Original Article - Accepted

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Accountability issues in an English emergency department: A nursing perspective

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(2020) International Emergency Nursing

Doi: 10.1016/j.ienj.2020.100881.

ABSTRACT

Introduction: Nurses confront doubts about their accountability and how it affects their clinical practice daily in the complex environment of an emergency department. Therefore, nurses' experiences can provide vital information about the decisions and dilemmas in clinical practice that affect both healthcare professionals and patients alike.

Aim: The aim of this study was to explore the perceptions of nursing staff in an English emergency department in relation to their ethical, legal and professional accountability.

Methods: Ethnographic content analysis was used to analyse 34 semi-structured interviews from registered nurses working in an emergency department.

Results: There were five categories found during the coding process: nursing care, staff interactions, legal and professional accountability, decision-making process and ethics and values.

Conclusion: Several issues related to nursing accountability were found, including the effects of nursing shortages and the reasoning behind multidiscipinary team conflicts. Different approaches of individual and institutional accountability, the evolution of Benner's nursing model and nursing value progression was also identified as key issues. All these phenomena affect nursing accountability in different ways, so their comprehension is paramount to understand and influence them to benefit both patients and nurses

KEY WORDS

Accountability, Emergency nursing, Decision making, Nurse–patient relationship, Motivation, Work conditions

ETHICAL STATEMENT

As part of the research study "Ethical and legal accountability in nursing clinical practice: analysis of protocols and clinical activity in an English emergency department", it had the approval of the National Health Service Health Research Authority, University Hospitals of Leicester Research and Innovation Department and De Montfort University Faculty of Health and Life Sciences Research Ethics Committee (reference 1933).

FUNDING

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

CONFLICT OF INTEREST STATEMENT

None declared.

INTRODUCTION

National Health Service (NHS) nurses that work in an English emergency department (ED) have to perform their duties in a challenging environment that affects their working conditions [1]. Aggravated by this context, nurses confront doubts about their responsibilities and how these affect their clinical practice daily. These doubts are answered individually with help from theory and experience, but they also have to consider their accountability towards the patient, the public, the Nursing and Midwifery Council (NMC) and themselves when making decisions [2].

Even though we did not find ample research in the specific subject of English emergency nurses' perceptions of their accountability, there is evidence that can be linked to it. Krautscheid published a detailed analysis of accountability as a theoretical concept, but it was aimed mainly at nursing education [3]. Similarly, Person et al. delved into the culture of an emergency department but did not examine how that culture affects nursing accountability [4].

Moreover, this topic is an international issue due to the globalization of emergency care and the shared accountability challenges that it brings, such as care prioritisation in a crowded department [5]. Accountability issues found by Hassanian et al. [6] in Iran, are similar to the ones found in English EDs. Additionally, Lin et al. showed that appropriate interventions can promote nursing accountability and improve outcomes in a Taiwanese ED [7].

Considering that trust is a subjective concept [8] and that nurses' experiences can provide vital information of their decisions and dilemmas in practice [9], examining nurses' perception of their own accountability can provide reliable information on how nursing accountability is understood and applied during decision-making processes. Therefore, this research is aimed to analyse those experiences to understand emergency nursing accountability holistically and use this knowledge to find causes and possible solutions for current problems like clinical errors, defensive practice or nursing recruitment and retention.

Consequently, the main research question was: how do emergency nurses perceive their accountability in relation to the decisions made during clinical practice?

Aim

The aim of this study was to explore the perceptions of nursing staff in an English ED in relation to their ethical, legal and professional accountability.

METHOD

Study design

This study used an ethnographic content analysis (ECA) approach [10], which allowed the contextualisation of human action in relation to their environment through fieldwork. Ethnographic content analysis is a methodology that combines the ability of qualitative content analysis for discovering emergent patterns in data with the reflective nature of ethnography techniques [10]. This facilitated a holistic exploration of different perspectives on nursing accountability without removing them from their context or simplifying their values.

This study is part of a research project involving observation, interviews and policy analysis, which were triangulated together to provide a model for nursing accountability [11]. Nonetheless, this study delves deeply into nurses' experiences only, providing key information that is lost during triangulation and analysing it differently to provide different results.

Sampling

Participants were recruited through purposeful sampling from a large ED within the region of the East Midlands in England between May and August 2017. 186 nurses worked in that ED in the study period.

Purposive sampling was employed to ensure similar demographic distribution between the sample and the total of ED nursing staff. All nurses that worked more than four shifts per month for more than six months in ED were eligible to participate (inclusion criteria) to ensure that they had clinical experience in making decisions. The exclusion criteria were nurses that worked in another ED as permanent members of staff or nurses that did not have capacity to consent. Recruitment strategies included advertisements in the ED staff room and during the shift meetings. Interviewees contacted us after seeing the advertisements and then we sent them the information leaflet and arranged an interview. Thirty four participants were recruited before data saturation was reached.

Data collection

Demographic information was collected from each interviewee. Most of the participants were adult nurses, while the gender, experience and culture ratio were consistent with the total number of ED nurses (see Table 1).

Face-to-face individual interviews were completed between May and August 2017, lasting between 25 and 86 min, by a PhD student that had extensive research training and worked as a nurse in the same ED at the time of the study.

We chose to use semi-structured interviews due to how sensitive accountability as a topic was for the participants, as it allows exploring in-depth experiences when little is known about a sensitive topic without deviating from it [12]. The interview guide had nursing

accountability as the core question, being supported by task prioritisation, decision making, team perception and stress management, since there are linked to the different aspects of their accountability. These questions were developed using the researchers' reflections on practice and expert support from two nursing experts [10,13].

All interviews were audio-recorded, transcribed verbatim and anonymised prior to data analysis. At the end of the interview, the recorder was turned off and a member check was done, clarifying concepts and verifying the accuracy of the information obtained. Only one interview was carried out per participant and no participant feedback was necessary after the interview day due to the member check.

Data analysis

Recorded interviews were transcribed and coded, adding the member checks. These were anonymised and analysed. The data analysis segment included six phases: (1) coding frame creation, (2) transcript division, (3) first pilot phase, (4) second pilot phase, (5) first main coding phase and (6) second main coding phase (see Fig. 1) [10,14].

Categories and subcategories were established in a coding frame using both transcripts' information and ED's context through Saldaña's descriptive coding (coding by topic) and subcoding (coding in two different layers to create detailed subcategories) [15]. This coding frame was then applied to a random selection of 25% of the transcripts, which were divided as units of coding based on a thematic criterion (defining the limit between units of coding when the category changes), in two pilot phases which were 13 days apart. After evaluating both pilot phases using Schreier's requirements for coding frames [14], the coding frame was verified and used in the first and second main coding phases, when the researcher codified all the transcripts twice 11 days apart. This enabled the results to be compared and consistent categories to be created, again meeting Schreier's requirements.

All transcripts were then transferred to Nvivo (version 11.4.1.1064) to organise them in a digital format. However, no automated computerized methods were used to code data. As a result, a list of emergent categories with their subcategories was created, representing all the data collected through inductive methodology.

Ethical considerations

Informed consent was obtained from every participant before their interview. This study had the approval of the correspondent research ethics committees and NHS authorities.

All potential participants were sent the participant information sheet in advance and were contacted before the interview to ask any questions. Before each interview, in order to obtain written informed consent, the researcher explained the purposes and procedures of the research, the risks and benefits associated with the study, the right for participant withdrawal at any time without penalty and how the data provided by the participant would be protected and stored to protect confidentiality, offering a second opportunity to ask any questions before obtaining informed consent. No participants refused to participate

or withdrew after being recruited. No further ethical issues or sensitivities were identified by the participants or the researchers.

Trustworthiness

Korstjent and Moser's definition of trustworthiness criteria was used [16]. Prolonged engagement, persistent observation and member checks after each interview were employed to boost credibility, while thick description of the results increased transferability.

Dependability and confirmability were established following the COREQ checklist [17], providing a thorough description of the research steps taken and adding all interview transcriptions to a public repository [18]. Moreover, the role of the researcher in the field was considered and documented in the discussion, which enhanced reflexivity.

RESULTS

1. Nursing care and the nurse–patient relationship

Staffing levels were the factor most often mentioned by participants when asked what they would change in their ED. Interviewees indicated that there was not enough staff, which directly affected patient safety, quality of care and staff morale.

> Participant (P) 23: More staff will be lovely, that's not going to happen. I know nurses that have been in tears just because they feel that they are not doing enough for their patients.

Creating and maintaining a relationship between the nurse and the patient was deemed essential to provide care that met the patient's needs. A common prejudice on the nurse-patient relationship was the patient's lack of knowledge about the available healthcare services, which in turn can create unrealistic expectations.

> P31: [My priority] will always be the patient and keeping as many people informed around that patient as to what's going to happen to make their expectations realistic.

Patient satisfaction depended primarily on meeting patients' needs while they waited, not on the time they waited for diagnosis, treatment or transfer.

> P22: I think people don't mind waiting for a long time, but people mind waiting for a long time when it's uncomfortable, if they're cold, if they're hungry or thirsty.

2. Staff interactions

Person-to-person interactions between staff members were diverse but the ones mentioned continuously by participants were related to communication between colleagues. One of the most mentioned problems was the lack of communication, and how it caused clinical errors or unnecessary conflicts.

> P4: If we just communicate a little bit more, […] just make sure that someone can give

> it [medication] straight away and not only prescribe it and leave the prescription chart back in the draw.

Another factor affecting person-to-person interaction was hierarchy. Vertical social interactions (which are held between two professionals at different hierarchy levels) were considered destructive. This was exemplified by the interaction between junior nurses and managers.

> P10: Because we need to obey our managers too, it puts you in a tight corner that can move you away from working by evidencebased practice or following the NMC Code.

Participants indicated that leadership as an interaction between a person and a group could be constructive, treating his subordinates respectfully to facilitate teamwork, or destructive, basing it on a lack of respect towards the subordinated professionals.

> P30: I had someone say to me to change a flip-flop on a urinary catheter and I said "sorry, what's that?" and she said "that's why you should have a ward placement before you come here, shouldn't you?"

The participants mentioned two common group–group interactions: conflict and cooperation. Conflicts between two groups were relatively common, with conflicts between groups of nurses (horizontal conflicts) described differently than conflicts between groups with different professional roles (vertical conflicts). Horizontal conflicts were usually due to inappropriate clinical workload distribution, while vertical conflicts had other causes like abuse of power by doctors.

> P10: I have seen doctors giving drugs and not checking with anyone […]. Because the patient is under your name as well, if anything goes wrong you will definitely be dragged into a court case.

The most discussed case of vertical cooperation was among nurses and managers, through which managers provided nurses with the necessary resources to provide care, while horizontal cooperation was a support mechanism among different nursing groups to reduce stress and distribute clinical workload fairly.

> P3: We help each other as well when one of us is feeling stressed or upset about something […] we go and help each other to make everyone's job a little bit easier.

3. Legal and professional accountability

Individual accountability was perceived differently by junior and senior nurses, since junior nurses were accountable for the safety of patients under their care, while senior nurses were indirectly accountable for the safety of all patients in their area. However, both considered patient safety their main priority.

> P22: My priority is keeping the patient safe. I think it needs to be the overriding priority.

Participants knew the professional and personal consequences that an error could entail. In addition, junior and temporary nurses were more worried, so they were more prone to

actively protect their personal interests.

> P9: So many years of training to get the license and you do not want to throw it away. […] So, those [nursing] notes are done for no reason at all, just for when we are sued or blamed.

Despite the potential workload imbalances, participants tended to work together and did not try to blame each other for mistakes. On the other hand, shared accountability between nurses and other professionals was centred on the nurse, since healthcare assistants (HCAs) performed delegated tasks and doctors tended to blame nurses.

> P22: I think for a doctor delegating to a nurse, I think there's a case of "I told the nurse to do it" as opposed to a combined approach to the patient. […] They very much say "I wrote it down and it's not done".

Institutional accountability was managed through NHS Trust's targets by managers that frequently went to ED demanding actions to meet such targets. In their view, those managers were unaware of the risks that imposing their orders over the registered nurses' decision may have. Therefore, nurse coordinators supported registered nurses against managerial harassment.

> P8: I believe I become my staff's advocate to an extent. I am their buffer against anyone more senior coming down bullying and telling them what to do.

The hospital utilised policies to defend itself against possible litigation by protecting employees and patients, which entailed extensive documentation. This increased nurses' workload and forced them to choose between clinical practice and protecting the hospital

and themselves.

> P27: The most common thing that the Trust asks us to do is to document. It's very important because it gives us some data to rely on […]. That said, it takes time that I could spend doing something more practical for the patient.

4. Decision-making process

Decisions made by nurses in their professional role could involve several factors, but participants regularly mentioned three basic ones: clinical knowledge, clinical intuition and hospital policies.

Clinical knowledge was a combination of evidence-based theoretical knowledge and practical knowledge based on professional experience. The problem this entailed, as stated by the participants, was that practical knowledge progressively displaced theoretical knowledge, strengthening routines obtained during observed practice or their own, which were not always adequate to maintain optimal care standards.

> P4: I personally came across people that have been doing it [nursing practice] their way for so long that it's more difficult for them to change. Either they do not want to change because they believe there is nothing wrong with their practice in the first place or they just find it difficult.

Clinical intuition was a factor based on knowledge and past experiences, so it could be considered more subjective than clinical knowledge, at least as it is understood by the participants. Although it was not based on verified information, intuition was often used by the participants and was built into several policies.

> P25: I think gut feeling is brilliant. […] On the paediatric observation priority score we have a gut feeling bit in that it's integral.

Policies were considered the objective factor in clinical decisionmaking. They provided nurses with a professional and legal basis for decision-making. Nevertheless, policies were unable to adapt to different situations, demanded unreachable results and nurses were not aware of their content.

> P21: I know it's there for a reason, but some of the policies seem written by people that aren't actually working in those situations. They're like doing a table-top exercise "what's the best way of doing this in this situation?"

Senior nurses were engaged in coordinating teams, being accountable for the patients and the performance of their area, with all the additional factors that this involved. Therefore, they used policies more and clinical intuition less to support their decisions.

> P19: I had it where there were 175 patients in the department. Again, as long as I follow the procedures I would go out and say "look, we've got this waiting time, you're allowed to go home".

When asked about environmental factors, the participants consistently stated the importance of the relationship between patient flow, nurses' workload and crowding. They indicated that the lack of bed spaces in hospital wards slowed patient flow, which increased workload and crowding.

> P19: It is a top-down approach that requires, mainly for safety, capacity and flow because don't forget that if you don't have capacity and you don't have flow you can't be safe either.

Human resources were more complex to manage due to their scarcity, as every participant denounced even if there was no prepared question on this topic. They indicated the link between staffing levels, staff satisfaction, training and clinical workload, and how the lack of training and fellow nurses affected them.

> P22: You either need to lower your standards, which I don't think is preferable to anybody, or you need to increase staffing to meet the standards that are in place.

5. Ethics and values

In England, the NMC sets some values that all nurses must assimilate and demonstrate during their clinical practice through the NMC Code [19]. Junior participants assimilated the NMC Code in their clinical practice, while senior ones replaced the values stipulated by the NMC Code for personal values forged during clinical practice.

> P7: Yes, I think I am following the rules set by the NMC but… obviously the longer

> you've been qualified the more experience you get following your gut and I feel that when you feel something is not right normally it isn't.

Participants from other cultures forged an ethical responsibility after their university training, through which they felt responsible for fulfilling the values that their nursing culture represents, whereas acts related to legal accountability like defensive practice were more common in British participants.

> P1: I think that is a cultural issue, as I think it's [English custom] finding who's guilty of mistakes that happened rather than preventing those mistakes from happening in the first place.

Other values linked to professional culture are the ones related to following orders and rules, since while the British participants were accustomed to following policies, overseas participants tended to ignore policies based on what they believed will be beneficial for the patient.

> P26: Also, even if you think that you could do it quicker or have a better result, you have to follow them [policies] because they are procedures, […] but they're not very helpful.

As shown in these interviews, personal values were the ones mainly used in practice. However, if some professional or institutional values were compatible with the nurse's personal values, they were assimilated as part of the nurse's personal values.

> P22: Where we draw the line between my personal feelings and my professional feelings? I'm not really sure I can separate the two because my personal beliefs are driven by my professional work.

These interviews showed an evolution between the junior and the senior nurse and the dissociation of ethical accountability and clinical practice during this process. This began with the junior nurse, who connected practice with their personal moral looking for holistic care that satisfied them as a professional. However, the limitations of real practice generated frustration that decreased the nurse's satisfaction.

> P27: Some days like that are unmanageable because we don't have staff, too many patients, but this is not a surprise, we know that it's always like this, but what can you do?

When nurses gained experience, elements such as a constant high clinical workload and an unsafe work environment started to slowly dissociate their personal values from their clinical practice. Therefore, their values did not change but they ceased to apply them to their practice.

> P28: Sometimes you cannot follow your personal beliefs, there is no time.

The result of this process was that a percentage of senior nurses continued to maintain appropriate values for clinical practice, but since they were dissociated from their practice they did not feel accountable if they violated those values. This precipitated decentralisation and dissipation of their ethical accountability, since nurses blamed the institution and its managers for hampering the quality of the care that they provided

through the orders that they must follow.

P5: There are other situations that are out of your control but it isn't your fault.

DISCUSSION

The category mentioned by every interviewee was the lack of human resources and training and how it affected nurses' accountability through factors such as crowding and patient satisfaction. Ramsay et al. highlighted the connection between the lack of trained human resources and poor outcomes [20], while Recio-Salcedo et al. indicated the effect of unsafe staffing levels. Both articles are linked to negative effects on the accountability of overstretched ED nurses [21]. Therefore, healthcare institutions should reassess their targets and staff numbers to ensure that poor resourcing does not hinder nursing accountability.

Nurses interact with their colleagues in different ways, but traditional relationship models are still in place. The conflict between junior nurses and managers is relatively common in English nursing practice, which is supported by Brinkert's statement "conflict is a routine feature of Nursing" [22]. He further states that the sources and costs of conflict have been established and are tied to violence, staff turnover, patient outcomes and financial factors. Brinkert's sources of conflict were mentioned by the participants, but they are unable to avoid them because they practice in a conflicted bureaucratic structure that discourages multidisciplinary practice and teamwork.

The relationship and the use of the basic factors in clinical decision making were slightly different for each participant, but they followed a similar pattern to the one exposed by Benner in From Novice to Expert: increased used of clinical intuition by senior nurses and critical application of policies and evidence [23]. Those skills were obtained with clinical experience in a process that progressed forward, implying that more experienced nurses will always make better decisions based principally on their intuition. However, the traditional Benner's model of expertise progression differs from the results of this research when nurses become leaders, since their dissociation with practice and their increased responsibility made them more likely to follow institutional policies instead of their clinical intuition. This difference could be due to many different factors that changed since Benner's research in 1984 like the higher impact of litigation, the progression of nurses towards leadership roles or the higher level of accountability, but this dissociative phenomenon indicated that clinical seniority should not be the only aptitude to consider in an accountable nursing leader.

Furthermore, if we acknowledge the mentioned negative impact of human and environmental factors in nursing accountability, it could be understandable why participants rationalised the use of defensive practice as a tool to defend themselves. As a solution, Avelin et al. argued that institutional accountability could be used as an oversight for the subjectivity of individual accountability, preventing defensive practice [24]. However, institutional accountability should also be supervised by impartial entities to avoid malicious management practices.

A dissociation of nursing values when conflict between professional values and practice reality arises, mainly due to institutional factors like higher workloads, was mentioned repeatedly. Sastrawan, Newton and Malik [25] recognised how factors like culture or the nature of work forced the nurse to adjust their values to compensate the difference between their expectations and reality, supporting the fact that institutions can have a detrimental influence into nursing values if this difference is not addressed appropriately.

Strengths and limitations

This study included a diverse collection of participants, which offered a realistic representation of ED nursing accountability. The information from these interviews was coded (see Table 2) and recontextualised in a reproducible manner, filtering unstructured dialogue into a comprehensive group of categories.

However, there were two main limitations. Firstly, the number of participants was limited, since this research was performed in only one large ED. Nevertheless, data saturation was reached following 26 interviews, but a further eight were undertaken so as to confirm that saturation had been reached. Therefore, following the definition of Fusch and Ness [26], from the 27th interview there was enough information to replicate the study, no new information was obtained and additional coding was not necessary.

Secondly, the researcher's possible influence on the participants' responses was also considered. The interviewer was a charge nurse during the interviews, which implies a position of power in relation to the registered nurses, thus in order to minimise its effect various measures were conducted (e.g. non-coercive advertisements, passive recruitment, informal interviews, etc.). The participants knew about the interviewer's reasons for doing the research and the goal of obtaining a PhD through it.

CONCLUSION

Accountability in ED nursing practice is a complex concept that affects how nurses provide care. The perspective brought by the interviewees showed that accountability can modify and is modified by care provision, social interactions, decisions and values for both the nurse and the healthcare institution.

The exploratory nature of this research study facilitated finding several issues related to nursing accountability, including the effects of nursing shortages and the reasoning behind multidiscipinary team conflicts. Different approaches of individual and institutional accountability, the evolution of Benner's nursing model and nursing value progression was also identified as key issues. All these phenomena affect nursing care and accountability in different ways, so their comprehension is paramount to understand and influence them to the benefit of both patients and nurses.

More research is needed to confirm and expand the main issues found, since all the participants were recruited in the same department. However, some of the results coincide with other research, so elements such as the negative effect of nursing shortages in

crowding and patient satisfaction should be considered in practice.

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Table 1 - Interviewees' demographic information.

Gender	Male Female	19 (55.88%) 15 (44.12%)
Professional role	Adult nurse Paediatric nurse Specialist nurse Agency nurse Adult nurse practitioner	29 (85.29%) 2 (5.88%) 1 (2.94%) 1 (2.94%) 1 (2.94%)
Experience (senior nurses have ≥ 2 years of experience)	Junior Senior	15 (44.12) 19 (55.88%)
Professional culture (ethnicity, not nationality)	British Non-British	21 (61.76%) 13 (38.24%)
Total number of participants		34

Table 2 - Coding tree How nurses work, how they interact and how they uphold their accountability in ED.

Categories	Subcategories 1st level	Subcategories 2nd level	Subcategories 3rd level
Nursing care and the nurse-patient relationship	A. Assessment		
	B. Treatment		
	C. Care		
	D. Nurse-patient relationship	i. Patient satisfaction ii. Etiquette iii. Public health education iv. Public expectations	
Staff interactions	A. Person-person interactions	i. Communication ii. Hierarchy	 ii(a) Horizontal ii(b) Vertical
	B. Person-group interactions	i. Leadership ii. Compliance	i(a) Horizontal i(b) Vertical
	C. Group-group interactions	i. Conflict ii. Cooperation	 ii(a) Horizontal ii(b) Vertical
Legal and professional accountability	A. Individual Accountability	i. Seniority ii. Convictions	
	B. Shared accountability	i. Blame sharing ii. Nurse-centric accountability	
	C. Institutional accountability	i. Regulations ii. Targets iii. Vicarious accountability	
Decision making process	A. Basic factors in clinical decision making	i. Clinical knowledge ii. Clinical intuition iii. Policies iv. Leadership responsibilities	i(a) Theoretical knowledge i(b) Professional experience
	B. Human factors		
	C. Environmental Factors	i. Crowding ii. Patient flow iii. Clinical workload	
	D. Material and human resources	i. Staffing levels ii. Staff morale iii. Training iv. Material resources v. Infrastructure	
Ethics and values	A Professional values	i. NMC Code ii. Professional culture iii. Emergencies	
	B. Institutional values	i. Objectivised efficiency	
	C. Personal values	i. Job security	
	D. Ethical accountability	i. Dissociation from clinical practice ii. Care dehumanisation	
	E. Ethical theories	i. Kantian ii. Utilitarian	
	F. Bioethical principles	i. Non-maleficence ii. Beneficence iii. Autonomy iv. Justice	

Figure 1 – Data analysis diagram