse oneself in the data.

The next step in data analysis was to code the data content or create categories by grouping codes or categories under headings, and formulating a general description of the phenomena (Elo & Kyngas, 2008). This included creating initial codes or categories, defining or naming themes, reviewing the themes, and searching for themes. The researcher carefully read through each interview and extracted significant statements and quotes from narratives. Significant statements were then extracted and placed into corresponding numerical lists that pertained to either stressors or coping strategies. There were one hundred and ninety-six statements particular to stressors, and two hundred and three particular to coping. Statements were combined into theme clusters where meanings were organized into groups and sub-groups to thoroughly describe the phenomenon.

The researcher sought feedback from committee members prior to approaching participants for feedback on the themes and subthemes that would be used to describe the phenomenon of working as a mental health nurse on an EMHT. Three randomly chosen participants were contacted for feedback nine months post-interview. A brief summary was written based on each interview alongside a summary of research findings and reviewed with each participant during a telephone interview. The participant then had the chance to clarify or provide feedback during that time to ensure the description accurately reflected their experiences. The researcher also summarized their understandings of the participant's experiences back to the participant at the conclusion of each original interview. Any feedback obtained during these interviews was included in the description of the phenomenon. Participants that participated in providing feedback indicated that the identified themes, subthemes, and description of each summarized their experience well. One participant stated that one or two of the subthemes might have not been particularly

relevant in their own personal experience, but acknowledged that those subthemes were likely commonplace for others working on the EMHT. Therefore, there were no modifications made to the themes based on feedback from participants.

Elo and Kyngas (2008) described the final step as reporting the results of the analysis in terms of a story line, map, or model. Polit and Beck (2012) described this final stage as including a thorough description of the phenomenon as it was described by participants. A description was written for each theme and subtheme which, as a whole, comprises a thorough summary of what it was like for participants to work as a mental health nurse on an EMHT. These results will be reported in written format in this thesis report as well as orally in a prepared defense.

Reflexivity

According to Polit and Beck (2012) the researcher should be aware of one's personal effect on the research process. This can include a particular background or set of values, and personal and professional character (Polit & Beck, 2012). While the researcher kept personal notes throughout the interview process, the researcher did also engage in self-reflection beforehand and during the research process.

I have not worked in an ED nor an EMHT however, I currently work on a small locked psychiatric unit. This unit is considered a highly acute practice setting therefore I anticipated that personal experiences regarding stressors about patient care in this environment may be similar to what participants in this investigation may have experienced. Previous to this position, I worked in a capacity that was in regular contact with EMHT's and nurse consultants from various ED's and was privy to the external pressures that influenced ED services.

As part of the graduate thesis research process, a literature review on emergency department nursing and emergency department mental health nursing was completed prior to participant interviews. Therefore, I was previously aware of what might be identified as stressors and coping techniques in this environment. I also considered what my own responses might be when developing the interview questions. It was helpful for me to consider personal experiences and awareness of existing knowledge on the topic to remain self-aware and objective through the research process.

During participant interviews I used broad open-ended questions to initiate the interview and used participant cues to guide the discussion. I intentionally used silence and minimal encouragers to encourage the participant to continue talking. Paraphrasing, short probing questions, and refining statements were also used to seek clarification of participant answers. While I discovered that numerous participant experiences and responses were indeed similar to those of my own, I refrained from sharing personal experiences during the interviews. I chose to focus on participant answers to gain a more thorough understanding of the participant experience. As a result, a detailed description of the lived experience of a nurse working on an EMHT was derived.

Trustworthiness

Polit and Beck (2012) reviewed the framework of Lincoln and Guba (1985) for developing trustworthiness of a qualitative study. These are: 1) credibility, 2) dependability, 3) confirmability, and 4) transferability. Confidence in the truth of research findings was described as credibility, while dependability was described by Lincoln and Guba (1985) as the stability of the data over time and circumstances (Polit & Beck, 2012). The circumstances of working in the ED are constantly fluctuating due to

the unpredictability of patient presentations and circumstances. However, participants had similar experiences when it came to discussing the past and present challenges of this workplace environment. It would be very likely that should this research be conducted an additional time, that similar experiences would be shared. Two ways the researcher sought to enhance credibility and dependability within this investigation were through data triangulation and member checking.

Data triangulation utilizes the use of more than one data source for the intention of authenticating conclusions (Polit & Beck, 2012). Principles of data triangulation (Polit & Beck, 2012) were utilized, as participants were gathered from two EMHTs embedded in their respective EDs in an urban setting. Member checking (Polit & Beck, 2012) was completed during the original interviews throughout the interview and at the conclusion of each interview, and then again with three randomly chosen participants nine-months post interview when a description of the phenomenon had been developed. The researcher used member checking as a way to verify the accuracy and clarify their understanding of participant's experiences working in the ED on the EMHT.

Other ways the researcher sought to enhance the credibility of this investigation was through audiotaping interviews, transcription rigor, and reflexive journaling. Polit and Beck (2012) outlined that transcribing interviews must be done with rigor by checking the quality of the transcriptions. The researcher personally transcribed the interviews and listened to each interview a minimum of three times. The first time was during the initial transcription, a second time to ensure accuracy, and a third time to consider prominent themes and topics evident in each interview. This was done within three days of each interview and gave the researcher an opportunity to also review their

interviewing techniques. The researcher also kept a reflective journal document with brief notes following each interview to document personal thoughts and feelings. This was in an attempt to identify personal experiences with the phenomenon to ensure the influence of the researcher's previous expectations and experiences were minimized.

Confirmability was known as the objectivity of data where the interpretation represents the participants experiences rather than the researchers' imagination (Polit & Beck, 2012). Developing an audit trail enhances the confirmability and dependability of a study as it outlined how the researcher processed the original data from transcribed interviews into a description of the phenomenon was significant when establishing authenticity and trustworthiness of the description (Streubert & Carpenter, 2011). The researcher maintained an audit trail to show each step of data analysis reflecting how data was extracted, grouped and described. This included locked word documents of the transcribed interviews and the numerical list of significant statements and quotes for both stressors and coping as they were coded and grouped into themes and subthemes.

Transferability is the potential for findings to be applied to other settings or groups (Polit & Beck, 2012). A thorough description including verbatim descriptive phrases from participants was derived from the interview data. Writing a vivid description of participant experiences augments the transferability and credibility of this study. It should be noted that due to the small sample size and unique design of the EMHT's included in this study, findings are limited to the environments from which they came.

Ethical Considerations

Approval was obtained from the Brandon University Research Ethics Board and the University of Alberta Health Research Ethics Board, as well as operational approval from Alberta Health Services management. In research, the researcher is viewed to be in a position of power over participants therefore participants may feel obligated to do as instructed. For the purposes of this project, the researcher was not in a supervisory position over potential participants and not in a position of authority. To address the power gradient between researcher and participant, Polit and Hungler (1999) described that participants must be treated with self-determination. That is, the participant has the right to decide voluntarily to participate and/or withdraw from the study at any time without risk of prejudicial treatment or penalty; furthermore, participants have the right at any point in time to refuse to give information or ask clarification about the purpose or procedures if the study is free of coercion (Polit & Hungler, 1999). Participant's written consent was obtained (Appendix C). The consent form notified participants that they had the right to withdraw at any time, outlined the primary focus of the investigation, described methods chosen for data collection, strategies to protect participant confidentiality, and associated risks and benefits of participation (Creswell, 2013). Prior to the start of each interview, each participant was asked if they understood their rights as a participant in the research study and were asked if they needed clarification about any aspect of the study.

This study was deemed by the researcher and the ethics review panel to be minimal risk to participants. Minimal risk was determined as the anticipated risks of taking part in the study are no more than those encountered in day-to-day life (Polit & Hungler, 1999). Participants contributing to this research described the impact of

occupational stress on their lives that may have been distressing. Appropriate supports were identified to staff both before and immediately following the interview process and were also included on the informed consent document of which the participants were given a copy.

Transcribed data derived from interviews were securely stored into locked word documents and protected by a confidential password. Direct identifiers of participant identities were removed from all documents during the transcription process therefore the risk of re-identifying participants are low. Indirect identifiers, such as basic demographic information used to provide context to research findings, was kept separate from transcribed interview data as an effort to maintain participant anonymity. Digitally recorded interviews, consent forms and research notes were locked in separately secured locations. All efforts were made to maintain participant confidentiality in the storage of data and during the dissemination of findings. This was particularly important as participants may have relayed information that reflected poorly upon the healthcare organization. Should participants identities be made known, it was possible that they may have faced criticism or prejudice from their employers. Only the primary researcher has exclusive access to the password of the transcribed research files.

Summary

This chapter included the research design details utilized from a qualitative descriptive approach to explore the research question: what is the lived experience of dealing with occupation stressors as a mental health nurse working on an emergency mental health team? This approach is concerned with how individuals experience a phenomenon. The theory of stress and coping was employed as a foundation for this

investigation as it considered an individuals' cognitive appraisal of a situation and how that individual coped with the associated stressors. A content analysis was conducted as part of the data analysis, to process participant narratives. Eight participants were recruited for this study who met the inclusion criteria and were interviewed via telephone using open ended questions. Reflexivity on behalf of the researcher was discussed, as were factors impacting trustworthiness and limitations of the study. Ethical considerations were also outlined.

Chapter 4: Findings

The themes that emerged in the data analysis process were divided into two major categories of stressors and coping strategies. Under stressors, the identified themes include: feeling morally distressed about patient care, working in an exhausting environment and incivility in the workplace. Coping strategies include: learning to work together, a shift in perspective, and maintaining work-life balance. Many of these themes were broken down into subthemes to further specify participants' experiences and will be described in detail in each section.

Demographic Data

Participant #	1	2	3	4	5	6	7	8
Age	48	37	43	32	37	28	27	29
RN/RPN	RPN	RPN	RN	RN	RN	RPN	RN	RN
Number of years working as a nurse	11	10	13	9	11	5	5.5	6
Number of years working on an EMHT	7	5	6	3	4	3.5	5.5	5

Table of Themes

Stressors

Theme	**Subthemes**
Feeling Morally Distressed	Managing time scarcity Feeling spread thin Doubting one's clinical competence Not having the ability to influence patient movement
Working in an Acute and Uncertain Environment	Feeling on edge Feeling desensitized Lack of a purposely built space Dealing with the impact of stigma towards patient care

Incivility in the Workplace	Having discord with the general emergency department staff Experiencing friction among EMHT colleagues

Coping Strategies

Theme	**Subthemes**
Learning to Work Together	Developing and nurturing positive work relationships Supporting EMHT colleagues Feeling supported by management
A Shift in Perspective	Remaining patient focused Utilizing professional skills to navigate the workplace Adapting one's nursing practice
Maintaining Work-Life Balance	

Stressors

Participants identified being constantly exposed to workplace stressors when working on an Emergency Mental Health Team. Many of these stressors related to seeing patients during the most acute phases of the patients mental health crisis, and the acute care environment where time pressures were high and there was a continuous demand for services. Participants recognized a number of ways they were impacted by workplace stressors including emotional and physical health, as well as social isolation from family and friends. The themes include: 1) feeling morally distressed about patient care, 2) working in an acute and uncertain environment, and 3) incivility in the workplace. These themes contain subthemes to further specify participant experiences.

Feeling Morally Distressed

In this theme, participants described how they felt morally distressed that patient care did not meet standards of care due to conflicting environmental factors. Participants described feeling frustrated and anxious in the ED due to an increased sense of

responsibility for patient care and a lack of control over the environment. Participants explained that patients presenting to the ED were often in the acute stages of their illnesses and therefore required more time and effort to assess and care for. Due to the quick turnaround time for ED services, participants felt pressured to quickly assess and determine a suitable path of care including either inpatient or outpatient involvement, for each patient. EMHT participants involved in this investigation were also expected to subsequently treat both psychiatric and medical comorbidities. However, when a patient's primary diagnosis was medical in nature, it was felt their care should be prioritized by general ED nursing staff. The EMHT was relied upon by the general ED for their specialized skillset but indicated they had little influence over whether a patient was discharged or admitted to inpatient psychiatric units. Thus participants felt restricted by the environment at times when trying to do what was best for their patients. Participants said it was commonplace to second-guess their clinical judgment and were often frustrated by constantly having to advocate for patients seeking help. Feeling morally distressed is divided into four subthemes which includes: managing time scarcity, feeling spread thin, doubting ones clinical competence, and not having the ability to influence patient movement.

Managing time scarcity. Participants described feeling pressured to complete tasks quickly and competently in this environment to be able to keep up with the complex and urgent nature of ED services and patient presentations. Participants described a dynamic, fast-paced, and time sensitive practice setting where they were challenged to perform a wide range of nursing skills in both their mental health and medical training. For many participants, promptly dealing with acute medical complexities was identified

as a challenging component of this environment and proved to be a huge learning curve especially when first hired. Many participants had previously spent time working in areas of mental health care where medical skills were not the primary focus of their roles. Participants identified that managing medical comorbidities had become easier over time but was difficult to balance at times while also prioritizing mental health status examinations and behavioral crises of other patients. One participant summarized how time scarcity played a role in managing patient care:

'So while you are running around and dealing with the physical nature of someone's issues due to bed shortage, um, you can't move them to a medical bed, so you have to deal with them on the mental health side. And um, you're hanging this and that, as in you're doing IV therapy and doing ECGs and you know so um, many you're dealing with so many physical health aspects of the patients care. And then you also have other patients that also demanding your time. And once you're dealing with all those…that means you're not up to grab the next client that needs an assessment done. So that can be a very huge source of stress' (Participant #1).

Participants often voiced that there was minimal time to give extra care and attention to patients if needed, particularly when it came to medical comorbidities. One participant gave an example of not being able to keep up to an hourly alcohol withdrawal assessment that was needed for a patient due to the heavy workload in the department.

'…I have had four patients at night and I had to do CIWA's [Clinical Institute Withdrawal Assessment] *on two of my patients and the other nurses too were also very busy. We couldn't help ourselves but sometimes in those situations we don't even have the chance to help you at that point… I think I had to do that every hour, and I couldn't even keep up to that hour. So every hour plus which is not so good for the patients. Because if you have to do some other things on top of still caring for these patients that need extra care' (Participant #4).*

Participants felt time constraints were especially impactful when attempting to develop therapeutic rapport with patients. Having minimal time to develop a relationship with a new patient could pose challenging particularly when managing difficult patient behaviors or mitigating crises situations. Participants outlined that in comparison to an

inpatient setting where nursing staff had days or weeks to develop their relationship with a patient, EMHT nurses had a much shorter period of time usually consisting of a few hours to one or two shifts.

Feeling spread thin. Participants indicated they felt overextended in the workplace on a regular basis. Factors that were thought to influence these feelings included heavy workload, high turnover of patients and staff, orientation of new staff, and continuous demand for EMHT services. Participants speculated that staff turnover and shortages were likely due to continuous exposure of a high volume and acuity of patients moving through the EMHT and the associated workload. It was indicated that after prolonged exposure, some staff no longer enjoyed that type of environment or may have felt overwhelmed. This was identified as a factor that led to staff calling in sick for their shifts.

Several participants expressed concern about the process of orientating new staff as a tiring experience that added to the overall workload, especially if one was orientating new staff on a regular basis. Participants stated when working with staff that weren't fully trained meant they also had to keep an eye on the new staff member and their patient assignment on top of their own. Yet participants indicated there were times when it was very difficult to find enough staff to cover shifts especially when acuity in the area was high. One participant stated it was not uncommon to hear that casual staff were no longer picking up in the EMHT area and felt that this could be attributed to inability of EMHT staff to fully support these casual staff members. This participant described the scenarios as follows:

'…especially with casual staff because they only (casual staff) only come there when they are needed where you are having 4 or 5 patients, … but on top of your own patients you

are also looking into some else's patient load as well. So the pressure seems to be too much sometimes' (Participant #5).

Participants described staffing ratios as acceptable when the team was fully staffed during the day and evening shifts. However, there was a general consensus that on nights or at times when the EMHTs were down a nurse, participants felt unsafe and overwhelmed by the amount of work. Participants explained that the amount of work did not stop or lighten during night shift and was just as busy and acute as a day or evening shift. Participants stated they often felt it was unsafe to leave their coworkers to take a break during these times in the event a dangerous situation was to occur. A participant summarized how overwhelming this increased staffing to patient ratio could be:

'Sometimes we fill it up sometimes we don't, with the turnover. Most times, at night we are down a nurse and we are still doing all of these things. Most times at night it makes you, you don't really give the patients the care they deserve because triage is always calling 'oh there is a patient and you need to drop what you are doing to take this patient'. When they know that at night we are down a nurse taking care of (a number) of patients. And at the same time there might be 2 or 3 beds that we might be discharging and charting, and that can be challenging' (Participant #5).

Participants also felt overwhelmed, frustrated and helpless that the demand for mental health services in the ED seemed to rely solely on the EMHT. It was thought that basic mental health competency within the general ED nursing staff was diminished and as a result, EMHT staff were constantly sought after to assist with patients outside of their designated space. The mental health assessments provided by the EMHT were thorough, comprehensive, and took a great deal of time to complete. EMHT nurses determined an appropriate care plan for each individual patient including either inpatient care or discharge home with a connection to outpatient services, for example. This could be a laborious process on top of managing the patients the team had within their designated areas, meaning they were not always available to assist the greater ED if requested.

Doubting one's clinical competence. Participants described feeling self-doubt when it came to their clinical practice particularly as it pertained to the level of responsibility involved in their nursing care. Patients presenting to the ED often had complex care needs and had serious mental health concerns that could be threatening to themselves or others. EMHT staff responsibilities included caring for patients, completing thorough and accurate mental health assessments, managing physical care needs, and assisting physicians in determining appropriate patient dispositions. Participants stated ED physicians and psychiatry staff trusted the assessments and recommendations from the EMHT nursing staff. Mental health assessments and managing patient behaviors were described as lengthy, time-consuming processes where outcomes were not immediately measurable. Determining a plan that was suitable and safe for each patient took time to organize, particularly when coordinating community supports and resources. Participants described feeling frustrated when they felt their clinical opinion was not considered. An example of this included when nursing staff felt a patient needed to stay and be seen by psychiatry, but felt the ED casualty officer would not consider the nurses' assessment or plan and discharged the patient instead. One participant described how nurses often ended up upset with this process:

'Where I find um, some frustration for the nurses can come from, um with some doctors, it's not about your assessment, it's about um, what route or what decision they want to make. And that is um, on every situation or every case you deal with them. So it's almost like, um, why did you actually sit down and do the assessment if someone is not going to listen to you. At least in part. You know. It is good when you're listened to and then if the doctor decides to make a different decision, that's fair. Um, at the end of the day, um they are the most responsible care provider at that time. That responsibility lies with them. And like I said, that difference of clinical judgment is a good thing. The most important thing is the outcome for the client' (Participant #1).

Another aspect of doubting one's clinical confidence was in relation to missing an important piece of a patient assessment particularly in reference to suicidal and homicidal risk. The majority of participants mentioned how they doubted their decision-making skills and recommendations for care. This worry was described as follows:

'…it's rewarding and um, you know like um, but at the same time there's also situations where, you know, like, you finish your shift and you're reflecting and asking yourself, you know like, was this decision the best decision? Was it safe? You know, like that kind of thing' (Participant #1).

Participants described that having keen mental and physical assessment skills was important to their jobs on the EMHT. While most participants expressed doubting their mental health assessments at one point or another, many indicated weariness when it came to managing medical comorbidities. Several participants described that re-familiarizing oneself with the medical aspect of patient care, after working for several years in mental health focused roles, was overwhelming at the time of hire and continued to be a challenge of working in the ED. One participant described their experience managing both medical and psychiatric comorbidities:

'It's interesting I think it's difficult to juggle the medical acuity and the psychiatric acuity. Um, I think there's a lot of prioritization that needs to happen there. That's with any nursing job but I do find that is especially difficult if you have someone on close monitoring, and then there's also behavioral management in the next room. So that's an interesting aspect of it I guess' (Participant #7).

Participants described how an unnoticed or untreated medical condition such as delirium could have potentially serious consequences on the patients' overall well- being. Additionally, participants voiced feeling limited in their ability to manage medically compromised patient situations. Partly this was due to differences in training and scopes of practice compared to general ED nurses, but also to the lack of necessary medical equipment such as cardiac monitors within the EMHT space. This medical monitoring

equipment was seen as a safety risk that may be used by a patient to harm themselves or others. Generally, participants described having to care for patients who required a higher level of medical care that was not easily given by the EMHT, but due to bed unavailability and high ED volumes were unable to move the patient requiring this care back into the general ED.

Not having the ability to influence patient movement. Participants felt powerless when a patient was assessed and admitted to psychiatry then spent lengthy periods of time in the ED awaiting the availability of an inpatient bed. Participants considered this a significant stressor as EMHT areas were not set up for lengthy stays and had limited options for engaging patients in therapeutic activities. Wait times for inpatient beds were noted by participants to be lengthy, upwards of several days at times. One participant described:

'Especially when its like, those heavy patients and they've been waiting to be admitted for 5 days and you're beginning to feel like this is an inpatient unit only it's not because you don't have any of those like, they're not going to groups they're not actually making any med changes they don't have privs, you can't let them go anywhere or tell them you know, go to the TV room for an hour and take a break kind of thing. Um, they're just in this really small confined space and after five or six days of that everyone is just feeling kind of on edge' (Participant #8).

This participant also conveyed their feelings about the larger healthcare system in general:

'It's not the patients fault, it's not the managers fault, it's not the bed managers fault, it's not the doctors fault. So you're just left feeling like, I think sometimes I start to feel like you're just stuck in a system that is so broken and it's never going to get better which you know, is not anything that has to do with the patient. It's just the feeling that alternately gets brought up. Like, oh god the system sucks…and you start to kind of feel like you're just this tiny cog in this big system and, but I mean on a more personal level it's just a lot more frustration…' (Participant #8).

Participants recognized they had no control over patient movement within the system and therefore felt helpless when there was increased pressure from the ED to transfer admitted patients onto inpatient units. The backlog of patients awaiting an inpatient mental health bed was attributed to a systems issue where blame cannot be placed on any one person or individual. Yet participants clearly described the impact of this aspect of the environment as it contributed to the development of other challenges in this workplace such as increased patient and staff tensions.

Working in an Acute and Uncertain Environment

Under this theme, participants described how factors that contributed to the high acuity and uncertainty of the environment influenced their outlook of patient care. Participants reported that patients presenting for mental health concerns did so during times of psychiatric emergency or crises. The perceived demand for inpatient and EMHT services was described as high, and participants felt continuously overwhelmed and over-stimulated. Working with patients in the most acute stage of their illnesses often coupled with substance abuse, was reported to be challenging and emotionally and physically exhausting. Participants always felt they needed to be on high alert to maintain the safety of themselves and others and were accustomed to dealing with patients when they were angry or aggressive. Participants outlined how their ability to provide care was impeded by the physical space of their work environment. Additionally, participants indicated they spent a considerable amount of time ensuring that patients mental health history did not overshadow their potential medical concerns. The theme of working in an acute and uncertain environment is divided into four subthemes that include: feeling on edge,

feeling desensitized, lack of a purposely built space, and dealing with the impact of stigma towards patient care.

Feeling on edge. Participants described a persistent need to be hypervigilant of their surroundings while on shift. This was particularly prevalent when patient acuity was high and the staff to patient ratio was perceived as not ideal. One participant emphasized:

'The lasting stress is just going to be, I guess not necessarily from the aggression, but having to be on edge when we are sort of overwhelmed with numbers. Like having three or four secure admissions that are unsettled and we only have two secure rooms plus there's an AWOL risk and we have maybe have uh, less diligent staff on duty' (Participant #2).

Due to the high turnover of patients in this setting and the acute nature of the majority of patient presentations, participants emphasized it was important to be thorough in regards to their assessment skills. If an important detail was missed during the assessment and treatment of a patient, it was likely the patient would no longer be in the department for the oversight to be corrected. Participants mentioned that missing a crucial piece of information from a patient, usually referred to as suicidal or homicidal risk, could potentially have serious safety consequences for staff on shift, the patient, and others in the patients' life. Participants viewed the stakes as being higher in this environment as they saw themselves as the last stop for many individuals seeking mental health services and supports. One participant described how constant patient turnover in the ED contributed to safety concerns:

'A lot of the patients are new and you aren't familiar with them and maybe don't have a lot of history so I think there's always that need to be aware of your surroundings and because you don't know what the potential for violence is. And I think a lot of the drug, the meth use and drug use opens, the potential for violence too' (Participant #5).

Participants described a notable difference in the perception of patient and staff safety between the general ED and EMHT staff. In the general ED, patients are taken to a

bed when a bed was ready and the nurse received and assessed the patient when they were able. In contrast, participants from the EMHT placed an overwhelming emphasis on the need to control the incoming patient flow into the EMHT area. Many patients requiring consultation and care by the EMHT are certifiable under the mental health act who may be a risk to oneself or others. Participants explained that moving a patient into a mental health bed without notifying staff meant that patient may be unsupervised for a period of time and may therefore have the opportunity to harm themselves or others, or to flee from the department.. Additionally, participants outlined the need for controlling where a particular patient would be best managed within the small department based on their individual presentation. This participant described:

'And then like, they don't always understand that, we need some control of the incoming flow into the department because, um, especially now there are (a number of) beds and if there is aggressive patients that we are having trouble dealing with at the time like, I don't think they realize the safety risks and stuff like that' (Participant #7).

Participants described a heightened awareness of the location of all individuals within the EMHT area and constantly assessed the safety of the environment. This included staff, patients, visitors, security personnel and exits. Participants explained that the EMHT spaces were small and self-contained within the ED, and the acuity was often high. Most patients are either checked on every 15 minutes, or are maintained on constant observation. Participants stated they were always worried about watching their patients and the unknown factors about what their patients would do within the department including harming themselves, others, or attempting to leave suddenly. Therefore being alert and diligent about managing the patient milieu was imperative to ensure the safety of staff and patients alike.

Feeling desensitized. Participants described resigning that it was normal to experience patient agitation, aggression, and violence as part of their workday. Patients brought into the EMHT area were often brought into the ED against their will by police, had limited insight into their mental status, were in the acute stages of their illnesses, may have been under the influence of illicit substances, and could not leave on their own. This contributed to both the verbal and physical types of aggression and violence that participants described experiencing on a recurring basis in the ED. Several participants explained they were always dealing with patients who were unhappy for one of two reasons: the patient was being admitted to hospital against their will, or alternately, patients who were seeking admission were being discharged home. A participant explained this dynamic:

'…so people a lot of the time, I find it either goes one way or another, it's like people either don't want to be there and usually that's often the people we end up having to keep, or the people who want to be hospitalized are the people who don't need to be hospitalized so don't know I always feel like you have that dynamic with people who aren't, are not happy' (Participant #4).

While the experience of being verbally or physically attacked can be a jarring one, many participants described over time they generally felt familiar with these frequently occurring situations. Participants stated they felt more confident dealing with agitated or aggressive patient events the longer they spent working in the ED. Most participants stated they felt mostly well supported by their colleagues when dealing with these situations, but alluded there was still a feeling of uneasiness when it came to receiving threats. One participant described their mixed emotions in regards to this situation.

'When someone threatens to get people after me, 'My people are coming for you, they're going to find you, they're going to chop you up and there's going to be nothing to find'. And when they're antisocial then yeah, yeah, I might be a little bit concerned. So you

know it desensitizes so much that every time someone says that we're like yeah sure, 'yeah okay, try and find me' (Participant #3).

Participants often referred to aggressive patient situations when giving examples of sources of conflict within the ED. Yet despite the ongoing stress of experiencing verbal and physical abuse from patients, participants felt they were able to remain patient-focused and empathetic towards the patient. One participant described knowing their patients were not feeling well and would not ordinarily speak with the participant in an angry manner if this was not the case.

Lack of a purposely built space. The physical work space and layout of the EMHTs were believed, at times, to have a negative impact on the provision of patient care. Numerous participants cited both the physical work spaces in the EDs as ongoing environmental challenges that were beyond their control. Participants from site B expressed concern about being fit into an available space in the ED and indicated the space could have been set up for a better patient experience had it been planned from the beginning. There were numerous exits in the immediate proximity of the site B EMHT space and the secure rooms were located in an area separate from the nursing desk. A notable concern from site B participants was the appearance of the secure rooms and the impact these rooms had on patients and patient care. One participant explained:

'So even the environment we have (a number of) secure rooms so that gives us some space to work with but then there's times where like, you have people in them that can't come out so we have (a number of) stretchers that are not really… if you have a patient that is escalating or agitated they don't have, you are limited with what you can work with, and even our secure rooms are not very, um, therapeutic. So people come in and they look like a jail cell and they can really put a damper on that relationship, right? So you bring them back from the waiting room and they're like 'why am I in a jail cell?' and you're like 'its not a jail cell…' (Participant #4).

Within the last couple of years, participants from site A had been moved into a larger renovated space designed specifically for the EMHT. Participants indicated this had a significant number of positive impacts on services and was a more conducive area for providing mental health care. One commonly expressed challenge among all participants was being limited in the number of secure rooms available when there was numerous patients requiring secure placement. These patients were often increasingly agitated, exit seeking, or could be aggressive both verbally and physically. In these instances it was preferable the team had access to a room with a locked door to contain the individual for safety reasons. In these instances, EMHT staff managed these patients on a stretcher in a curtained area between several other patients. This scenario was indicated to be less than ideal and could pose a significant safety risk to the patient, staff and other patients in the vicinity. One participant outlined:

'We are right by the doors to the waiting room, so you know you have patients that want to AWOL. It's like that high risk or people when patients are escalating, the doors are opening and everyone in the waiting room can see this escalating behavior and kind of how we deal with it. It's not nice to have people witnessing everything and not nice for the patient when they're not feeling well for people to be walking by.' (Participant #4).

Without access to a quiet and secure room, the ability to reduce stimulation within the ED environment when attempting to de-escalate and settle the patient was difficult to do. In summary, the physical layout of the EMHT spaces influenced participants nursing care options when dealing with patient agitation and aggression while also impacting their ability to maintain patient dignity and privacy.

Dealing with the impact of stigma towards patient care. Participants indicated they felt a patients' mental health history frequently overshadowed their presentation to the ED and thus spent a great deal of time advocating for patients to have their physical

health care needs addressed first. Participants described the need to complete basic medical screening for and care of patients' medical comorbidities. However, this was often complicated by the patients' lack of insight into their own health due to the acute phase of their illness. Participants indicated that what may appear to be an acute stage of a mental illness may, perhaps, be related to an untreated medical comorbidity. Therefore this was identified as an important aspect of caring for the patient as a whole.

Oftentimes, participants described feeling as though they were told an inaccurate story about the patients' presentation with the intention of moving the patient out of the waiting room into an available EMHT bed. While participants agreed it was generally better for patients to wait in a bed rather than in the waiting room, it was felt as though the team was sent behaviorally difficult patients whether they met the criteria of requiring the EMHT or not. Participants described feeling concerned about being sent patients whose medical concerns had been overlooked due to their mental health history. One participant elaborated on this:

'Like someone will come in with a medical concern but they have a history of anxiety or depression and they'll automatically get kind of stigmatized and say oh they're just anxious. And then, it doesn't happen a whole lot but it happens enough that someone is sent to our end when they are presenting for a medical concern and that causes some tension, because it's stressful for us because we're limited with what we can do for their medical concerns there and we often have to really advocate for them to get them properly treated' (Participant #8).

Another participant described how advocating for patient care can create conflict between the EMHT and the general ED team:

'…so many times, we will have to try to educate the nurses at triage why someone who has a history of mental illness on this presentation is unsuitable for, um, to be triaged as a mental health case. So someone comes in with the complaint of an ear ache, you know, but they look into the persons history, the person has a history of schizophrenia. With some nurses think that person automatically has to go to mental health. And when we look at situations like that and we say to them no, in this case that person needs to be

medically cleared for the issue that they came in for first of all, so sometimes that can cause, you know, some rifts' (Participant #1).

Many participants emphasized the need to advocate for patients to be in an area where they could receive proper care. Two examples frequently referenced during participant interviews included patients who have misused substances during recreational use or in a suicide attempt and when patients were thought to be delirious.

Incivility in the Workplace

In this section, the types of conflict between healthcare providers within the ED is discussed. While participants indicated they anticipated conflict with patients, they were often impacted by conflict amongst colleagues. Participants described incivility as unsupportiveness and disrespectful relationships between colleagues in the workplace. Participants reported that conflict within the workplace was the most stressful factor of working on the EMHT. However, it was felt that incivility could come from sources external and internal to the EMHT. Discord between the EMHT and general ED staff resulted in a notable division between the two teams even though they were part of the same ED environment. Additionally, participants generally expressed feeling well supported by their EMHT colleagues however occasional disputes could lead to a stressful workplace environment. This was exacerbated by the acute nature of the ED environment in general. Incivility in the workplace is categorized into two subthemes: having discord with the general emergency department staff and experiencing friction among emergency mental health team colleagues.

Having discord with the general emergency department staff. Participants described having an unprofessional and tumultuous relationship with the general ED nursing staff. Dealing with nursing staff from the general ED was identified by

participants as the most significant stressor working on the EMHT. Participants felt there was an overall lack of respect for the EMHT. Participants expressed feeling as though they were sold inaccurate stories of patient presentations with the intent of getting the patient into a bed regardless of whether or not EMHT services were appropriate at that time. This was reported to have led to a breakdown of trust between the EMHT and many of the triage nursing staff. Participants admitted this was not the case with every nurse working triage and that some triage nurses have a greater understanding of patient presentations and appropriateness for the EMHT than others. Participants voiced concern that the EMHT had limited ability to deal with medical comorbidities but they often felt pressured into taking patients they were uncomfortable dealing with. This relationship is explained:

'We work a lot with triage as they are kind of triaging patients that need to come to our beds and deciding where people need to go, right, so we work a lot with them. So some days its like, you'll have nurses who are really good and they'll be like 'no this person is too agitated and they need to be monitored like, they've clearly misused substances so we will send them to (medical area) before they come to you. So you feel supported like they're not putting you in situations where you feel unsafe, maybe ingested things and could crash so are not exactly appropriate for our (mental health) rooms so we don't have a medical stuff in our rooms, they're secure and safe. Where other days you'll get the opposite where they're pushing patients that aren't appropriate so you're having those conversations about whether or not they're appropriate. So again it just fluctuates based on who is working' (Participant #4).

Participants described feeling like outsiders within the general ED. Many felt this was likely due to the stigma that surrounded mental illness as a whole. The original intent of the development of the EMHTs in these EDs was to provide increased bedside nursing care for patients requiring mental health support, to filter patients for the psychiatric team for more efficient use of specialized consultation services, to assist with clinical decision making, and to improve flow through the general ED. Some of the participants with a

registered nurse (RN) designation perceived an attitude from RNs within the general ED that suggested participants had chosen to work in psychiatry because they were not comfortable or capable of dealing with the medical aspect of patient care. Both registered psychiatric nurse (RPN) and RN participants hesitantly used the term 'bullying' when describing the feeling they got from general ED nurses in this workplace setting. Participants identified they had not anticipated this type of reception from other healthcare providers as they moved into this workplace. Two participants described their feelings in regards to this:

'…I think probably the biggest thing that was difficult was uh, possibly unique to our emergency, but um, sort of bullying from some staff on the medical side, like other nurses. Um, but I don't know it's just in general like, it's just kind of like distain towards our team in general by the other nurses and it feels disrespectful most of the time. But yeah, and that's still an issue' (Participant #2).

'But I think in the department there's definitely a lot more stigma towards I think like, the healthcare providers working in that area so I can't imagine what it's like for the patients… But I didn't expect maybe that, kind of I don't know, it's like unsupportedness, and I didn't expect that kind of stigma towards healthcare providers working in psychiatry' (Participant #7).

One participant reasoned that this may be due to the ED attracting a certain type of nurse who is interested in highly acute, life saving work. They thought that the work done by the EMHT may be seen as less medically acute and therefore less important. It was believed that most general ED nurses had never worked in mental health and therefore did not know the skillset or associated tasks involved with patient care in the EMHT area. One participant voiced their frustration with this dynamic:

'Or some of the RNs on the other side will make snippy comments about how when they come see us we are sitting there, but we have (a number of) patients and we've just done a take down. No one questions how busy we are when they hear the yelling and the kicking and security is there. They never question how busy we are then. Which happens at least probably three times per shift' (Participant #3).

The relationship between the EMHT and the general ED was described as dynamic. Participants stated general ED staff were grateful for the EMHT to take patients requiring mental health services, but were then quick to blame when the EMHT spaces were full and patients requiring psychiatric consultation or admission occupied a designated medical bed within the ED. Participants felt that psychiatric patients seemed to make general ED staff uncomfortable.

Experiencing friction among EMHT colleagues. Discord between EMHT colleagues impacted the functioning and safety of the EMHT and emotional well-being of nursing staff. Participants generally described their EMHT colleagues as a close-knit, easy-going group that were supportive of each other within and outside of the clinical environment. Participants stated that working together as a team in this setting was particularly important while managing highly acute patients. However, there was occasional discord between EMHT colleagues which led to a breakdown of the supportive environment. One participant explained:

'Sometimes I would say um, a culture evolves in a place where it's not supportive. So over my years in the team I have noticed that there are periods when the team have not gelled, and there are fractions in the team. Or you might have a few individuals on the team that create friction in the team, and the team doesn't bond as well as it's supposed to bond. And in that kind of environment you're supposed to work as a team, in all situations. But like um, in certain situations, certain, um, certain nurses have found themselves kind of like, isolated among themselves, dealing with stressful situations where no one is helping them out. You know, yeah, so. With experience it's always about asking for that help no matter what the situation at the time is about. It's about always asking for help. It's a team situation, it's not your situation' (Participant #1).

Participants gave several examples where it was difficult to navigate relationships with their EMHT colleagues due to differences in nursing practice and clinical opinion, especially in regards to how difficult or escalating patient situations were managed. Some of the emotions elicited by participants associated with discord between colleagues

included frustration, disappointment, and anger. Emotional reactions were particularly notable when participants believed their colleagues were not open to debriefing about a situation or receiving feedback about how a situation was handled. Participants emphasized there were no right or wrong ways to handle patient care and that it was important to respect and acknowledge that everyone had a unique approach. One participant admitted feeling anxious and worried about how they were perceived by their peers in regards to their patient approach, yet felt little stress about how they chose to handle a patient situation. Participants stated they wanted to support their colleagues, but felt distressed when they felt a different approach could have been taken to mitigate an escalating patient event. While participants voiced a strong preference for prioritizing verbal de-escalation and a strong aversion to mechanical restraints they expressed that it could be difficult to prioritize this approach when EMHT colleagues were not on the same page in regards to behavior management. One participant described feeling isolated when constantly dealing with colleagues who had different attitudes in regards to providing patient care. They summarized:

'You know like trying to debrief, I always try to talk to the other person but it doesn't always, they're not always receptive to feedback right? If that's how they're doing it. They might just laugh and say 'oh whatever, like it's not a big deal, that's what needed to happen'. Like its not a big deal but I am kind of like 'well no it didn't need to happen'. For me I always think about like, okay if I was that patient or that was my family member I wouldn't want them treated like that. You know, that's the struggle for me. And I put that back on some of my coworkers I've said that, like 'if that was your son coming in like would you want them treated like that?' (Participant #4).

Some participants stated they felt it was often difficult to provide feedback to their team members while debriefing post-incident, particularly if it was known that their colleagues would not take the feedback constructively. Not being able to provide feedback to team members or resolving differences within the workplace was an aspect

of conflict management that participants indicated they tended to ruminate about after their shift was over. Another participant indicated that it could be equally frustrating to not receive feedback from colleagues but instead hear from the manager that there was a concern.

Summary

In conclusion, participants identified many stressors present in this workplace environment. These stressors included feeling morally distressed, working in an acute and uncertain environment, and dealing with incivility in the workplace. Participants indicated the top most notable stressors specific to working on the EMHT as being in a state of constant hypervigilance and having to navigate a difficult and dynamic relationship with general ED nursing staff. In the following section participant experiences in regards to how they coped with these ongoing workplace stressors will be explored and summarized.

Coping Strategies

Throughout participant interviews, a number of coping strategies were described, including how participants learned to work in this demanding environment as well as how participants coped with the demands of the workplace on their own personal health. In this section, coping strategies are divided into themes including: learning to work together, a shift in perspective, and personal coping strategies.

Learning to Work Together

In this section, participants identified that establishing and maintaining collaborative working relationships within a multidisciplinary team was integral for safe and cohesive patient care within the ED environment. While there were numerous

stressors associated with conflict in this particular workplace setting, participants demonstrated ways they have learned to support, rely on, and work alongside EMHT colleagues and other health care professionals. This included general ED nursing staff, EMHT management, physician teams and security staff. Learning to work together is separated into three subthemes including: developing and nurturing positive work relationships, supporting EMHT colleagues, and feeling supported by management.

Developing and nurturing positive work relationships. Participants emphasized that developing and continuing to foster relationships with general ED staff, physicians, and security personnel was one of the most significant ways the EMHT was able to mitigate conflict and decrease incivility in the workplace. Several participants indicated they worked to be able to initiate a clinically based dialogue about a clinical presentation as opposed to an immediate conflict with general ED nursing staff if they had a personal relationship with that individual. One participant described their increased efforts to get to know nurses in the general ED in more informal settings and how this effort impacted their interactions in the workplace.

'It was honestly, and it sort of came from the occasional extra-curricular activity where we would go to some function and just uh, socialize, or just like, engaging in like kind of small talk. Honestly it was going out for a (break) with some of the senior nurses or just like chatting with them to get you know a bit of a relationship with them. So when I would have to kind of disagree or present my reason for disagreeing to them it wasn't immediately met with resistance or hostility, like having that personal uh, relationship is really informal it was, that has been the biggest help for me so I at least get a chance to explain myself' (Participant #2).

A few strategies identified by participants that were utilized to continue to foster a positive relationship with general ED nursing staff included having ED nurses shadow EMHT staff, sharing relevant clinical information, assessing bed pressures throughout the ED as a whole, and assisting with simple medical tasks. Efforts such as these were in an

attempt to improve the working relationship between the EMHT staff and general ED nursing staff. Participants discussed that decision-making about patient placement within the ED was often influenced by ED bed pressures. EMHT staff was often familiar with many patients that frequented the ED and were able to help triage determine the best way to manage those patients within the department. Furthermore, when EMHT staff knew the general ED and waiting rooms were busy but there were vacant EMHT beds, participants indicated they were more lenient on who they accepted into an EMHT bed and would occasionally assist with patients requiring simple medical investigations. One participant outlined:

'There's the people that are really on board with this is, we are part of the ED, the goal is to get patients taken care of regardless of what the issue is and it is all about working as a big department to get people flowing through to keep everybody safe to support each other. And there are some nurses that are really fantastic about that and are on board with making sure that we are treated as part of the bigger team' (Participant #8).

Participants identified their connections with the physician teams as another important relationship within the ED. This included both the on-call physicians for the ED as well as the psychiatry team. Both physician groups were described as a good resource for nursing staff and participants described working closely with them for best clinical outcomes. Participants identified the psychiatry team as being a huge source of support for the EMHT in particular. This physician group was noted by participants to be strong advocates for EMHT staff within the ED and helped the team feel like valued colleagues in the ED. Physicians played a significant role when participants discussed managing acute medical, psychiatric, and behavioral crises; physicians ensured the EMHT had the tools they needed to manage a situation promptly and safely. This often referred to being readily available to the team in the event of a question of medical

instability, or having patient care orders completed quickly for environmental, chemical or mechanical restraint if needed. This physician-nursing team dynamic is described as follows:

'We have really good psychiatrists too. That we work with, I will say that. And our residents who, um yeah with the psychiatry program, I have to say we are very lucky, it's a really good team dynamic… Like, I feel way more embedded in the team and like tthey use our assessments, they're appreciative of the work we've done, they find it helpful. You know, so it's nice to have that team and work together' (Participant #4).

The security teams at each site were also indicated as a heavily used resource and absolutely necessary when managing patient and staff safety. Security staff was described as being readily available to the EMHT and were an asset when it came to dealing with agitated or aggressive patient situations. Participants described feeling more confident when they were supported by security to deal with difficult situations in a safe manner. One participant described:

'Our security staff are absolutely integral to our team and how they function. Um, they're absolutely key players in again, making sure situations are safe and again, just being able to help assess where best to put a patient because if they end up on the medical side they might need a security constant sitting on them and so, sort of that, again, being able to help keep the flow through emerg. And if (community police team) is sitting in the waiting room trying to get rid of a patient then trying to get, security can take them over, is there someone in secure holding or someone handcuffed in ambulance bay. They're definitely part of that. They are really good, they'll see something happening on the camera and come running over or call and say do you need us. So they are absolutely key' (Participant #8).

In conclusion, participants described that working to facilitate positive working relationships with ED colleagues external to the EMHT staff was beneficial to being able to provide better patient care.

Supporting EMHT colleagues. Participants identified their coworkers on the EMHT as their primary sources of support within this workplace environment. This was indicated by the importance of communication and upholding a collaborative relationship

among team members. Participants described that knowing they had the support of their EMHT colleagues significantly decreased the amount of stress they felt and increased their confidence, particularly when dealing with difficult situations. One participant outlined how communication and collaboration helped EMHT staff to alleviate the anxiety of dealing with a stressful situation:

'So making sure everyone is accounted for is always my number one and then just like getting support we need, and security back up, if a patient isn't appropriate for our area talking to the team. Um, but I think communication is big. It's hard when you're working with a team and everyone's communicating and take that two minutes before someone makes a decision so everyone can be on the same page where like you have other people who just take charge and go and do it and everyone else is just left standing there like 'I don't know what I should do…' do they want help, don't they?' So that little bit of communication and everyone getting on the same page' (Participant #4).

Participants described the importance of communication and debriefing with colleagues in two ways: one as a more formal process during a shift, and the other as a more informal process that participants often referred to as 'venting.' Continuous communication, or 'checking in' with one another about what was happening throughout a shift was viewed as a way staff supported one another, and was also seen as a means to spread awareness of potential environmental threats or challenges. A formal debriefing process with EMHT colleagues following a significant event was a positive strategy to validate team members and to brainstorm how that event could have been managed differently in the future. Debriefing was seen as a valuable way participants learned from their colleagues, received support and feedback from one another, and helped to relieve pressure after a stressful event. Receiving positive feedback from colleagues helped participants feel motivated and supported in the workplace. Participants indicated that it was important to keep an open and approachable attitude during the debriefing process.

Alternately, participants described informal 'venting' with colleagues as a form of debriefing where stressors and situations were discussed unofficially. Participants felt that after informally debriefing with colleagues they could then problem solve with a clear head about how to best approach a situation in the future. Informal debriefing with a trusted colleague was stated to be valuable in the workplace, as EMHT staff could say that they needed to say, including their feelings and subjective opinions, before they could then view the situation from a more objective perspective. One participant explained:

'… we work together as a team. So yeah we support ourselves in terms of adding to what maybe if you have doubt, if you have questions, if you have any concerns, if you are not comfortable doing' (Participant #5).

Humor was identified by participants as a communication strategy that helped deal with a hard shift or difficult patient behaviors. Many patient situations experienced by EMHT staff were difficult to cope with; this includes instances of suicide or self-harm and struggles with substance abuse. Patient presentations to the ED could be a traumatic time for patients, but also for staff who were repeatedly exposed to these upsetting circumstances. Participants stated that a dark sense of humour could help to lighten the mood amongst nursing staff and make it easier to cope with the shift. One participant outlined:

'I understand the severity of people having to come into emergency. No one that works emergency doesn't know that.… We all fully understand. The way that we cope as a team is to laugh, support each other, we check in with each other' (Participant #3).

Some participants identified that working in the ED could be socially isolating and that their EMHT colleagues had become part of their social circle outside of the workplace. They described that family and friends did not understand what they dealt

with at work and participants were unable to discuss ongoing workplace stressors with others. Spending time with coworkers outside the workplace was identified as a positive way to cope, and was one factor that participants identified as being a reason to continue their employment in this highly acute area of nursing.

Feeling supported by management. Participants expressed they were better able to cope with workplace stressors when they felt they had the support of their managers. Participants indicated that the workplace was more positive when they felt they were supported and were less worried about clinical decision-making when they knew management trusted their judgement about clinical care and team decisions. This included obtaining additional staff when it was needed to maintain staff and patient safety. It was believed that this positive relationship dynamic had developed from clear expectations from management to the team, and that management trusted the EMHT to do what they needed to do to provide safe patient care.

Participants felt their manager was a member of the EMHT rather than simply an authority figure or outside administrator. While participants indicated feeling that all levels of management were supportive, the direct patient care manager was seen as a reassuring figure in the midst of a chaotic environment where pressure could be high. Participants viewed their current managers' past experience working in mental health as an asset and believed their manager fully understood the challenges the EMHT faced in the workplace environment. Participants stated they felt their concerns were heard and addressed by management who checked in frequently with the team to see how the team could be further supported. Participants indicated their manager emphasized staff health and well being both on and off shift and maintained an open door policy where staff

could easily access them with any concerns or feedback. One participant described how they felt supported by management in this busy workplace:

'…I know the manager covering seems a lot more open to feedback and will call to check in and you know, remind us that if you bring back 6 patients at once you can't do six assessments in two hours. Like, people can sit that's okay, like, you still need your breaks. So it's a good reminder that I am supported to take a step back take a deep breath, you can't do everything' (Participant #4).

Participants also identified that current management worked continuously to facilitate communication between the EMHT and general ED to facilitate a more positive working relationship. Management was seen as a buffer between the EMHT and alternate teams and was a good resource for support in difficult situations.

A Shift in Perspective

In this theme, participants described the numerous ways they adapted and coped with the negative impact of the occupational stressors present in the ED. Participants indicated they acted to stay psychologically self-aware and made the effort to maintain a positive outlook on patient care as it was important for helping to prevent burnout. Over time, participants stated that working in this environment could change one's overall perspective of their roles as caregivers within the healthcare system. The subthemes in this section include remaining patient focused, utilizing professional skills to navigate the workplace, and adapting one's nursing practice.

Remaining patient focused. Participants explained that clinical decisions were made with the individual patient's holistic care needs in mind by seeing the person rather than their illness. Participants identified that remembering to remain objective was one of the most important ways they coped with difficult clinical situations. When it came to approaching conflict with general ED staff about patient situations, participants described

putting the patient first, focusing on the objective clinical facts, and presenting their arguments in a logical fashion. Participants described it was important not to blame patients for their behaviors upon presentation, and to keep a sense of empathy and unconditional positive regard. One participant described how this approach to patient care helped them to deal with challenging patient behaviors:

'The decreased stress that I felt with patient interaction um I don't think anything has changed with the types of situations that we'd encounter, but the biggest one is borderline personality was just sort of why or like, why some of the behaviors might occur or, really having to get or believe that nobody chooses to have borderline personality and I think part of it in general might have been the idea of trauma informed care like, and that there's probably a lot more going on than this snapshot we see. Nobody comes to the ED on a good day so not taking that stuff personally. Um, I think it's been on me and recognizing that, I don't know, was a big thing' (Participant #2).

Remaining patient focused often translated into putting the patient first and approaching patient care with transparency. This was described as a helpful method that had a positive impact on the effectiveness of nursing interventions, and was key to being able to quickly developing therapeutic rapport. This participant continued:

'I think I am very careful, I don't think I've ever lied to the patient and being aware that even the perception of being deceived is like, a real threat to that therapeutic relationship and so that, I said I might not have always been forthright with patients, I've found with patients who are admission seeking and who are regular presenters, right from the start saying like 'I have little to no control over you getting admitted, history has shown that you are likely going to be discharged but let me know what is going on and I will try to problem solve with you. But if it's something different or unusual and you don't have the possible resources to deal with it or ability to deal with it I will absolutely fight to get you what you need but that said right now you are probably going home.' So that has actually been really helpful in that there is a person coming in who has been very dysregulated. The amount of time from like that full on crisis to settling has gotten a lot shorter just by doing stuff like that. Just letting them know that you will be heard and respected but this is the reality of the situation' (Participant #2).

Ultimately, participants indicated that when they were feeling overwhelmed it was helpful to remind themselves of why they chose to work in this patient care

environment. For some, it was the fast-pace and exposure to a variety of patient situations. For others, it met an internal desire to help and to care for people.

Utilizing professional skills to navigate the workplace. Participants described that the skills they learned to work with patients also helped them navigate difficult scenarios within the workplace. This was mostly outlined as having the necessary communication skills to have difficult conversations and deal with diverse personality types. Approaching conflicts in a calm and objective manner, avoiding an argument or power struggle, and not reacting to situations emotionally were primarily discussed by participants. Particularly as it related to disagreements between the EMHT and general ED staff, participants stated they chose to try and not react to challenging behaviors or to respond in a passive aggressive manner. Participants felt that coming from a mental health background had given them a different perspective on people's behaviors and therefore it was easier to not take conflicts and disagreements personally. Participants described that being self-aware and taking a step back if participants found themselves becoming emotionally reactive was a positive way to deal with conflict. One participant described their approach to utilizing mental health techniques while dealing with workplace conflict.

'Also, I won't argue like, or I won't be emotionally reactive to it and that was a turning point for dealing with two of the worst like straight up bullies, was being able to just treat them like I am working with someone with borderline personality and not react to their um, sort of like, I don't know, just nonsense behavior' (Participant #2).

Participants routinely expressed the need to advocate for themselves as a team in the ED alongside patient care and stated that negotiating and being direct were more useful communication techniques than arguing. Utilizing objective clinical information to support decision-making was one of the most beneficial ways participants dealt with

conflict in the ED setting. Validating the concerns of others and explaining the reasons for the decisions made by the EMHT nursing staff were viewed as helpful methods of communication. Participants emphasized that facilitating a dialogue was more conducive to problem solving between nursing teams.

Adapting ones' nursing practice. Participants described that over time their approach to patient care changed and adapted to fit the unique needs of patients in this environment. Participants were continuously exposed to challenging situations that required them to constantly evaluate the effectiveness of their roles as mental health practitioners. Numerous participants described feeling an increased level of confidence and insight into their own nursing practice the longer they spent in this workplace environment. This was also described as developing more realistic expectations of their nursing interventions with patients. Participants indicated it could be particularly challenging to work with particular patient populations who frequented the ED. Learning to adapt one's nursing approach was one way participants were able to prevent feeling burned out. One participant described:

'Probably like, one way for sure was with I guess like, resistance or trying to engage people. Not seeing it as like this person is being resistant or oppositional but um. Learning more about motivational interviewing that like not viewing resistance as a failure on the therapists' part in that you're not adapting well enough or, and I realize that it's not an absolute, some people will just never engage them or at least in that moment there's nothing I can do. But challenging myself to adapt my approach or reflect on what I did or didn't do and so putting it on me as a challenge that way is one major thing' (Participant #2).

Another participant stated their perspective of working in mental health was naïve prior to graduating nursing and moving into this workplace environment. When they had initiated employment in this area of nursing they felt increased stress when exposed to challenging situations. Over time they learned to manage a variety of situations thus

developing a more realistic view of their role as a mental health practitioner. As they explained:

'…maybe you're more realistic about situations um, now. Like, you're able to cope in a way where you know you can, like. And you try not to worry so much about, like the extra, like, there is only so much you can do so you have to draw some boundaries with people, right? Whereas maybe it's harder to find that when you're first graduated and you didn't realize the outcome is not always ideal but you try your best' (Participant #7).

Participants described knowing their actions and nursing interventions impacted patients and that even by acting with benevolence patient outcomes were not always perfect. Making mistakes was identified as a way participants learned from their environment, but by approaching these situations with an open and transparent attitude led to ongoing professional development. Problem solving and working through scenarios with EMHT colleagues was a helpful way participants learned about their approach to patient care and how to develop their effectiveness as a nurse.

Maintaining Work-Life Balance

This stand alone theme refers to the ways that participants acted to take care of themselves outside the workplace, as well as during a shift. This included prioritizing physical health, emotional health, enjoying time away from work, and being mindful while at work. Some participants prioritized being physically active as a way to ensure they were able to meet the physical and energy demands of the job. Most participants worked long 12-hour shifts and needed strength to physically intervene in a situation if necessary. Participants stated they tried to get enough sleep between shifts to feel rested and mentally alert. One participant explained:

'…going to the gym… I've um, always had sleep issues. Yeah. Sleep issues. So I am beginning to address those issues. Because um, being physically fit and um, having a good sleep, you know definitely prepares you for your day and your shift' (Participant #1).

This participant elaborated:

'There are also spontaneous situations that you have to deal with like people trying to run off the unit or people uh, doing things just off the cuff that you didn't expect them to do. Yeah, so being physically fit and able, um, does help you manage those situations' (Participant #1).

Outside of meeting their physical needs, participants illustrated a number of ways they looked after themselves emotionally ranging from identifying and talking with support people in their personal lives to seeking professional help. Participants primarily sought support from coworkers however some mentioned seeing a psychologist or mental health professional as well as the employee assistance program. Regardless of who was the identified person of support, having someone to talk to was identified as a helpful outlet for managing personal and workplace issues.

Participants identified a number of extra-curricular activities throughout the interviews alongside spending time with friends and family when discussing how they prioritized work-life balance. Most participants mentioned making a concerted effort to leave work stress at work and not think about work once they had left their shift. One participant described making a conscious effort to think about the positive aspects of the day on their drive home, as opposed to focusing on negative events that may have happened during the shift. Participants who were employed part-time stated that not being a full-time employee was one way they had chosen to cope with the work environment. These individuals indicated that having autonomy and some level of control over their schedule was one way they were able to maintain work-life balance. Another advantage identified with being a part-time employee was that participants still had adequate time to pursue hobbies and interests. Participants discussed recognizing when

they needed a day off or a break from the workplace environment and would not pick up extra shifts during these times. One participant discussed:

'I am lucky that I am part-time so if I'm starting to feel like I am having a hard time leaving work at work and I am starting to get a bit burned out then I just don't pick up extra shifts or I can pick up somewhere else' (Participant #6).

Participants revealed several strategies that helped them take care of their own health and wellness while at work. One participant described the importance of having good intake throughout the shift and would bring snacks and a water bottle in the event they were unable to take a break to eat. Some participants limited caffeine intake throughout the middle and end of their shifts to ensure they were able to rest following a shift. Most participants mentioned missing breaks was common in this workplace environment due to the high level of acuity, however they made an effort to take breaks when they were able. Breaks were one way participants were able to relax and recharge for the remainder of their shift.

Summary

In summary, participants outlined numerous ways they coped with many different challenging aspects in this environment. These strategies ranged from developing interpersonal relationships with colleagues from the general ED and learning how to work more effectively with others, shifting their perspectives and expectations, and further developing their own personal coping strategies. Participants highlighted the support of their EMHT colleagues as being their primary source of support on the EMHT.

Chapter 5: Discussion

The purpose of this research project was to describe how mental health nurses working on an Emergency Mental Health Team (EMHT) in an urban setting experienced and coped with occupational stressors. As far as the researcher was aware, this was the first investigation where the experiences of nurses working on an EMHT were explored in regards to occupational stressors and their developed coping strategies. The findings of this research addressed a significant gap in the literature in regards to ED services and took into account mental health nurses points of view within this acute care setting. It is hoped that findings from this investigation will lend to the overall understanding of the stressors present in this workplace environment, development of coping techniques in similar nursing care teams, and to decrease nursing turnover and absenteeism in this highly acute patient care area. Improving support for nurses and teams working in the ED would ideally improve the experience of individuals seeking and accessing emergency mental health services.

The first part of this discussion will be divided into two sections: stressors, and coping strategies. Findings from this investigation will be compared and explored in relation to previously documented literature. Suggestions for continued development of EMHT services will be discussed along with recommendations for future research. Finally the strengths and limitations of this project will be acknowledged.

Stressors

The body of literature included in this research study identified numerous occupational stressors in the ED environment that included: heavy workload, overtime and staffing shortages, repeated exposure to traumatic events, overcrowding, lengthy wait

times for admitted patients requiring an inpatient bed, time pressures, frequent users, violence and aggression towards staff, poor managerial support and shift work (Adriaenssens, De Gucht, & Maes, 2015; Browning, Ryan, Thomas, Greenburg, & Rolniak, 2007; Fernandez-Parsons, Rodriguez, & Goyal, 2013; Flarity, Gentry, & Mesnikoff, 2013; Garcia-Izquierdo & Rios-Rizquez, 2012; Healy & Tyrrell, 2011; Hu, Chen, Chiu, Shen, & Chang, 2010; O'Brien-Pallas, Murphy, Shamian, Li & Hays, 2010; Ross-Adjie, Leslie, & Gillman, 2007; Sawatzky & Enns, 2012; Wolf, Perhats, Delao, Moon, Clark, & Zavotsky, 2016). Participants in this investigation listed all of these factors aside from overcrowding and poor managerial support, as stressors present while working in the ED on an EMHT. Overcrowding did not exist within the EMHT area as the team does not go over capacity but was noted to be a factor within the general ED.

Clarke, Hughes, Brown, and Motluk (2005) investigated psychiatric nurses working within EDs and reported that triaging, interdisciplinary functioning, safety concerns and workload were the primary stressors in their environment. Challenges specific to nurses working within acute care areas of mental health were heavy workloads, managing patient aggression and dealing with limited resources (Edward, Ousey, Warelow, & Luis, 2014; Jackson & Morrissette, 2014; Jenkins & Elliott, 2004; Humble & Cross, 2010; McArthur & Montgomery, 2004). Happell (2008) noted that stressors specific to nurses working within psychiatry were influenced by the fact that the patient population often posed a threat to themselves or others, and there were frustrations related to role overload, role conflict, and issues with the physical environment. When considering that the majority of existing literature is particular to

general ED settings and not towards mental health nursing teams, it is notable that participants experience the stressors relating to both areas of ED nursing.

Participants described some of the ways they were impacted long-term by workplace stressors that included sleep difficulties as a result of an irregular shift work pattern, health problems such as musculoskeletal injuries and obesity, difficulty with energy and motivation levels, a more negative outlook on patient care or the healthcare system, and social isolation from family and friends. The psychological and physical effects of ongoing exposure to stressful workplace situations were noted to include: emotional exhaustion, depression, anxiety, irritability, mental health concerns, lashing out at one's spouse and family members, relationship problems, increased likelihood of substance abuse, weight gain or loss, stomach issues, generalized aches and pains, and difficulties sleeping (Armstrong, 2001; Edwards, Guppy, & Cockerton, 2007; Gillespie & Melby, 2003; Healy & Tyrrell, 2011; Udod, Cummings, Care, & Jenkins, 2017). The themes under stressors included: 1) feeling morally distressed about patient care, 2) working in an exhausting environment, and 3) incivility in the workplace.

Theme One: Feeling Morally Distressed about Patient Care. The subthemes in this theme include managing time scarcity, feeling spread thin, doubting one's clinical competence, and not having the ability to influence patient movement. Being unable to pursue what was believed to be the right action due to environmental limitations was described in the literature as moral distress and was a contributing factor to attrition within nursing positions and the profession (Austin, Bergum, & Goldberg, 2003; Jameton, 1984; Wolf et al., 2016). Austin et al., (2003) indicated that being a healthcare provider came with great responsibility but not great power or control. Participants

described workplace constraints such as the time limitations, complex care needs of their patients, and demand for their services within the ED as being significant contributors to stress. Participants described how hectic it could be when balancing the medical and psychiatric needs of their patients and how they often felt overwhelmed by their patients' complex care needs. Managing time scarcity and feeling spread thin meant that participants often felt unable to provide the type of care they envisioned as ideal due to environmental constraints.

Managing time scarcity and feeling spread thin may also relate to the experience of compassion satisfaction, or the fulfillment one feels as a result of delivering care to others (Hooper, Craig, Janvrin, Wetsel, & Reimels, 2010; Sawatzky & Enns, 2012; Simon, Pryce, Roff, & Klemmack, 2005). ED nurses were thought to have lower scores for compassion satisfaction when compared to nurses working on inpatient specialties (Hooper et al., 2010). This may be attributed to the nature of ED services such as the quick turnaround time (Garcia-Izquierdo & Rios-Risquez, 2012). Participants described the unpredictable, fast-paced nature of their jobs where patient turnover was constant and participants had to develop rapport quickly. While this investigation did not examine levels of compassion satisfaction, it was evident that some participants felt fulfillment and pride when caring for patients in this environment despite the presence of numerous occupational challenges. Alternatively, other participants stated they missed being witness to and assisting with the patients' progression towards wellness.

Doubting one's clinical competence and not having the ability to influence patient movement were not outlined in previously documented literature. Participants identified that their assessments and recommendations for patient care were usually relied upon and

valued by the physician teams, participants had little influence over whether a patient was ultimately discharged or admitted. As well, participants indicated they had no influence over patient flow in regards to when, where, or how long it took to move admitted patients into an inpatient bed. While participants stated they received pressures external to the EMHT, there was very little ability to influence these situations. These factors may relate to role conflict, as it is discussed previously by Happell (2008) but also that participants felt continuously constrained by limited resources for their patients, especially when patients had been waiting for an inpatient bed for a lengthy period of time.

Fernandez-Parsons, Rodriguez, and Goyal (2013) found that ED nurses generally had low levels of moral distress but those who were considering leaving their positions experienced high levels of moral distress. None of the participants in this investigation identified they were considering leaving their positions regardless of current or past feelings relating to moral distress. Based on the findings in this study, it was thought that participants had developed positive coping strategies over their increased time in this environment that had helped them become resilient towards the occupational stressors.

Theme Two: Working in an Acute and Uncertain Environment. Working in an exhausting environment includes the subthemes of feeling on edge, feeling desensitized, lack of a purposely built space, and dealing with the impact of stigma towards patient care. Most participants mentioned they had felt emotionally exhausted and that they had a more cynical outlook on patient care and the healthcare system as a result of their experiences working on the EMHT. Feeling emotionally exhausted and having a cynical outlook was two of the three stress response outcomes as noted by

Maslach, Jackson, and Leiter (1996) in the Maslach Burnout Inventory. A common response from participants in relation to workplace stressors was that they often felt physically and emotionally exhausted. The primary factors from this study that contributed to exhaustion included the heavy workload associated with a high acute practice setting, medical aspect of patient care, managing conflict between the mental health and general ED team, advocating for patient care, being hypervigilant or feeling on edge, and mitigating dynamic patient situations. Participants admitted their outlooks had become more cynical based on interactions with the general emergency department nursing teams. The third stress response outcome in the Maslach Burnout Inventory was a lack of professional accomplishment (Maslach, Jackson, & Leiter, 1996). Participants did not discuss this as a common experience.

Feeling on edge was not specifically discussed in the literature included in this investigation, however feeling desensitized could be related to compassion fatigue. Persons working in caring professions were described to be at a higher risk of developing compassion fatigue due to frequent exposure to individuals that had experienced trauma (Figley, 1995; Hooper et al., 2010). When participants described situations involving patient agitation, aggression and violence, they indicated strong feelings of frustration and emotional exhaustion in response to facing ongoing verbal and physical aggression and violence from patients. Most participants stated as a result, they felt desensitized to these situations that were indicated to happen numerous times a day, on a daily basis. Burtson and Stichler (2010) described that compassion fatigue in acute care settings may impact nurse caring where the nurse may feel emotionally disconnected when providing patient care.

Concerns about the physical layout of the EMHT environment and dealing with the impact of stigma towards patient care were not mentioned in existing literature as these experiences were specific to EMHTs. As previously noted, existing literature on EMHTs is minimal. Participants outlined the difficulties working in a traditionally laid out ED as it related to providing acute mental health care. One team was accommodated in a space that was not specifically for mental health and this was seen as dynamically challenging; the other was operating in a space custom built for the team and therefore, these participants did not voice the same concerns. Participants continually felt the need to advocate for patients to have their physical needs addressed prior to being seen by the EMHT. It is unknown if this is a common occurrence in general ED settings where there is an absence of an EMHT. This constant need to advocate for holistic patient care was identified to have led to continuous discord between EMHT staff and general ED staff.

Theme Three: Incivility in the Workplace. Incivility in the workplace is the third and final theme under stressors and includes two subthemes: having discord with general emergency department staff and experiencing friction among EMHT colleagues. While either subtheme are not directly discussed in current literature due to the lack of investigation into EMHTs in general, it could be suggested that the difficulties participants faced when dealing with general ED staff could be labeled as role conflict or confusion. As noted by McArthur and Montgomery (2004), nurses working in a mental health capacity within an ED may be perceived as gatekeepers to inpatient services. A misperception by general ED nursing staff in regards to the actual function of EMHT staff may be a contributing factor to discord between these two teams. Jackson and Morrissette (2014) indicated that nurses working in mental health care settings often face

the same stigma that burdens their patients. This was mentioned several times by participants in this investigation who stated they felt they were treated differently by other RNs for choosing to work in a mental health setting and they were viewed to be uncomfortable dealing with the medical aspects of patient care. Participants believed being treated differently was due to the stigma that surrounded mental health as a whole.

Coping Strategies

Folkman, Lazarus, Dunkel-Schetter, DeLongis, and Gruen (1986) described coping as process-oriented where the individual reacts to a situation based on their assessment of the demands and available resources. This included managing internal and external environmental demands through various cognitive and behavioural approaches (Folkman et al., 1986; Lazarus & Folkman, 1984). There was no right or wrong way to cope with a stressful situation; what was important was whether or not the efforts to cope with a situation were deemed to be successful (Folkman et al., 1986). Lazarus and Folkman (1987) indicated that short-term outcomes focused on the resolution and quality of the outcome of a situation whereas long-term outcomes included physical health, wellbeing and social functioning of the individual.

There were many similarities noted between participants and the ways they coped with the person-environment relationship. Yet each participant had a unique way they chose to regulate their own emotions. The findings in this investigation aligned with Riberio, Pompeo, Pinto, and Riberio (2015) who identified that nurses working in ED settings used more than one coping strategy. These commonly included problem solving, positive reappraisal, and social support (Riberio et al., 2015). Participants described numerous ways they used problem solving and negotiating to work through conflicts with

their general ED colleagues. They also described the need for self-awareness when dealing with stressful situations in the workplace. How they felt emotionally, mentally, and physically at those times were noted to impact how they reacted to a stressful situation. Determining whether or not a situation was relevant to ones wellbeing is known as cognitive appraisal (Folkman et al., 1986; Lazarus & Folkman, 1984). Particularly when it came to situations involving patient care, participants identified being cognizant of potential risks and dangers in their immediate environment. This included exits, items that might be present in the vicinity of the patient, and the location of visitors and other patients. When dealing with challenging conversations with staff from the general ED, this included strong communication skills.

The themes included under coping strategies in this thesis include learning to work together, a shift in perspective, and maintaining work-life balance.

Theme One: Learning to Work Together. Learning to work together includes the subthemes of developing and nurturing positive work relationships, supporting EMHT colleagues, and feeling supported by management. Workload and lack of supervisor and colleague support were some of the workplace stressors or environmental factors noted to impact the three stress response outcomes as part of the Maslach Burnout Inventory (Ersoy-Kart, 2009; Escriba-Aguir & Perez-Hoyos, 2007; Flarity, Gentry, & Mesnikoff, 2013; Jenkins & Elliott, 2004; Rios-Risquez & Garcia-Izquierdo, 2016; Yoder, 2010). While participants referenced the workload and relationship with general ED colleagues as large contributing factors to these stress response outcomes, it was noted that supervisor and EMHT colleague support was integral to coping in this stressful environment and did not contribute to stress response dynamics. Additionally,

participants indicated their positive relationships with physician teams in this environment as a significant contributor to feeling supported. This finding was previously noted by O'Mahoney (2011) who stated that positive nurse-physician relationships decreased the occurrence of emotional exhaustion and cynicism.

Participants strongly emphasized the importance of supporting fellow EMHT colleagues and engaging in teamwork. This was one of the primary ways participants were able to cope with this workplace environment and often stated this was done through an informal process known as 'venting.' Participants stated that being able to express their thoughts and feelings with coworkers was a helpful way to process a situation and to problem solve together. This finding aligned with Healy and Tyrrell (2011) who found that nurses often approached colleagues to reflect and debrief informally with one another. This was perceived as a positive way to cope with challenging workplace situations. Ersoy-Kart (2009) identified that nurses who sensed increased social support from their colleagues were less likely to experience feelings of depersonalization.

Theme Two: A Shift in Perspective. This theme includes the subthemes of remaining patient focused, utilizing professional skills to navigate the workplace, and adapting one's nursing practice. Remaining patient focused and utilizing professional skills to navigate the workplace were not previously discussed in the literature included in this study. However, all participants stated they had adapted and changed their expectations of their roles as clinicians as well as how they were affected by workplace stressors through increased time and experience working in this environment. Burtson and Stichler (2010) and Hunsaker, Chen, Maughan, and Heaston (2015) discussed that

nurses with more years of experience in the ED demonstrated higher compassion satisfaction scores and lower compassion fatigue scores than their younger or less experienced counterparts. While compassion satisfaction and fatigue were not the focus of this study, the participants who chose to contribute their experiences to this research had been working on an EMHT for several years. It was speculated that these participants had likely learned effective and productive ways of coping with the environment. The literature identified less functional ways of coping, but participants did not commonly focus on ways they coped poorly rather focusing on the ways they found were helpful.

Participants in this investigation discussed that when initially beginning to work in this environment they felt distressed that they could not do more to help patients. One way their expectations had shifted over time was to focus on a realistic view of their nursing interventions and not defining success through patient outcomes. One participant indicated that success was described as not dependent on what a patient chooses to do following an interaction with the EMHT, but rather helping that patient to problem solve during their current presentation. This was one example provided by participants that supported how an increased amount of time immersed in this environment eventually led to the development of positive coping strategies.

Difficulties for the novice nurse in the ED environment were identified by Burtson and Stichler (2010) and Hunsaker et al. (2015) and included gaining practical experience, learning new information, and keeping up to the workload where timeliness and skill was essential. Participants discussed that learning how to be flexible and adaptable to deal with the unpredictable environment as both a novice and experienced nurse was challenging at first but became easier over time. As nurses continued to face

frequent exposure to trauma and stressors, they adapt and learn to cope accordingly (Burtson & Stichler, 2010; Hunsaker et al., 2015). Participants indicated that part of this learning process included determining which colleagues to learn from and problem solve with.

Theme Three: Maintaining a Work-Life Balance. The third and final theme in coping strategies is characterized by the efforts participants engaged in to take care of themselves outside of the workplace. Previous literature mentioned personal coping strategies as one of the many ways nurses dealt with stressful environmental circumstances. Participants in this investigation were quick to identify how they took care of themselves and were intuitive to know that this was important. Prioritizing ones health by going to the gym and being physically active, bringing snacks to their shifts, making an effort to hydrate, and ensuring they got enough rest were some ways participants took care of their physical health. Participants identified seeking support from colleagues and mental health care professionals as ways they took care of their mental and emotional wellbeing. Making time for family, friends, and extra curricular activities outside of work was seen as important for social functioning.

Recommendations for Development of Emergency Department Mental Health Teams

There are two general recommendations for ongoing education and development of EMHTs based on the findings in this investigation. These recommendations may be helpful for centers with pre-existing EMHTs or for centers that are working to establish an EMHT within an ED. It is important to recognize that there is no 'one size fits all' when it comes to EMHT services due to various extraneous factors. However, there were

commonalities between the findings in this investigation and the current body of literature that suggested some findings may be generalizable to similar services.

First, enhanced orientation for new EMHT staff including a review on physical assessment and medical skills, conflict resolution, and workplace incivility training would be beneficial. Participants identified experiencing a huge learning curve when first employed in this environment in regards to dealing with medical comorbidities and facing stigma and conflict from other healthcare providers. Some felt completely unprepared for the challenges they faced and stated it took time to learn how to meet the medical needs of patients and handle challenging situations with general ED colleagues.

It is also recommended that nurses who have frequent communication with the EMHT, such as triage nurses, also spend time shadowing the EMHT staff. It was commonplace at one site for newly hired general ED nursing staff shadow EMHT staff as part of their orientation. While it is important for that practice to continue, existing staff who may have been working in the ED for several years should also be considered. This would hopefully lead to an increased understanding of the challenges and barriers faced by the EMHT and a decreased occurrence of conflict between these nursing groups. It would also be recommended to have EMHT staff shadow or cross train in the ED. The benefits of this would be two-fold; for EMHT nurses to understand the challenges faced by general ED nursing staff while also increasing knowledge and competency when dealing with medical acuity. Additional orientation time for new EMHT staff may prove helpful to be able to anticipate what to expect in this workplace environment.

Recommendations for Future Research

This investigation focused solely on the experience of Registered Nurses and Registered Psychiatric Nurses working on a mental health team in an emergency department in large urban centers in Western Canada. Due to the limited amount of literature on the topic of psychiatric and mental health care within an ED context, the recommendations for future research in this area are many.

It would be beneficial to conduct a similar study with nurses employed in a general ED setting with respect to working with patients presenting with a mental health concern. Gaining a holistic perspective of mental health care within the ED setting rather than within a specialized area would be helpful in the development of mental health supports and services for all areas. Studying the experiences of other healthcare team members such as psychiatrists, ED social workers, and addictions counselors involved with the EMHTs would provide further insights into patient services. One psychiatrist was interviewed for this investigation, however due to the inclusion criteria of the study, the findings were not included in the findings alongside nursing experiences. However, it was evident from this interview that emergency psychiatry is a rapidly growing area of healthcare. Given the closeness of the EMHT and the psychiatry team, the perspectives of these physicians would enhance the understanding of the functioning of these teams as a whole within the ED environment.

Additionally, repeating a similar study in EDs where a mental health nurse consultant role is utilized as opposed to a specialized mental health team in a designated area would highlight the differences and experiences of nurses between the two models. In these EDs, there is no mental health nursing care team, but rather a single mental health nurse consultant that assists with patients presenting with a mental health concern. This would

explore the impact of this stressful environment, with similar stressors and a different level of involvement of the nurse with patient care, without having mental health team colleagues to rely on for support.

It is recommended to conduct research on the patient experience within the ED setting in areas where a mental health team and or a mental health nurse consultant exist. When developing services intended on meeting a healthcare need, it is important to recognize and value the experiences of individuals accessing services in those areas. Significant limitations exist in relation to this suggestion, however, due to the acute nature of most patient presentations to the ED. A study of this undertaking would need to be considered once patients had moved towards wellness.

Acknowledging the experiences of nurses working in EDs in rural settings may also be beneficial, where mental health resources may not exist or may be limited. Nurses in these environments may be less supported when it comes to dealing with patients who are acutely unwell from a mental health or psychiatric standpoint. Highlighting deficits within the workplace are important for ongoing service development and process improvement for mental healthcare delivery and streamlining services to help all patients in all areas access timely and knowledgeable mental health care.

Limitations and Strengths

There are several limitations and strengths associated with this study. This investigation focused on recruiting participants from two sites that had previously established EMHTs within a large ED, in respective urban settings in Western Canada. Due to the small sample size, the findings are highly specific to the ED environments where these two EMHTs exist and may not be generalizable to other EDs where current

services may vary. While there were commonalities between the two participant groups, findings were also noted to vary slightly due to factors such as location of hospital, physical space within the ED, amount of time each team had been established, and social dynamics at each site. However, one may argue that the general experiences discussed in this research study may be helpful for anticipating the types of challenges other EMHTs may experience. To the researchers' knowledge, there are no other EMHTs that are structured like the ones studied in this investigation in Western Canada. Depending on the available resources and perceived need, the roles of mental health nurses within EDs greatly vary from site to site, city to city.

Secondly, the reasons nurses may have chosen to participate in this investigation may reflect an inaccurate reflection of perceived occupational stressors and functional or dysfunctional coping strategies. Nurses may have chosen to participate in the study to voice frustration about unresolved workplace concerns that may have led to an exaggerated perception of workplace stressors and poor coping strategies. Additionally, nurses may have chosen not to participate in the investigation due to anticipated fear and potential repercussions for speaking out against their supervisors and healthcare organizations. Nurses that participated in this investigation had been in their roles for several years and therefore, had likely developed positive coping strategies and techniques to deal with this challenging environment. This does not reflect the experiences of all staff working in these environments that may have had less effective ways of coping or staff who may have left the work environment due to the inability to cope. Nurses who were thinking of leaving their nursing positions may have chosen not to participate because they were too exhausted, indifferent, or perhaps had already left

their jobs. Previously published literature and evidence from this investigation suggested that increased time spent in a stressful environment led to a more productive way of coping. Therefore, as all participants had been immersed in this workplace for several years, this investigation may reflect an underestimation in the level of dysfunctional coping.

Most of the nurses who chose to participate in this investigation knew the researcher prior to the initiation of this study through the researchers' previous places of work. While none of the participants currently work directly with the researcher, there was the chance that participants chose to participate in the investigation because they were familiar with the researcher and therefore may have disclosed more information to the researcher than they might have to another investigator. Streubert and Carpenter (2011) indicated that in qualitative research, the researcher acts as an instrument as a part of the study. Therefore, all research has an element of subjective bias (Streubert & Carpenter, 2011). All attempts were made to minimize the impact that this bias had on the research by attempting to recruit all potential participants on each EMHT rather than the ones the researcher specifically knew as well as by ensuring other methods were in place to enhance the rigor of the study.

Thirdly, this investigation focused solely on the experiences of nurses working on an EMHT and not on nurses in the general ED that also worked with patients with mental health or psychiatric concerns. Previous literature had exclusively focused on the experiences of nurses working in a general ED setting but not specifically on how these general ED nurses perceived and coped with the circumstances and associated stressors

of working with patients presenting with a mental health concerns. Therefore, it was difficult to draw comparisons between general ED nursing staff and EMHT nursing staff.

A fourth limitation of this investigation was the use of telephone interviews to gather data from participants. The researcher would have been unable to assess the body language of participants in response to matters relating to stressful events. During the interviews, the participants' rate, tone, and volume of their voices were evenly paced and appropriate for the general conversation about the day to day experiences of working in the ED. Emotional reactions to stressors were evident by the changing rate, tone and volume of participants speech. Participants were forthcoming during these times and identified their emotions in relation to the experience being discussed. These descriptions included feeling annoyed, frustrated, and anxious.

One of the strengths associated with this investigation included the amount of time participants spent in their jobs. As previously discussed, participants who contributed to this study had been in their roles for several years and had developed positive coping strategies for dealing with this high stress work environment. Learning from these findings will hopefully contribute to the development and increased support of other successful EMHTs based on participants experiences with stressors and coping strategies. Another strength is that both EMHTs included in this study were supervised by the same management team and were set up with the same functions in regards to patient care. This contributed to some consistency in findings between participants from both teams.

Chapter 6: Conclusion

This research investigation explored emergency department (ED) mental health nurses' experiences of occupational stressors and coping strategies in context of working on an emergency department mental health team (EMHT). The intent of this research was to describe the unique stressors in this environment and to highlight positive and helpful coping strategies developed by nursing staff in this highly acute area of mental healthcare. Findings are hoped to improve nursing turnover and absenteeism by lending a greater understanding of both stressors and supports within the ED setting. The research question that this study sought to answer was: what is the lived experience of dealing with occupational stress as a mental health nurse working on an emergency department mental health team?

The method chosen to answer this research question was a qualitative descriptive approach where participants described their lived experiences and a common description was derived. The Theory of Stress and Coping was used as a theoretical framework platform to guide the development of this research as it is concerned with cognitive appraisal and coping while taking into consideration the individualized approach to stress and coping. This acknowledged the influence of the person-environment relationship. This theory was used as a foundation to guide the data analysis and discussion portions of this research by examining stressors and coping strategies.

Participants shared they generally enjoyed this work environment where they were constantly learning, felt like a valued member in a rewarding team environment, were challenged daily, and utilized a variety of experiences and nursing skills. One of the main aspects of this job that participants enjoyed was working to a full scope of practice.

However, participants did share many stressful factors associated with this environment whose themes included feeling morally distressed about patient care, working in an exhausting environment, and incivility in the workplace. Some of these stressors were divided into sub-themes. Feeling morally distressed about patient care included managing time scarcity, feeling spread thin, doubting one's clinical confidence, and not having the ability to influence patient movement. Working in an acute and uncertain environment included feeling on edge, feeling desensitized, lack of a purposely built space, and dealing with the impact of stigma towards patient care. Incivility in the workplace included discord with the general emergency department and experiencing friction among team members.

Participants described their abilities to remain patient focused in this challenging environment and described a strong sense of caring for their vulnerable patient population. Some of the themes derived from the study for coping strategies included learning to work together, a shift in perspective, and personal coping strategies. Similarly to stressors, coping strategies were further divided into sub themes. Learning to work together included developing positive relationships, supporting EMHT colleagues, and feeling supported by management. A shift in perspective included remaining patient focused, utilizing mental health skills and adapting one's nursing practice. Under the theme of maintaining work-life balance, participants discussed their personal strategies to maintain wellness while away from work and on shift.

This research has provided further understanding of the experience of the mental health nurse working on an EMHT. Previous literature had not addressed this important and emerging area of healthcare. Gaining the perspectives of participants was

enlightening, particularly in comparison to information gathered from previous literature. Participants have provided insight into the unique stressors one may experience in this workplace environment and have offered coping strategies that are helpful to mitigate them. It is hoped that these findings will be used to further support the ongoing development and support for EMHTs, and provide information to EDs to help develop their emergency mental health services. Identifying the factors, challenges and barriers faced by these teams is integral in developing support for resilient nursing care teams that in turn provide quality patient care.

References

Adriaenssens, J., De Gucht, V., & Maes, S. (2015). Causes and consequences of occupational stress in emergency nurses, a longitudinal study. *Journal of Nursing Management, 23*(3), 346-358.

Adriaenssens, J., De Gucht, V., Van Der Doef, M., & Maes, S. (2011). Exploring the burden of emergency care: Predictors of stress-health outcomes in emergency nurses. *Journal of Advanced Nursing, 67*(6), 1317-1328.

Alberta Health Services. (2018). *Restraint as a Last Resort Policy.* (Document# HCS-176). Retrieved from: https://extranet.ahsnet.ca/teams/policydocuments/1/clp-prov-restraint-hcs-176.pdf#search=least%20restraint%20policy.

Armstrong, J. (2001). *Workplace Stress in Ireland.* Irish Congress of Trade Unions, Dublin.

Austin, W., Bergum, V., & Goldberg, L. (2003). Unable to answer the call of our patients: mental health nurses' experience of moral distress. *Nursing Inquiry, 10,* 177-183.

Basu, S., Yap, C., & Mason, S. (2016). Examining the sources of occupational stress in an emergency department. *Occupational Medicine, 66*(9), 737-742.

Browning, L., Ryan, C. S., Thomas, S., Greenburg, M., & Rolniak, S. (2007). Nursing specialty and burnout. *Psychology, Health & Medicine, 12*(2), 248-254.

Burtson, P. L., & Stichler, J. F. (2010). Nursing work environment and nurse caring: relationship among motivational factors. *Journal of Advanced Nursing, 66,* 1819-1831.

Canadian Federation of Nurses Unions. (2017). *Overtime and Absenteeism Fact Sheet, 2017*. Retrieved from https://nursesunions.ca/research/overtime-and-absenteeism-fact-sheet-2017/

Clarke, D. E., Hughes, L., Brown, A., Motluk, L. (2005). Psychiatric emergency nurses in the emergency department: the success of the Winnipeg, Canada, experience. *Journal of Emergency Nursing, 31*(4), 351-356.

Creswell, J. W. (2013). *Qualitative inquiry & research design: Choosing among five approaches* (3rd ed.). Thousand Oaks, CA: Sage Publications.

Edward, K., Ousey, K., Warelow, P., & Lui, S. (2014). Nursing and aggression in the workplace: a systematic review. *British Journal of Nursing, 23*(12), 653-659.

Edwards, J. A., Guppy, A., & Cockerton, T. (2007). Relationships between occupational stressors, non-work stressors and work performance: a longitudinal multi-group investigation. *Work and Stress, 21*(2), 99-116.

Ekstadt, M., & Fagerberg, I. (2005). Lived experiences of the time preceding burnout. *Journal of Advanced Nursing, 49*(1), 59-67.

Elo, S., Kyngas, H. (2008). The qualitative content anslysis process. Journal of Advanced Nursing, 62, 107-115.

Ersoy-Kart, M. (2009). Relations among social support, burnout, and experiences of anger: An investigation among emergency nurses. *Nursing Forum, 44*(3), 165-174.

Escriba-Aguir, V., & Perez-Hoyos, S. (2007). Psychological well-being and psychosocial work environment characteristics among emergency medical and nursing staff.

Stress & Health: Journal of the International Society for the Investigation of Stress, 23(3), 153-160.

Fernandez-Parsons, R., Rodriguez, L., & Goyal, D. (2013). Moral distress in emergency nurses. *Journal of Emergency Nursing, 39*(6), 547-552.

Figley, C. R. (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized.* New York, NY: Brunner/Mazel.

Flarity, K., Gentry, J. E., & Mesnikoff, N. (2013). The effectiveness of an educational program on preventing and treating compassion fatigue in emergency nurses. *Advanced Emergency Nursing Journal, 35*(3), 247-258.

Folkman, F., Lazarus, R. S., Dunkel-Schetter, C., DeLongis, A., & Gruen, R. J. (1986). Dynamics of a stressful encounter: Cognitive appraisal, coping, and encounter outcomes. *Journal of Personality and Social Psychology, 50*(5), 992-1003.

Garcia-Izquierdo, M., & Rios-Risquez, M. I. (2012). The relationship between psychosocial job stress and burnout in emergency departments: An exploratory study. *Nursing Outlook, 60*, 322-329.

Gillespie, M., & Melby, V. (2003). Burnout among nursing staff in accident and emergency and acute medicine: a comparative study. *Journal of Clinical Nursing, 12*(6), 842-851.

Happell, B. (2008). Putting all the pieces together: Exploring workforce issues in mental health nursing. *Contemporary Nurse Journal, 29*(1), 43-52.

Healy, S., & Tyrrell, M. (2011). Stress in emergency departments: experiences of nurses and doctors. *Emergency Nurse, 19*(4), 31-37.

Hooper, C., Craig, J., Janvrin, D. R., Wetsel, M. A., & Reimels, E. (2010). Compassion satisfaction, burnout, and compassion fatigue among emergency nurses compared with nurses in other selected inpatient specialties. *Journal of Emergency Nursing, 36*(5), 420-427.

Hu, Y., Chen, J., Chiu, H., Shen, H., & Chang, W. (2010). Nurses' perception of nursing workforce and its impact on the managerial outcomes in emergency departments. *Journal of Clinical Nursing, 19*(11/12), 1645-1653.

Humble, F., & Cross, W. (2010). Being different: A phenomenological exploration of a group of veteran psychiatric nurses. *International Journal of Mental Health Nursing, 19*, 128-136.

Hunsaker, S., Chen, H., Maughan, D., & Heaston, S. (2015). Factors that influence the development of compassion fatigue, burnout, and compassion satisfaction in emergency department nurses. *Journal of Nursing Scholarship, 47*(2), 186-194.

Jackson, J., & Morrissette, P. J. (2014). Exploring the experience of Canadian registered psychiatric nurses: A phenomenological study. *Journal of Psychiatric and Mental Health Nursing, 21*, 138-144.

Jameton, A. (1984). *Nursing practice: The ethical issues.* Englewood Cliffs, NJ: Prentice Hall Inc.

Jenkins, R., & Elliott, P. (2004). Stressors, burnout and social support: nurses in acute mental health settings. *Nursing and Health Care Management and Policy, 48*(6), 622-631.

Joinson, C. (1992). Coping with compassion fatigue. *Nursing, 22*(4), 118-121.

Jones, C. B., & Gates, M. (2007). The costs and benefits of nurse turnover: A business case for nurse retention. *Online Journal of Issues in Nursing, 12*(3), Manuscript 4.

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping.* New York, NY: Springer.

Lazarus, R. S., & Folkman, S. (1987). Transactional theory and research on emotions and coping. *European Journal of Personality, 1*(3), 141-169.

Li, B., Bruyneel, L., Sermeus, W., Van den Heed, K., Matawie, K., Aiken, L., & Lesaffre, E. (2013). Group-level impact of work environment dimensions on burnout experiences among nurses: A multivariate multilevel probit model. *International Journal of Nursing Studies, 50*, 281-291.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic Inquiry*. Newbury Park, CA: Sage.

Marynowski-Traczyk, D., & Broadbent, M. (2011). What are the experiences of emergency department nurses in caring for clients with a mental illness in the emergency department? Australasian Emergency Nursing Journal, 14, 172-179.

Maslach, C., Jackson, S. E., & Leiter, M. P. (1996). *The Maslach Burnout Inventory*. (3rd ed.). Palo Alto, CA: Consulting Psychologists Press.

McArthur, M., & Montgomery, P. (2004). The experience of gatekeeping: a psychiatric nurse in an emergency department. *Issues in Mental Health Nursing, 25*(5), 487-501.

Moustakas, C. (1994). *Phenomenological research methods.* Thousand Oaks, CA: Sage.

O'Brien-Pallas, L., Murphy, G. T., Shamian, J., Li, X., & Hays, L. H. (2010). Impact and determinants of nurse turnover: a pan-Canadian study. *Journal of Nursing Management, 18,* 1073-1086.

O'Mahony, N. (2011). Nurse burnout and the working environment. *Emergency Nurse, 19*(5), 30-37.

Patton, M. Q. (2015). *Qualitative evaluation and research methods* (3rd ed.). Newbury Park, CA: Sage.

Polit, D. F., & Beck, C. T. (2012). *Nursing Research: Generating and Assessing Evidence for Nursing Practice.* (9th ed.). Philadelphia, PA: Wolters Kluwer

Polit, D. F., & Hungler, B. P. (1999). *Nursing Research: Principles and Methods*. (6th ed.). Philadelphia, PA: Lippincott Williams & Wilkins.

Ribeiro, R. M., Pompeo, D. A., Pinto, M. H., & Ribeiro, R. C. H. M. (2015). Coping strategies of nurses in hospital emergency care services. *Acta Paulista de Enfermagem, 28*(3), 216-223.

Rios-Risquez, M, I., & Garcia-Izquierdo, M. (2016). Patient satisfaction, stress and burnout in nursing personnel in emergency departments: A cross sectional study. *International Journal of Nursing Studies, 59,* 60-67.

Ross-Adjie, G., Leslie, G., & Gillman, L. (2007). Occupational stress in the ED: What matters to nurses? *Australian Emergency Nursing Journal, 10,* 117-123.

Sawatzky, J. V., & Enns, C. L. (2012). Exploring the key predictors of retention in emergency nurses. *Journal of Nursing Management, 20*(5), 696-707.

Simon, C. E., Pryce, J. G., Roff, L. L., & Klemmack, D. (2005). Secondary traumatic stress and oncology social work: Protecting compassion from fatigue and

compromising the worker's worldview. *Journal of Psychosocial Oncology*, *23*, 1-14.

Streubert, H. J., & Carpenter, D. R. (2011). *Qualitative research in nursing. Advancing the humanistic imperative.* (5th ed.). Philadelphia, PA: Wolters Kluwer | Lippincott, Williams & Wilkins.

Udod, S., & Care, W. D. (2017). 'Walking a tight rope': an investigation of nurse managers' work stressors and coping experiences. *Journal of Research in Nursing, 18*(1), 67-79.

Udod, S., Cummings, G., Care, W. D., & Jenkins, M. (2017). Impact of role stressors on the health of nurse managers: A Western Canadian context. *Journal of Nursing Administration, 47*(3), 159-164.

Vaismoradi, M., Turunen, H., & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. Nursing & Health Sciences, 15(3), 398-405.

Wilkinson, J. M. (1987/1988). Moral distress in nursing practice: Experience and effect. *Nursing Forum, 23*(1), 16-29.

Wolf, L. A., Perhats, C., Delao, A. M., Moon, M. D., Clark, P. R., & Zavotsky, K. E. (2016). "It's a burden you carry": Describing moral distress in emergency nursing. *Journal of Emergency Nursing, 42*(1), 37-46.

Yoder, E. A. (2010). Compassion fatigue in nurses. *Applied Nursing Research, 23*, 191-197.

Appendix A

Definitions

Canadian Regulated Nurses – includes Licensed Practical Nurses, Registered Psychiatric Nurses, and Registered Nurses who are governed by a recognized regulating body.

Mental Health Nurse – in this investigation includes both Registered Psychiatric Nurses and Registered Nurses that work in the Emergency Department on Emergency Department Mental Health Teams.

Q15 – A short hand clinical term meaning every 15 minutes. Participants indicated this occasionally as they referred to observational levels of patients within the ED where the patient must be observed by a nursing staff every 15 minutes.

Appendix B

Emergency Department Mental Health Nurses' Perceptions of Occupational Stressors and Utilization of Coping Strategies

Invitation to Participate

Hello, my name is Michaela Vermeulen and I am a Graduate student in the Master of Psychiatric Nursing program at Brandon University. As part of my graduate research, I am looking for Registered Nurses or Registered Psychiatric Nurses who have worked on an Emergency Department Mental Health Team in either a part or full time role for a minimum of one year. I am inviting these individuals to participate in an investigation that will seek to describe the lived experience of mental health nurses facing occupational stressors and coping strategies

The purpose of this research project is to determine how nurses perceive and cope with occupational stressors. This information will be used to recognize the impact of occupational stressors on nurse caring, aide in the development of resilient Emergency Department Mental Health nursing teams, and identify areas requiring additional organizational support.

This research is being conducted for a graduate thesis. All efforts to maintain participants' confidentiality will be done and any identifying information will not be traceable back to participants. Participants will be asked to set up an interview with myself, where I will ask you to describe your experience working in the Emergency Department and how you have coped with them in both short, and long term. I will gather demographic information from you to give context to findings from this investigation which will include your: age, gender, professional designation, number of years worked as a nurse and number of years worked in the emergency department. This information will be kept separate from interview findings and will not be traceable back to your identity. I will also be asking you questions pertaining to your own health and wellness as it relates to these occupational stressors. Interviews are anticipated to take between half an hour, and an hour to complete.

Please be aware that participation in this study is completely voluntary and you may decline to answer any specific questions and may withdraw at any time. However, once recorded interviews are transferred from verbal recording into a written document, all identifying information will be removed. Once your data is anonymized, participants will not be able to withdraw their data.

This research project is deemed to be "minimal risk", which means that there is no forseeable harm that may come to you by participating in this study. However, some participants may feel distressed when discussing the impact of stress on their lives. If you do require emotional support, you can contact free counseling services through the Employee Assistance Program at 1-877-273-3134, or may access workhealthlife.com for online information, support and services.

You can contact me at PRATTM165@BRANDONU.CA or at 780-405-3398 if you have any questions or concerns or are interested in participating in the study.

Dr. Dean Care is the thesis supervisor of this project and can be contacted at CARED@BRANDONU.CA with any questions or concerns.

If there are any concerns regarding possible ethical issues, concerns with this project, or questions about your rights as a potential research participant, you may contact the Brandon University Research Ethics Board at BUREC@BRANDONU.CA or at 204-727-9712, or the University of Alberta Health Research Ethics at 780-492-2615.

Appendix C

PARTICIPANT CONSENT FORM

Title of Study: Emergency Department Mental Health Nurses' Perceptions of Occupational Stressors and Utilization of Coping Strategies

Principal Investigator: Michaela Vermeulen
780-405-3398

Research/Study Coordinator: Dr. Dean Care

Why am I being asked to take part in this research study?

You are being asked to be in this study because you are a Registered Nurse or Registered Psychiatric Nurse that works on an Emergency Department Mental Health Team in a part- or full time position for more than one year. This study will provide insight into how nurses perceive and cope with occupational stressors that will, in turn, lead to increased awareness for support needed in this area of healthcare.

The purpose of this Information Sheet is to describe to you the specific purpose of this study and how it will be conducted as well as your rights as a potential participant. Before you make a decision one of the researchers will go over this form with you. You are encouraged to ask questions if you feel anything needs to be made clearer. You will be given a copy of this form for your records.

What is the reason for doing the study?

The purpose of this research project is to determine how nurses perceive and cope with occupational stressors. This information will be used to recognize the impact of occupational stressors on nurse caring, aide in the development of resilient Emergency Department Mental Health nursing teams, and identify areas requiring additional organizational support.

What will I be asked to do?

You will be interviewed in a place of your own personal choice at a time that is convenient to you. You will be asked some questions about your experience as a mental health nurse working in the emergency department, your experience with occupational stressors and how you have chosen to deal with stressful situations. You will be asked to provide some demographic information to provide context to research findings including your gender, age, professional designation, years of experience and number of years working in the emergency department on a mental health team.

Your interview with the researcher will take about 30 minutes to an hour to complete. These interviews will be audio-recorded and will be kept in a secured location.
You may be contacted via telephone within a three month time period and be given the opportunity to provide feedback on a summary of the description of findings from the investigation. You can choose to decline a follow-up interview, or can provide verbal consent at that time for a brief follow-up conversation with the researcher about the study's findings.

What are the risks and discomforts?

Discussing your experiences with occupational stressors may be distressing to some participants. If you do require emotional support, you can contact free counseling services through the Employee Assistance Program at 1-877-273-3134, or may access workhealthlife.com for online information, support and services.

It is not possible to know all of the risks that may happen in a study, but the researchers have taken all reasonable safeguards to minimize any known risks to a study participant.

What are the benefits to me?

It may be beneficial for participants to have a chance to share their experiences of working in a stressful environment with someone outside of one's normal social circle or work environment. However, you may not get any benefit from being in this research study. This study may help to recognize them impact of occupational stressors on nurse caring, aide in the development of resilient nursing teams and identify areas that may require additional organizational support both in and outside of your organization.

Do I have to take part in the study?

Taking part in this study is your own choice. If you decide to be in this study, you can change your mind at any time, and it will in no way affect your employment that you are entitled to. You do not have to answer any questions during the interview that you are not comfortable with and can end the interview at any time.

You are free to withdraw from this study at any time by notifying the principle investigator, Michaela Vermeulen, verbally in person or via telephone, or written via email. However, once your audio recorded interview has been transferred into written format, your information and data will be anonymized and your interview will not be able to be removed from the study. Transferring of audio recorded interviews into written format will happen within 72 hours of your interview. If you choose to withdraw from the study and your interview has been transcribed, you will be informed of this and you will not be contacted again regarding this study.
By participating in this investigation you do not waive any rights to legal recourse in the event of research-related harm.

Will I be paid to be in the research?

There is no financial compensation for participating in this investigation.

Will my information be kept private?

Your audio recorded interview and answers to interview questions will not be reviewed or shared with anyone other than the primary investigator.

During the study we will be collecting demographic information for the purpose of providing context to findings from this investigation. We will do everything we can to make sure that this data is kept private. No data relating to this study that includes your name will be released outside of the researcher's office or published by the researcher. Sometimes, by law, we may have to release your information with your name so we cannot guarantee absolute privacy. However, we will make every legal effort to make sure that your information is kept private.

What if I have questions?

If you have any questions about the research now or later, please contact Michaela Vermeulen at prattm165@brandonu.ca or 780-405-3398.

If you have any questions regarding your rights as a research participant, you may contact the Brandon University Research Ethics Committee at burec@brandonu.ca or 204-727-9712, or the University of Alberta Health Research Ethics Board at 780-492-2615. These offices have no affiliation with the study investigator.

There are no declared conflicts of interest on the part of the researcher and their institutions with this research study.

CONSENT

Title of Study: Emergency Department Mental Health Nurses' Perceptions of Occupational Stressors and Utilization of Coping Strategies

Principal Investigator(s): Michaela Vermeulen **Phone Number(s): 780-405-3398**
Study Coordinator: Dr. Dean Care **Phone Number(s): 204-727-7456**

Yes	No
Do you understand that you have been asked to be in a research study?	
☐	☐
Have you read and received a copy of the attached Information Sheet?	
☐	☐
Do you understand the benefits and risks involved in taking part in this research study?	
☐	☐
Have you had an opportunity to ask questions and discuss this study?	
☐	☐
Do you understand that you are free to leave the study at any time,	
☐	☐
without having to give a reason and without affecting your employment without penalty?	
Has the issue of confidentiality been explained to you?	
☐	☐
Do you understand who will have access to your study records?	
☐	☐

Who explained this study to you?
_____

I agree to take part in this study:

Signature of Research Participant
_____

(Printed Name)
_____

Date:_____

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

Signature of Investigator or Designee_____ Date _____

THE INFORMATION SHEET MUST BE ATTACHED TO THIS CONSENT FORM AND A COPY GIVEN TO THE RESEARCH PARTICIPANT

Appendix D

Emergency Department Mental Health Nurses' Perceptions of Occupational Stressors and Utilization of Coping Strategies

Verbal Consent script for follow-up phone call

Hello [participant name],

This is Michaela Vermeulen. I am contacting you in follow-up from your participation in the study titled 'Emergency Department Mental Health Nurses' Perceptions of Occupational Stressors and Utilization of Coping Strategies' to give you an opportunity to provide feedback on the study's findings.

Is this something you are interested in participating in?

(If yes…)
In review, the purpose of this study was to determine how nurses perceived and coped with occupational stressors. I will read to you a summary of your interview and a description that was created based on participants interviews, and you are welcome to provide any feedback. I will make notes on your feedback that will be incorporated into the study's findings. All feedback will remain anonymous. This follow-up interview is meant to be brief and will take anywhere from 10 to 20 minutes to complete based on your feedback.

Taking part in this follow-up interview is your own choice. If you decide to participate, you can change your mind at any time. You will not be penalized in any way. There is no financial compensation to participating in this follow-up interview. Please refer to the full consent documents provided at the study outset. Would you like a new copy to be sent to you?

Would you like to continue participating in this follow-up interview? By continuing with the interview, your consent is implied.

Appendix E

Interview Questions

1. Please tell me about your experience as an RN/RPN working in an urban ED setting, on an Emergency Mental Health Team?
2. What are some demands (pressures) of working in the Emergency Department on a Mental Health Team?
3. How did you feel in situations that you perceived to be threatening, but were unable to deal with the threat? What strategies did you use, or what did you do to manage this stress?

    a. What are some resources available to help cope with these demands in the Emergency Department on a Mental Health Team?
    b. What influences how you assess a stressful event or situation?
    c. What are some situations that you perceive to have no threat to you personally?
    d. What are some situations that you perceive to be harmful, threatening, or challenging?
    e. How did you feel in situations that you perceived to be threatening, but were able to cope with the threat? What strategies did you use, or what did you do to cope with this stress?
        i. What are some short-term outcomes in these situations as they pertain to your physical and emotional health?
        ii. What are some long-term outcomes in these situations as they pertain to your physical and emotional health?
    f. What do you do to take care of your physical and emotional health (i.e. self-care activities)?
    g. What do you do to care for other nurses working in the Emergency Department on a Mental Health Team?
    h. What is your perception of how other nurses on the team perceive and cope with stressful events or situations?
    i. How do the leaders in your organization support the team when it comes to dealing with stressful events or situations?

Appendix F

Demographic Data Form

Consent Signed Date and Time:	
Age:	
Gender:	
RN or RPN:	
Number of years working as a nurse:	
Number of years working in the Emergency Department on a Mental Health Team:	

Appendix G

Brandon University Research Ethics Committee (BUREC) Ethics Certificate for Research Involving Human Participants

The following ethics proposal has been approved by the BUREC. **Ethics Certification is valid for up to five (5) years from the date approved, pending receipt of Annual Progress Reports.** As per *BUREC Policies and Procedures*, section 6.0, "At a minimum, continuing ethics research review shall consist of an Annual Report for multi-year projects and a Final Report at the end of all projects... Failure to fulfill the continuing research ethics review requirements is considered an act of non-compliance and may result in the suspension of active ethics certification; refusal to review and approval any new research ethics submissions, and/or others as outlined in Section 10.0".

Any changes made to the protocol must be reported to the BUREC prior to implementation. See *BUREC Policies and Procedures* for more details.

As per *BUREC Policies and Procedures*, section 10.0, "Brandon University requires that all faculty members, staff, and students adhere to the *BUREC Policies and Procedures*. The University considers non-compliance and the inappropriate treatment of human participants to be a serious offence, subject to penalties, including, but not limited to, formal written documentation including permanently in one's personnel file, suspension of ethics certification, withdrawal of privileges to conduct research involving humans, and/or disciplinary action."

Principal Investigator:	**Ms. Michaela Vermeulen, Brandon University**
Title of Project:	**The Experience of Stress and Coping Among Emergency Department Mental Health Nurses**
Co-Investigators:	**n/a**
Faculty Supervisor:	Dr. W. Dean Care, Brandon University
(if applicable)	
Research Ethics File #:	22236

Date of Approval: January 17, 2018

Ethics Expiry Date: January 17, 2023

Authorizing Signature:

Mr. Christopher Hurst

Co-Chair, Brandon University Research Ethics Committee (BUREC)

Approval Form

Date:	March 6, 2018
Study ID:	Pro00078598
Principal Investigator:	Michaela Pratt
Study Title:	The Experience of Stress and Coping Among Emergency Department Mental Health Nurses
Approval Expiry Date:	Tuesday, March 5, 2019

Approved Consent Form:	Approval Date	Approved Document
	3/6/2018	Written Consent Form.docx
	3/6/2018	Informed Consent Document.doc
	3/6/2018	Verbal Consent.docx

Thank you for submitting the above study to the Health Research Ethics Board - Health Panel. Your application, approved under the Western Reciprocity Agreement and including the following, has been reviewed and approved on behalf of the committee;

- Invitation to Participate (2/20/2018)
- Interview Questions (1/20/2018)

A renewal report must be submitted next year prior to the expiry of this approval if your study still requires ethics approval. If you do not renew on or before the renewal expiry date, you will have to re-submit an ethics application.

Approval by the Health Research Ethics Board does not encompass authorization to access the patients, staff or resources of Alberta Health Services or other local health care institutions for the purposes of the research. Enquiries regarding Alberta Health Services approvals should be directed to (780) 407-6041. Enquiries regarding Covenant Health should be directed to (780) 735-2274.

Sincerely,

Anthony S. Joyce, PhD.
Chair, Health Research Ethics Board - Health Panel

Note: This correspondence includes an electronic signature (validation and approval via an online system).