Understanding Workplace Reciprocity of Emergency Nurses: A Qualitative Study

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UNDERSTANDING WORKPLACE RECIPROCITY OF EMERGENCY NURSES: A QUALITATIVE STUDY

by

CHRISTINE M. CORCORAN

A dissertation submitted to the Graduate Faculty in Nursing in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Nursing, The City University of New York

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This manuscript has been read and accepted for the
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Abstract

UNDERSTANDING WORKPLACE RECIPROCITY OF EMERGENCY NURSES:
A QUALITATIVE STUDY

by

Christine M. Corcoran

Sponsor: Keville Frederickson, PhD

Emergency nurses work with other health care providers under uncertain conditions to provide care to patients with all kinds of illnesses and afflictions from all walks of life. Despite implications that they must work together to accomplish their tasks, there are few studies that explore the relationships among emergency department personnel. Furthermore, there are even fewer that focus on the way emergency nurses work together to provide care to their patients. The purpose of the study was to understand the lived experience of workplace reciprocity of emergency nurses through the use of a qualitative phenomenological method. Nurses with three or more years of current emergency nursing experience were recruited using a purposive technique to obtain a convenient sample. Each participant was interviewed. The data was analyzed and interpreted using Giorgi’s Phenomenological Method. Findings from this study identified six essences: emergency department culture, balancing, technology, caring, bridging, and connection. These essences of the participants’ experiences were synthesized. Workplace reciprocity between and among emergency department nurses is influenced by the emergency department culture, balancing, and technology on caring for patients and each other as seen in the bridging and connection for the purpose of creating and maintaining workplace relationships. This statement synthesized the meaning of workplace reciprocity among this sample of
emergency nurses for this study. Paterson and Zderad’s Humanistic Nursing Theory emerged as a way to reflect on the findings in a way that was meaningful to nursing. Implications for nursing practice and recommendations for future research are identified.
Acknowledgements

There are numerous people to acknowledge and thank in my endeavor for my doctorate. Without them and their incredible support, I would not have been able to complete the journey.

First, the family!

My mother, Brenda, for always being there when I wanted to walk away from the whole process. Any academic degree that I hold, you hold in honor! You are the epitome of what a strong woman is!

My aunt, Marion, for initiating the journey for me into nursing when I was nine years old. You shared your textbooks and nursing journals. You inspired me. I am heartbroken that you didn’t get to see me finish what I started.

My brother, Bobby, for making sure way back when that I got registered for college. You are a stellar individual! Your intellectual humor always got me through anything. I will always hold you in the highest esteem!

My cousins, Dawn and Brenda, for helping me break away and pulling back in when I needed it. Only sisters can do that!

My little cousins, Daniella and Alanna, for letting me do my homework and before playtime. We’ve grown up together…

Second, my committee!

Dr. Keville Frederickson, my sponsor, who always seems to know the move I’m going to make before I make them. You understood my journey better than I did and all you had to do was shoot me that “look”. I truly hope to work with you in the future. There is so much more for me to learn and explore!
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Dr. Mario Kelly, your comment to me after completing my defense will help me pursue research.

Third, my friends and mentors!

Dr. Susan Apold, for planting the PhD seed in my head oh so long ago… And always being there to give me the support and encouragement that I required to complete it. You had faith in me when I had none.

Dr. Carol Vicino, for helping me to initiate the journey and becoming my dear friend. You pushed me when I needed it and told me when I had it. You backed me when I needed you. And… “I’ll always got your back!” whenever you need me!

Dr. Kathleen Flaherty, for helping me along the way simply by offering to read my work. You have no idea what those words meant to me!

My friend, Jimmy, who taught me twenty years ago to “break it down”. He made me want to learn more and never realized what he did.

For my friend, Beth, without your friendship, support, encouragement, shoulder to cry on, and ears to listen, I don’t think this journey would have been accomplished. Kindred spirits upon meeting as ED RNs so many years ago…

My other kindred spirit, Lee Anne, who has always been there for me.
For my GC girls: Karen, Mary, Ellen, Miriam, Dawn, Marie, and Anne. Our Friday lunches, decompression and debriefing sessions, celebrations of each other’s success, support of each other every time one of us said we wanted to quit, arguing quantitative versus qualitative research, and our silly laughter when we all needed it the most will stay with me forever.

Fourth, all the ED RNs who shared their experiences with me. Thank you!!! Not only for this study, but for what you do! Always there when patients need you the most… You have my utmost respect!

Fifth, Dr. Viji George, with whom I sat in a small chapel in Chennai, India, in the summer of 2013 listening to the story of doubting Thomas. All of a sudden I realized that I doubted myself and whispered it to him, he quietly looked at me and smiled warmly as the story was finished. I think I found the faith to finish my work in that moment…
Something I always share with my nursing students and I, myself, forgot it along the way…

Sometimes I compare things to a body of water.

Some people dip their toes in and find it is too hot or too cold and do not proceed.

Some people jump right in without realizing the temperature, depth, undercurrents, and vastness of the water.

Some people adjust to the temperature easily. Some take a bit. Some decide to get out of the water.

Some people find the water too deep.

Some people are good swimmers and make their way in the water.

Some people are not good swimmers. They struggle. They either return to the shoreline or learn to become good swimmers.

In the body of water there may be some undercurrents, “riptides”. Sometimes even the best of swimmers cannot swim with a riptide. They compete against it.

But some people find that there are times when it is best to swim with the riptide instead of resisting.

It takes them to amazing places they would not have discovered if they resisted. They realize the body of water is not so small and has some phenomenal things that require further discovery.

For me, my journey to my PhD in Nursing could be compared to an ocean. At times the water was a little chilly, until I adjusted. The depth was too deep, until I learned how to be a better swimmer. I did resist the undercurrent but did not want to back to the shoreline so decided to swim with it. Only to discover that there is more out there for me to explore. ~Christine
Dedication

This work is dedicated to the two most amazing women in my life…

For my mother, Brenda M. Corcoran, née Coady, who has always nurtured me and motivated me to be the best that I could be. You showed me that even through a struggle you can smile. I only want to make you happy and proud. I love you with all of my heart, Mommy.

For my aunt, Marion E. Wimmer, née Coady, RN, who was my nursing inspiration and my strength. You left this earth too soon. I love and miss you every day. I wish you were here, but I know you are watching from heaven.
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Chapter 1: Aim of the Study

Nurses are integral to the interdisciplinary healthcare group. For healthcare groups to optimally perform, effective human connections must exist. Reciprocity is the mutual exchange of knowledge, ideas, and resources that enhance the connectivity of humans (Coleman, 1988; DiCicco-Bloom, Frederickson, O’Malley, Shaw, Crosson, & Looney, 2007; Fukuyama, 1999; Nahapiet & Ghoshal, 1998; Portes, 1998; Putnam, 2000). Reciprocity has been empirically explored within cultures; however, it has not been explored in healthcare settings (Cheung & Yong, 2006; Lewis, 2006; MacCormack, 1976; Phongsavan, Chey, Bauman, Brooks, & Silove 2006; Qalyoubi-Kemp & Kemp, 2007; Shulman, 1976; Yip, Subramanian, Mitchell, Lee, Wang, & Kawachi, 2007).

Most healthcare settings can be unpredictable. In unpredictable environments, reciprocity may be an essential component of relationships (Neufeld & Harrison, 1995; Uehara, 1995). Emergency nurses work in unpredictable environments whereby patient census and acuity can change quickly (Emergency Nurses Association [ENA], 2007; Sheehy, 2003). Emergency nurses must adapt to these changes to maintain patient stability as well as to access resources that are not readily available (ENA, 2007; Sheehy, 2003). The purpose of this research is to gain insight into the meaning of reciprocity among emergency nurses to better understand and inform the relationship process among them.

Concept of Interest

Reciprocity is a necessary aspect of social groups (Bourdieu, 1986; Coleman, 1988). As described in the literature, reciprocity is the mutual exchange of knowledge, concepts, and resources (Lin, 2001; Molm, Schaefer, & Jessica, 2007). Resources may include material or
instrumental goods, which are tangible items such as money, food, cars, houses, etcetera; or symbolic goods, such as group membership, education, organizational titles, reputation, and etcetera (Lin, 2001; Molm et al., 2007). Mauss terms the mutual exchange of knowledge, concepts, and resources as “gifts” (Mauss, 1950). Gift giving can be exchanged to reward or to punish. The gift giving actions or behaviors are considered reciprocity (Douglas, 1925/1990; Malinowski, 1922).

An action or behavior that benefits, helps, facilitates and/or bestows a title of significance to someone or something else is a positive gift or positive reciprocity (Cox & Deck, 2005; Mauss, 1950). An action and/or behavior inspired because of another’s intentionally positive action and/or behavior is positive reciprocity (Cox & Deck, 2005). For example, performing a good behavior or act and receiving a beneficial behavior or act is positive reciprocity.

An action or behavior that is given to harm due to perceived actions and/or behaviors is a negative gift or negative reciprocity. Negative reciprocity is to impugn or penalize another individual, a unit or group, or population (Engelen, 2008; Gibney, Zagenczyk, & Masters, 2009; Gouldner, 1960). Negative reciprocity is the failure to either give or receive a symbolic or tangible gift. Mauss described how actions and/or behaviors should not be refused (Mauss, 2000). If an individual refuses an action and/or behavior, a subsequent action may be the refusal of a reciprocal gift in the future. Because refusal of behaviors and/or actions can create animosity among persons of a group or between groups of people, the culture among the group or between the groups becomes negative. Thus, the cultures among the group or between groups suffer.
Positive and negative reciprocity can be performed directly or indirectly within cultures (Mauss, 1950). The mutual exchange of actions and/or behaviors in kind (which are similar to a behavior, goods, or services rendered) directly to another individual is direct reciprocity (Gouldner, 1960; Mauss, 1950; Stanca, Bruni, & Corazzini, 2008). For example, direct reciprocity is considered when actions and/or behaviors are exchanged that directly affects the other.

When actions and/or behaviors are performed that affect others then the intended, this is considered indirect reciprocity. With indirect reciprocity, the action and/or behaviors are returned from someone other than the recipient (Jung, 1990; Leider, Mobius, Rosenblat, & Quon-Anh, 2007; Stanca et al., 2008; Tullberg, 2002). For example, with indirect reciprocity the actions and/or behaviors are provided generally without an intended recipient and those that receive the action and/or behavior received it indirectly.

Reciprocity has its impact on the culture being observed. Cultures have organizational levels: micro, meso, and macro (Johnson, 2008; Lenski, 1983; Weber, 1947). The levels can function independently, yet influence each other (Lewin, 1936; Schein, 2004). The micro level of cultures is individualistic, or person to person (Cruess, 2008). A mutual exchange among individuals is reciprocity on a micro level. The meso level of cultures is the middle level of an organization or population. A mutual exchange among a group of people within an organization’s population and/or is reciprocity on a meso level (Bourdieu, 1986; Dopler, Foster, & Potts, 2004; Putnam, 2000). Additionally, a mutual exchange between groups of people is a meso level. The macro level of cultures is the entire population (Johnson, 2008). A mutual
exchange on a macro level is reciprocity between populations. For example, a mutual exchange between two countries or two healthcare institutions is macro level reciprocity.

For this research examples of micro, meso, and macro are emergency nurses, emergency departments, and the healthcare institution, respectively. For the purpose of this research, the focus will be at the micro level and the experiences of reciprocity among emergency nurses. However, it is understood that all actions and/or behaviors at any organizational level, micro, meso, and/or macro, will influence all levels of the culture.

**Justification of Studying the Experience of Reciprocity**

Emergency Departments (ED) are unpredictable environments and are well-known for instantaneous change. At one moment, the ED may be relatively quiet and then suddenly ambulances and helicopters arrive with multiple patients from a serious car accident. Typically, nurses are the first healthcare provider encountered by the patient. Given the rapid changes, this is an environment with high levels of stress and more so for the ED nurse (Browning, Ryan, Thomas, Greenberg, & Rolniak, 2007; Spence, Laschinger, & Havens, 1997).

EDs are open for patient care all day, every day. The flow of patients and their reasons for presenting to the ED for care is not predictable. Multiple patients can present to an ED with a variety of healthcare problems and concerns. Prioritization of patient care in EDs is based on the patient’s acuity level. Acuity levels are designated by the patient’s presenting illness or injuries. This is termed triage. Triage sorts patients according to the severity of illness or injury and how rapidly they require treatment (Sheehy, 2003).

The current Emergency Severity Index (ESI) triage system recommends a five-level system: 1-resuscitation, 2-emergent, 3-urgent, 4-non-urgent, and 5-referred (Gilboy, Tanabe,
Travers, Rosenau, & Eitel, 2005). Level 1-resuscitation indicates that the patient requires immediate life saving interventions. A patient who is not breathing is a level 1. Level 2-emergent indicates that the patient is in a high risk situation with the potential to decompensate to a Level 1. A patient that has a severe asthma attack can progress to a more life threatening situation; therefore, the patient is categorized as a level 2. Level 3-urgent indicates that the patient will require at least two or more emergency services. A patient that arrives to the ED with nausea, vomiting and abdominal pain has the potential to become dehydrated and the cause of the pain must be discovered; thus, a triage level 3. Level 4-non-urgent indicates the patient will require at least one emergency service. A patient who has sprained their ankle is a level 4. Level 5-referred indicates that the patient does not require any emergency service. A patient that presents for cold symptoms is a level 5. Triage levels guide the timing of patient care with the first encounter with the healthcare provider and the any subsequent interventions. ESI five level, I-V, triage timing recommendations are 0, 10, 13, 30, 60, and 120 minutes, respectively (Gilboy et al., 2005). Table 1 illustrates the triage level and timing guidelines.

**Table 1:** ESI Triage System

<table>
<thead>
<tr>
<th>Triage level</th>
<th>Patient needs to be seen by healthcare provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>I Resuscitation</td>
<td>0 minutes</td>
</tr>
<tr>
<td>II Emergency</td>
<td>10 minutes</td>
</tr>
<tr>
<td>III Urgent</td>
<td>30 minutes</td>
</tr>
<tr>
<td>IV Non-Urgent</td>
<td>60 minutes</td>
</tr>
<tr>
<td>V Referred</td>
<td>120 minutes</td>
</tr>
</tbody>
</table>

ED RNs care for a multitude of patients at any stage of care. The number of patients in an ED is a census. The census of an ED includes patients who are: awaiting triage, have been triaged and are awaiting care, have had encountered the healthcare provider and care is in
progress or pending results of diagnostic tests, are admitted to the hospital and are awaiting bed assignments, and are pending discharge. The census can change at any time as can the acuity level.

Any ED can rapidly transition from low acuity and census levels into high acuity and high census levels at any point during a nurse’s shift. The unpredictability of the environment can impact the relationships of the workplace. Unpredictable environments can create stressful situations within workplace relationships. Continued exposure to high levels of stress may have negative effects on organizations (Manzoni & Eisner, 2006; Piko, 1999). Reciprocity is a crucial component of relationships (Chow & Chan, 2008; Flap & Völker 2001). Reciprocity yields productivity. For emergency nurses to maintain effective workplace performance, reciprocity is present within workplace relationships (Bowey & Easton, 2007). Reciprocal workplace relationships facilitate productivity, efficiency, and improved consumer outcomes (Back & Flache, 2008; Carpenter, Bowles, Gintis, & Hwang, 2009; Meeker, 1983). One question propelled this study: What is the emergency nurse’s experience of workplace reciprocity?

By interviewing ED nurses about their lived experiences of reciprocity in their workplace, there is the potential to contribute to the nursing practice, nursing theory, and most importantly, to patient care. The method used for this research was a qualitative phenomenological approach and consisted of interviews with ED nurses for their experiences of workplace reciprocity. Very few studies have focused specifically on ED nurses, their relationships, and workplace reciprocity.

There is a paucity of research on nurses working in the ED. Most research is clinically based regarding competency and patient outcomes (Dent, 2010; Johnson & Bakas, 2010; Kratz
As patient care is the focus and there is a lack of research among healthcare providers, exploring the lived experience of reciprocity among emergency nurses contributed to the current literature on workplace reciprocity. Additionally, the study enhanced the literature on emergency nursing and provides more information regarding the healthcare work environment.

**Assumptions and Biases**

I believe that when a nurse is hired, the reciprocity process is anticipated. The nurse brings skills, knowledge, and experience to the job position and in return the nurse earns a salary from the institution. This is financial reciprocity for services provided. On nursing units, reciprocity is not based upon financial reimbursement, but the social aspect of the nurse’s role. Nurses, new or experienced, use positive reciprocity. Nurses care for each other’s patients when they go on breaks or if a nurse is occupied with a very sick patient other nurses look after his/her other patients. Reciprocity is vital for the individual nurse, the unit, and the healthcare organization.

Ultimately, reciprocity rises to the macro, or institutional, level. Conversely, if reciprocity is present on the macro level, it filters to the micro, or nurses’, level. Positive reciprocity encourages nurses to participate within the unit, between units, as well as organizational involvement. Behavior of the kind is the hallmark of Magnet™ Hospital status. According to the American Nurses Association (ANA), Magnet™ status encourages hospital administrators to maintain communication among all members of the healthcare group, has exceptional social network support, retains nursing staff, and provides excellent patient care (American Nurses Association [ANA], 2007). I believe reciprocal workplace relationships and
the reciprocal nature of these relationships are the underlying dynamic of these Magnet™-types of institutions.

**Rationale for Qualitative Methodology**

In order to gain insight into and discover an understanding of the lived experiences of workplace reciprocity of emergency nurses, qualitative methodology was employed for this study. Qualitative methodology reflects the “beliefs, values and assumptions about the nature of human beings, the nature of the environment and the interaction between the two” (Munhall, 1989, p22). This method, specifically, the phenomenological approach, was utilized to allow for the essences of the participants experiences of workplace reciprocity to be identified.

**Significance of the Study**

According to the United States Department of Health and Human Services’ National Sample Survey of Nurses, there are 2.9 million registered nurses (RNs) in the United States (United States Department of Health and Human Services [USDHHS], 2004). There are 1,350,687 million nurses employed in the acute care, or hospital, environment (USDHHS, 2004). Of this number only 8.7%, or 117,637, are employed in the emergency department as compared to 229,914, or 17%, of nurses employed in the critical care setting (USDHHS, 2004).

Reciprocity has been studied in the past through both qualitative and quantitative research. However, very little research on reciprocity of emergency nurses exists. Furthermore, the research that exists on the sample, emergency nurses, is limited to clinical performance issues.

Work-related relationships have been studied in the past, but there has not been a focus on the processes that facilitate social aspects of organizational groups. There has been extensive
literature written about nurse recruitment, retention, and mentorship in nursing (Aiken, 1982, 1989; Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Aiken, Sochalski, & Anderson, 1996; Buerhaus, Donelan, Ulrich, Desroches, & Dittus, 2007). Most of the literature discusses competent care, job satisfaction, stress, and burnout (Collins & Long, 2003; Currid, 2008; Little, 2002; Maslach & Leiter, 1997; Payne, Dean, & Kalus, 1998; Robinson Wolf & Rager Zuzelo, 2006; Ross-Adjie, Leslie, & Gillman, 2007). More recently the research focus has been on work environments of nurses as well as patient safety (Institute of Medicine [IOM], 2004; American Association of Critical Care Nurses [AACN] & VitalSmarts, 2005; IOM, 2007); however, investigating reciprocity of emergency nurses brings a different research perspective to the literature. Healthcare literature focuses on goals and patient outcomes without exploring the social aspects of healthcare groups (Considine & McGillivray, 2010; Koran, 2007; McBrien, Wynne, & Reilly, 2009). A thorough search of the humanities, social sciences, health sciences, and business databases identified an absence of literature with the focus of social aspects of healthcare personnel and patient outcomes; thus, a there is a gap in the literature.

The purpose of this research was to understand emergency nurses’ lived experience of workplace reciprocity. As the literature focuses on competency and outcomes, this particular perspective is vital because it informs the process of attracting and retaining active practicing emergency nurses as well as quality care for patients.

**Summary**

The purpose of this research was to understand the lived experience of workplace reciprocity of ED nurses. The current literature on ED nurses is richly based on competencies, studying reciprocity allowed for exploration of the concept of reciprocity. The perspective of
ED nurses using a qualitative approach enhances the literature on reciprocity, emergency nursing, group relations, recruitment and retention of nurses, and care quality.
Chapter 2: Evolution of the Study

Introduction

This chapter discusses the historical context of emergency care, the conceptual context of reciprocity among cultures and workplace reciprocity, and the experiential context that influenced my desire to study and understand the concept of workplace reciprocity.

Historical Context

Military conflicts and world wars have added to the knowledge of health and responses to emergencies and disaster events. The aspects of human caring and responses to disease and trauma are imbedded in the origins of nursing as documented by Florence Nightingale and her experiences during the Crimean War (Nightingale, 1969). Nurses in the military were often confronted with the advances in health care that wartime emergencies present. Prioritizing wounded personnel, administering medications, and advancement of treatment protocols during wartime contributed to more sophisticated civilian emergency care.

Emergency rooms were not uncommon by the mid-20th century. Hospitals created emergency rooms as a primary place for patients to be examined and to provide initial treatment for sudden injuries or illnesses (Gebbie & Qureshi, 2006). These emergency rooms typically had on-call staff that provided patient care. The evolution to fully staffed emergency departments during all hours of the day derived from mid-century wars that revealed that immediate care could save lives. As the specialty of emergency medicine grew, the distinctive skills and abilities of emergency nursing set these nurses apart to their own specialty.

Emergency nursing involves providing care for individuals of all ages with perceived or actual physical or emotional alterations of health that are undiagnosed or require further
interventions (Sheehy, 2003). The care provided in emergency departments is based upon the client’s presenting health situation of non-urgent, acutely ill or injured, or life-threatening. The emergency department environment has unplanned situations, limited resources, perception of need for immediate care by patients and others, unpredictable number of patients, and unknown patient acuity levels and severity of diagnosis.

Emergency Departments (ED) have healthcare groups that consist of nurses, nurse practitioners, physicians, physician assistants, paramedics, emergency medical technicians, nurse technicians, and other ancillary staff. Care quality and patient outcomes are greatly influenced by the healthcare group’s efforts during stabilization and treatment. An inherent characteristic of the ED healthcare group is one in which all participants of the group must function with high levels of efficiency to provide optimal patient care to the ill or injured. With focus to emergency nurses, needs differ with the number of patients in the ED, the severity of their illness, unit protocols, and available resources, such as stretchers, sheets, irrigation fluids, intravenous fluids, medications, ancillary personnel, and access to additional patient services. Because acuity and census levels of EDs can transition so quickly, workplace relationships depend upon a mutual exchange of actions and/or behaviors in order to provide appropriate, timely patient care. A mutual exchange of actions and/or behaviors is reciprocity.

**Conceptual Context**

Phenomenological studies are not inherently based on theoretical frameworks; yet, they are motivated by concepts. The concept that drove this study is reciprocity; specifically, workplace reciprocity. Reciprocity is the give and take of a symbolic or tangible object, behavior, and/or act. It can be positive or negative in nature. Performed directly or indirectly for
Reciprocity

Reciprocity has been researched by numerous professions. Landmark ethnographic research by Malinowski (1922) and Mauss (1950/2000), respectively, revealed cultural behaviors/gifts were exchanged with the expectation of returned behaviors/gifts of similar value. In 1915, Malinowski studied the Trobriand Islanders through participant observation (Malinowski, 1922). He made observations on their daily behaviors, agricultural trade, and ceremonial exchange. Malinowski noted that even primitive societies had some form of reciprocal transaction that enhanced the social stability of the islanders, which created a cohesive community (Malinowski, 1922).

Mauss conducted ethnographic research to discover the reciprocal nature of cultures (Mauss, 1950/2000). In Polynesian society reciprocal behaviors were a norm in the form of gifts (Mauss, 1950/2000). Gifts were either symbolic or tangible. Polynesian society attached a spirit of the item given; thus, the value of the gift (Mauss, 1950/2000). Whether tangible or symbolic, gifts had purpose and could never be refused.

Supportive evidences of reciprocity were documented by Levi-Strauss (1955/1973) and Benedict (1934), respectively. Levi-Strauss’ research revealed reciprocal relationships of South American Indians. Trinkets were exchanged to establish relationships. Bartering occurred between the tribal people to secure relationships (Levi-Strauss, 1955/1973). Items such as food,
clothing, and cooking utensils were traded to maintain the society. Benedict’s research on the New Mexican people reported that the culture was based upon ceremonial exchange (Benedict, 1934). Gifts were offered ceremoniously. If expected results of the ceremony were not achieved, the gifts were re-examined by the people and a new ceremony conducted (Benedict, 1934).

With the norm of giving and receiving, gifts would be exchanged for various reasons. For example, gifts could be passed on through families as heirlooms; through work relations similar to bartering, giving one item in exchange for another item; through geographic locations, such as passing from innovative ideas from east to west; and/or through timing, such as a welcome or farewell gift. Gifts could be given or received to secure an agreement. The norm of reciprocity: to give, to receive (accept), to reciprocate is an unconscious activity that permeates all cultures and helps to initiate and maintain social ties and interactions among individuals (Benedict, 1934; Bourdieu, 1977; Levi-Strauss, 1955/1973; Levi-Strauss, 1969; Gouldner, 1973; Malinowski, 1922; Mauss, 1950/2000).

To maintain social connections, Gouldner (1960) further described the norm of reciprocity to include three specific aspects:

- Equivalence: the behavior or action returned is equal to that received;
- Immediacy: the time period for the reciprocal behavior to be returned; and
- Interest: the motivation of the exchange is dependent upon a mutual exchange, for the self, or for the other.

For an exchange to take place the behaviors are voluntary and motivated by the expected action of the other (Blau, 1964; Homans, 1958). Norms of reciprocity govern those of any social
exchange (Gouldner, 1960). Individuals initiate and maintain reciprocal behaviors because they desire resources that they could not otherwise obtain by themselves (Blau, 1964). Reciprocity creates ties between people and discloses the nature of the relationship between giver and receiver (Komter, 2005). The nature of the relationship gives rise to classification in the setting of which it occurs. When two parties know the classification of the relationship, appropriate forms of reciprocity can occur (Geddes, 2010). The mutual exchange can be either informal, such as friendship, or formal, such as work relationships.

All groups create patterns of culture and behavioral norms (Schein, 2004). Work relationships are no different. Aspects of organizational culture includes a shared language, specific boundaries and criteria for inclusion, distribution of power and resources, norms of intimacy, defined and allocated rewards and punishments (Schein, 2004). Work relations must learn to preserve the other or the social environment becomes unsafe (Kanter, 1977; Schein, 2004). If one member of an organization hurts another, the behavior can be retaliated. The negative reciprocity can lead to workplace incivility, which violates the mutual understanding and behaviors of the organization (Hartman, 1996; Soloman, 1998). Members who disturbed the norm of the organizational culture demonstrate deviant workplace behaviors, such as increased absenteeism, disregard of organization procedures, decreased productivity and the demonstration of poor workplace relationships as well as personal exhaustion and burnout (Bakker, Schaufeli, Sixma, Bosveld, & Dierendonch, 2000; Biron, 2010; Spitzmuller, Glenn, Barr, Rogelberg, & Daniel, 2006). With the deviant workplace behavior, it not only the individual that suffers, but the co-workers, witnesses of the behavior, the organization as a whole, and there is a potential loss of customers (Pearson, Anderson, & Wegner, 2001).
Workplace Reciprocity

The literature has shown that reciprocal exchange in the workplace based upon positive behaviors and attitudes is productive (Coli, Schaninger, & Harris, 2002; Cropanzano & Mitchell, 2005; Witt & Wilson, 1999). When workers feel that they are part of a culture that values them and they value that culture, they assimilate to the cultural norm and create trusting bonds with co-workers that allow them to reciprocate (Muse, Harris, Giles, & Field, 2008). The reciprocal behavior allows for enhanced workplace relationships, which improves communication, cooperation, work behaviors, attitudes, role performance, and organizational outcomes (Blau, 1964; Dirks & Skarlicki, 2009; Ferrin, Bligh, & Kohles, 2007; Molm, Takahashi, & Peterson, 2000; Schein, 2004). Holmstrom and Milgrom’s work argued that workplace productivity could be either positive or negative based upon cooperation levels (Holmstrom & Milgrom, 1990). Positive cooperation would improve coordination of work and enhance productivity (Holmstrom & Milgrom, 1990). Negative cooperation would impugn the employer thus reducing productivity (Holmstrom & Milgrom, 1990).

Workplace relationships that exhibit high levels of positive reciprocity among its workers have more productive outcomes (Barr & Serneels, 2006). Yet, evidence to support the relationship of employee behavior and productivity is limited. Numerous research studies have been performed on employee/employer interactions; however, more research is required on employee/employee interactions. Barr and Serneels’ interest in expanding upon the employee/employee interaction prompted their interest in workplace behaviors and productivity of employees (Barr & Serneels, 2006).
Barr and Serneels selected employees at random to play games after work hours. The purpose of their research was to investigate whether employees would reciprocate; specifically, give in order to receive. The play partners were kept anonymous from each participant. Coworkers did not know with whom they were paired. The game took place in two parts. Part one assessed the giving of a participant; part two assessed the giving of the receiver. The game would continue depending upon how much was given by both of the participants.

Part one participants were given money and asked to give to the unknown paired partner. They were instructed to determine how much money they would give to the unknown partner. Additionally, they were notified that depending upon how much was given to the paired partner, the game mediator would add a specified percentage of that amount given; thus increasing the side of the amount given. Part two participants were instructed to give money back to their unknown partner from the part one in order to receive the funds from the first participant and the additional funds provided by the game mediator. As long as funds were in play, the game continued.

Barr and Serneels’ research revealed that the employees in the part one gave more to the unknown partner in order to insure receipt of an action at the end of the game (Barr & Serneels, 2006). The analysis of their research showed that employees exhibited positive behaviors to maintain the workplace productivity (Barr & Serneels, 2006).

**Experiential Context**

As a child, I was instructed on moral behaviors. One was “to do unto others as you would have done unto you”. As an adult with the previous thought in mind, I added the adage, “you scratch my back and I’ll scratch yours.” The first moral behavior was to do good; the
second was reciprocity. These behaviors are important to me. As a nurse with 16 years of emergency nursing experience, I have worked in several EDs. From a novice ED nurse to an expert, I have experienced workplace reciprocity.

As a graduate ED nurse, with only school knowledge, working with more experienced ED nurses, I felt that I did not have the knowledge or skills to give back for the clinical knowledge they were providing to me. My early career was spent doing tasks for my colleagues in exchange for their expertise. Reciprocity continued with each ED position I obtained.

If I were to enter into an ED nurse position at this current time, my clinical knowledge could be given (or shared) in order to receive information regarding the new ED environment. With each new position, I felt the need to give in order to receive. The gifts exchanged were knowledge, status, financial re-imbursement, and group camaraderie.

Summary

Emergency departments are fast paced, unpredictable environments and its healthcare personnel are exposed to pressures of institutional demand and of those patients that present with high level of acuity. To intervene rapidly in emergent situations, the group commonality with its experiences and communication must respond quickly. Sudden alterations in departmental census and acuity require adaptive behaviors. This study stems from a personal desire to research ED nurses regarding perspectives of their environment. As the literature of healthcare settings focuses on patient care and competency, exploring workplace reciprocity among and between emergency nurses contributes to understanding of their workplace relationships; additionally, the study enhanced the literature on emergency nursing and provides more information regarding the healthcare work environment.
Chapter 3: The Methodology

Introduction

The intention of this study was to explore the lived experience of workplace reciprocity of emergency nurses. The qualitative research method employed was the phenomenological approach to understand the meaning of being (Munhall, 2007). Husserlian phenomenology is discussed, along with the rationale of why this approach was best suited to study the phenomena of interest. An overview of Giorgi’s method of inquiry for this study is also provided. This method of research will allowed participants to share experiences as they have experienced the phenomena of interest.

The Qualitative Perspective

During the 1900s, a new age came forward that introduced a different way of investigating the humankind and its phenomena. Modern qualitative research methods emerged from philosophy and psychology. Brentano’s philosophical writings of “intentionality” were vague. Husserl, a former student of Brentano’s, not only expanded Brentano’s philosophy of intentionality, but also initiated the philosophy of phenomenology (Giorgi, 2009). Husserl’s philosophical interest was the respective experiences of the mind and the body and their “life world” or lived experience. Three transcendental (descriptive) phenomenology concepts, epoche, intentionality and intersubjectivity, were the essential components of Husserl’s viewpoint of a lived experience (Husserl, 1900/1952).

Merleau-Ponty postulated that the mind and body are intertwined and experience the life-world together (Merleau-Ponty, 1945/1962). This existential philosophy declared the mind and body are symbiotic with life world and its experiences (Dreyfus, 1996; Merleau-Ponty,
The experiences with the life world are based upon the movement and perceptual awareness of environment related to any circumstance (Reuter, 1999).

In the 1960’s Duquesne University’s Psychology Department began to explore the significance of the philosophy of phenomenology (Wertz, 2005). Giorgi, a psychologist new to Duquesne, was influenced by Husserl’s and Merleau-Ponty’s philosophical ideas on phenomenology (Giorgi, 2009). Giorgi has been credited with creating the Duquesne Method of Phenomenological Research; a psychological research technique that explores existential-phenomenological understanding of human beings as persons, the description of the meanings, the modes of implementation, and the synthesis of the phenomenological concept of interest (Wertz, 2005).

The characteristics of phenomenology include descriptive data, use of reduction, the search for essences, and intentionality (Giorgi, 1985). Giorgi adapted Husserl’s philosophical phenomenology to analyze the psychological aspects of the experiences. To ascertain the lived experience, the researcher gathers data by in-depth interviews, which allows the researcher to understand the participant’s experiences.

According to Giorgi, the researcher is aware of their own perceptions towards the phenomenon being studied during the interview and subsequent analysis; Husserl’s epoche (Giorgi, 1985). This is the method of reduction, whereby the researcher brackets their own perspectives and prejudices as to not naively pre-judge the nature of the experience (Giorgi, 1985). Journaling and debriefing are two strategies that aide the researcher in attempt to bracket their own perceptions.
Phenomenology searches for essences within the data. The essences are intuitive. They identify themselves through the participant’s description of the experience. Intentionality is the consciousness that is directed toward something that is not conscious of itself (Giorgi, 1985). Operational intentionality is prior to consciousness. It can only be identified and understood within the description reduction and theme emergence (Giorgi, 1985; Husserl, 1952/1900).

Whereas physics, biology, and chemistry use quantitative research, the social sciences, anthropology, psychology, and sociology, use quantitative and qualitative research. The distinct process of exploring social or human perceptions is qualitative research. There are numerous ways to view the phenomena of interest especially when the human element is the added; yet, there is a specific purpose and approach to research the phenomena of interest, which individualizes each qualitative study. Qualitative research incorporates the researcher role as a tool in the study (Giorgi, 1985). The researchers’ observations are central to the ultimate outcome of the research. Qualitative research does not completely remove the bias of the researcher from the study, but uses it as a way to better understand the phenomena of interest. The role of the researcher is to assume an intersubjective approach (Giorgi, 2009). With this approach, the researcher is open to seeing or discovering a new experience as it was experienced by the participant. For this study, as emergency nurses recalled their experiences of reciprocity with other emergency nurses, I saw, discovered, and experienced workplace reciprocity of the emergency nurse participants based upon their stories during the interview process.

**Giorgi’s Method**

This study utilized Giorgi’s phenomenological methodology to gain an understanding of the lived experience of workplace reciprocity of emergency nurses. In order to psychologically
understand an experience, the experience must be described (Giorgi & Giorgi, 2003). According to Giorgi, exploration of an individual’s experience allows for subjective meanings to emerge (Giorgi, 1985). Giorgi’s method assisted in clarifying experiences from a psychological perspective. The Giorgi method was not used to interpret or predict outcomes. This method was used to illuminate and understand the lived experience of those interviewed. Specifically, how the participant relived the experience through storytelling.

Giorgi’s prescribes the following for the descriptive phenomenological method in psychology. A transcendental phenomenological attitude is assumed by the researcher. A transcendental phenomenological attitude differs from a natural attitude in that the researcher “views the objects of consciousness from the perspective of pure, essential consciousness”; thus approaching the research experience from a point of naiveté (Giorgi, 2009). This allows the researcher to view the phenomena of study from the perspective of the participants during the interviews.

Upon completion of each participant’s interview, the transcripts and audio recordings are reviewed both simultaneously as well as separately. This is performed multiple times by the researcher in order to gain a sense of the contextual whole of the interview from the participant’s point of view of the concept of study (Giorgi, 2009).

As insight into the participant’s experience of the concept of study is recognized, individual meaning units are identified. Individual meaning units are structures of meanings of the experience of the concept (Giorgi, 2009). They are the personal description of the experience(s) of the concept of study as expressed by each participant in their interviews; individual meaning units are the participants’ voices.
Individual meaning units are reviewed for each participant and then for all participants collectively for the purpose of reduction. Reduction is performed through two methods: transcendental phenomenological reduction and eidetic reduction. Transcendental phenomenological reduction views the essence in its purest form (Giorgi, 2009). Eidetic reduction reduces it to the essence of the concept of study (Giorgi, 2009).

Essences, which are intuited, are derived from the psychological dynamics that arise from the participants’ individual meaning units (Giorgi, 2009). They are thoroughly discussed using the participants’ description of their experiences with the concept of study.

Free imaginative variation can be used to explain the psychological understanding of the essences in the context of which the participants experienced the concept of study (Giorgi, 2009).

As the researcher moves from a transformational to a structural representation of the participants’ experiences of the concept of study, the researcher synthesizes the essences (Giorgi, 2009). If the data of the study lends to it and the discipline based study allows for the expression of the phenomenologically grounded data, “a researcher should always derive a single structure for all the subjects of the study” (Giorgi, 1997).

Participants are not re-interviewed once the initial interview has taken place. According to Giorgi’s method, re-interviewing to discuss the analysis of a lived experience interview may alter the participant’s perception (Giorgi, 1985).

**Research Trustworthiness**

Lincoln and Guba (1985) described the naturalistic method of validity and reliability. The naturalistic method allows for researcher objectivity: the characteristics of the data, not those of the researcher to prevail. Hence, the data speaks for itself. There are five terms related
to naturalistic or qualitative research: reactivity, credibility, dependability, transferability, and confirmability.

Reactivity in qualitative research speaks to the researcher’s influence on the setting and the interview. In qualitative research, it is impossible to remove the researcher and any possible influence that may occur. According to Maxwell (2005), the researcher is an integral part of the qualitative research process. The goal is not to eliminate the researcher and their impact on the research, but understand it and use it productively (Maxwell, 2005). The researcher is charged with the responsibility of describing any changes that occur in the interview setting and to document how these changes may affect the way the researcher approaches the study, such as wanting to protect the ED RNs that were interviewed or the premature identification of any data findings (Lincoln & Guba, 1985; Golafshani, 2003).

Credibility is the truth value of the research (Skrtec, 1985). Credibility is the equivalent term for “internal validity” of research (Lincoln & Guba, 1985). It is performed through persistent participant observation, triangulation of qualitative and quantitative data and member checks. Peer debriefing is an aspect of member checks. Peer debriefing is the process by which the researcher discloses their perceptions of and about the research process to disinterested peers. Peer debriefing aided in uncovering biases, perspectives and assumptions as well as an opportunity to become more aware of the data; an opportunity to test and defend emerging meaning units and essences to a disinterested debriefer; and provides an avenue of catharsis for the researcher (Lincoln & Guba, 1985).

Dependability, the naturalist’s equivalent term for “reliability”, is directly related to validity (Lincoln & Guba, 1985). Dependability questions whether the data will reveal the same
characteristics when reviewed more than once (Lincoln & Guba, 1985). The researcher must take reactivity into consideration when presenting the data for dependability. To maintain dependability, the researcher maintains strict record keeping of the research process for data auditing of an external party.

Transferability is the equivalent term for “external validity”; it is similarly referred to generalizability (Lincoln & Guba, 1985). Transferability in qualitative research is difficult to establish (Lincoln & Guba, 1985). It is difficult to generalize the qualitative phenomenological findings of one sample population to another. However, through thick description of the data, a contextual comparison may be possible (Lincoln & Guba, 1985; Skrtic, 1985).

Confirmability is the naturalist’s equivalent term for “objectivity” (Lincoln & Guba, 1985). Confirmability lends itself to dependability in that the audit process by the researcher can lead a trail for an external auditor. The audit trail allows for a visible link from the researcher’s interpretation of the data and the data itself (Skrtic, 1985).

Summary

The qualitative, phenomenological method, specifically Giorgi’s psychological method of inquiry, was used for this study to explore the lived experience of workplace reciprocity of emergency nurses. This chapter discussed Giorgi’s methodology in depth. The goal of using Giorgi’s method for this study was not to analyze, but to illuminate and understand lived experience of workplace reciprocity of emergency nurses. Research trustworthiness was also discussed.
Chapter 4: The Methodology Applied

Introduction

This chapter discusses recruitment and sampling procedures, the target population, data collection methods, security of data, and data analysis. A qualitative, phenomenological approach was used to collect and analyze the data for this study of the workplace reciprocity of emergency nurses. This was done in order to focus on the experience of the participant, allow experiential essences to emerge, and to understand those experiences. Strengths and limitations of the study are discussed at the end of the chapter.

Recruitment and Sampling Procedures

Once institutional review board (IRB) approval was obtained from the Graduate Center/City University of New York, recruitment, interviews, and preliminary data analysis commenced. Anticipated time period for this study was 12-16 weeks of recruitment, interviews, data analysis, and findings of research. In actuality, this phase required 10 months to recruit, interview participants, process the data and disseminate the findings.

Purposive sampling is essential to naturalistic inquiry. Random sampling is not appropriate for conducting a naturalistic inquiry (Erlandson, Harris, Skipper, & Allen, 1993). My focus was to discover the experience of workplace reciprocity among emergency nurses. Purposive sampling technique allowed me to deliberately search for participants because of certain qualities. For this study, currently practicing emergency nurses with three or more years of experience, who were willing to discuss their experiences of workplace reciprocity, were recruited. A sampling method specific to purposive sampling is snowball sampling. Snowball sampling, which is used when studying social groups, relies on referrals from initial participants.
to solicit another who has experienced similar attributes of the phenomena of interest; thus providing rich data from in-depth interviews (Babbie, 2001; Munhall, 2007; Streubert & Carpenter, 1995). For a snowball effect, former colleagues were contacted to refer potential participants for this study. Two colleagues were contacted by telephone, told of my study and the required criteria to participate. One colleague, who met the criteria, agreed to participate in this study and then referred potential participants. Another colleague, who did not meet the criteria, referred potential participants. Referred potential participants were told of this study and, if interested, they were given my card with my contact information (name, telephone number and email address) by the referring person. For this study, all of the potential participants interested in the study gave the referring person their telephone numbers and asked for me to contact them to discuss the study further. I called each potential participant, reviewed the criteria, and scheduled interviews with those who met the study criteria. At the end of each interview, each study participant was asked about referring another potential participant. This recruitment technique was used until the sample size has been obtained.

Additionally, with naturalistic inquiry there is no concrete rule for sample size. A small sample size that provides valuable information is better than a large sample size that provides useless information (Erlandson et al., 1993). Recommended sample size for phenomenological studies is 3-10 participants (Dukes, 1984; Giorgi, 2009). The smaller, more informative sample is adequate to establish credibility and dependability (Giorgi, 1985a and 2003a). With all phenomenological studies, the sample size was determined by saturation (Munhall, 2007). Saturation occurs when no new information is obtained (Munhall, 2007).
**Target Population**

A criterion for selecting a population was that the participants currently work in EDs. Nurses with three or more years of current emergency nursing experience were recruited for this study. Nurses experience five stages of skill acquisition (Benner, 2001). Novice/beginner stage occurs when entering into a new environment (Benner, 2001). The competent stage follows once the nurse has acclimated to the role and is able to reflect upon previous experiences; this is typically at two to three years of experience in the same areas (Benner, 2001). Nurses at the proficient stage perceive situations wholly and can anticipate long-term outcomes (Benner, 2001). At the expert stage, the nurse relies upon situational intuition (Benner, 2001).

Although it is dependent upon the individual nurse, novice/beginner stage nurses may not have had enough time in the ED to consciously reflect upon experiences of workplace reciprocity. Participants with three or more years of current emergency nursing experience will have had time to acclimate to their positions and may be able to reflect of more experiences of workplace reciprocity than those individuals with less than three years experience.

**Data Collection**

Interviews took place at the convenience of the participant in an area that afforded privacy: a diner, library, or the participant’s home. The purpose of the research was explained to the participant. All questions were answered regarding research, audio recording, and confidentiality. The interview process began with written consent. Consent was obtained for the interview and for audio recording the interview with the right to discontinue participation at any time without penalty.
Once consent was obtained, the electronic audio recorder was activated and consent was verbally explained again. Demographic data: age, years of nursing experience, years of emergency nursing experience, employment in which type of hospital, and if they had acquired the certification in emergency nursing (CEN) was confirmed. Once the demographic data was obtained, the participant was asked, “As an emergency nurse with current ED experience, what is it like to work with other emergency nurses?” As the participant reflected upon their experiences, I used communication techniques to clarify participant’s responses and to further facilitate recall of experiences of workplace reciprocity. This allowed for essences of each participant’s experiences to identify themselves.

**Security of Data**

Interviews were transcribed using a secure service that employs Collaborative Institutional Training Initiative (CITI) Program certified transcribers. The service maintains confidentiality, ensures that under no circumstances would the privacy of participants be jeopardized, and assured that all audio recordings saved in its system will be automatically deleted 30 days after the conclusion of assignment.

I maintained all data documentation, electronic and paper, in a locked file cabinet in my home office to which only I have access. Documentation will be stored for seven years post research after which all documentation will be shredded or electronically deleted.

**Data Analysis**

Data analysis was conducted and completed using Giorgi’s methodology. This section will describe the data analysis as well as my attempt to bracket my own perceptions of the interviews to maintain research trustworthiness. I performed each interview with a naiveté
viewpoint. After completion of each interview, I documented in a journal under the heading “Post Interview Researcher Experience”. In this journal I documented my experience and perspective of the interview including the environment in which it took place. Any thoughts or feelings, such as my feelings of being grateful the first interview was completed, wanting to return to work in an ED as an RN, wanting to protect the ED RNs that I interviewed, and having early thoughts of identifying early themes, were documented in the journal under this heading. This was done to bracket and track any specific thoughts and feelings that could influence the subsequent interview based on my thoughts about it or how I approached the interview. In accordance with Giorgi’s methodology, all interviews were transcribed within 48 hours and read upon return receipt to gain insight into the participant’s experience of workplace reciprocity. The audio recording of each interview and its transcript were reviewed to gain a perspective of the participant’s experience of workplace reciprocity. The overall perspective of each interview was documented in my journal under the heading of “Interview Perspective”. Journaling under this section allowed me to review the overall perspective of each participant’s experience of workplace reciprocity.

I then re-read each participant’s transcript and listened to the audio recording to identify individual meaning units and to clarify the emergency nurse’s experience of workplace reciprocity. Following this, I documented in my journal under the heading “Interview Meaning Units” for the interview. Journaling in the “Interview Meaning Units” section allowed for elaboration of findings as well as how each meaning unit relates to the whole experience of workplace reciprocity of the emergency nurse. By performing this, meaning units were transformed into essences of the participants’ experiences. Essences were the singular term
expression of what the participants identified their experiences to be. Each essence was defined and free imaginative variation assisted with visualizing how the ED RNs experienced the essences of the workplace reciprocity. This aided with the transformation of the essences synthesis of the essences and their relationship to each other essence and the concept of study: workplace reciprocity. Within the discipline of Nursing, the essences were transformed into one structural, consistent statement of the concept of study, workplace reciprocity of emergency nurses.

To address research trustworthiness throughout this of this study, I met with two peers to discuss my perspectives of the research and debrief. This was vital to bracket my own biases, thoughts and feelings. The two peers were nurse researchers, who had no connection to my research. Their sole purpose was to hold a neutral standpoint while allowing me to vocalize my thoughts and feelings and to point out any biases that I may develop. Additionally, I utilized an expert in phenomenology to confirm my findings of each interview and during the overall analysis of the data. As previously mentioned, I kept detailed journal entries for each interview and the data collected was examined and rechecked throughout the study. Journaling allowed for any of my own biases or perspectives to be captured. The data audits were performed after each individual interview and then collectively with each interview obtained. In order to prevent researcher data distortion from occurring, I corroborated my findings with an expert phenomenological researcher after each data audit.

**Summary**

The Giorgi’s phenomenological method of inquiry allowed for meaning units to emerge from participants’ experiences. The process of allowing emergency nurses to reflect on past
experiences of working with other emergency nurses illuminates the understanding of reciprocity of emergency nurses. Additionally, it enhanced the literature on emergency nursing, group relations, recruitment and retention of nurses, and care quality.
Chapter 5: Research Findings

Research Setting

This study was conducted to understand the lived experience of reciprocity of emergency nurses. The participants in this study were nurses with greater than three years of emergency nursing experience. Data analysis and interpretation was performed using Giorgi’s Phenomenological Method (Giorgi, 1985). This chapter includes a description of the study sample, the study participants, and the research findings.

Study Sample

The participants of this study were emergency nurses with greater than three years of current emergency nursing experience. The sample size consisted of nine participants of which seven were females and two were males who met the criteria of currently employed ED staff RNs with at least three years of experience. Participants’ ages ranged from early 30 to early 60 years. Years of ED nursing experience ranged from 5-35 years. Levels of formal nursing education included: Associates (AS) degree (n=2); Baccalaureate in Science of Nursing (n=4); and Master’s in Science degree (n=3). All participants performed the rotating in-charge position, which is a position that experienced staff nurses who know the ED and the institution are assigned by the ED nurse manager. Two participants had military experience in the past. Nursing was a second career for three participants. Four participants worked in an emergency department that was designated as a Level I, which means all patient care services are in the hospital at all times. The average participant was 40 years of age; baccalaureate prepared, was a registered nurse for 19.3 years, and had 16 years of emergency nursing experience. Three of the
participants previously held their certification in emergency nursing (CEN), but are no longer certified.

The participants for this study were identified using the purposive technique of snowball sampling. Two former colleagues were contacted by telephone, told the details of my study and the required criteria of three or more years of current emergency nursing experience to participate. One colleague, who met the criteria, agreed to participate in this study and then referred potential participants. Another colleague, who did not meet the criteria, referred potential participants. Referred potential participants were told of this study and, if interested, they were given my card with my contact information (name, telephone number and email address) by the referring person. For this study, all of the potential participants interested in the study gave the referring person their telephone numbers and asked for me to contact them to discuss the study further. I called each potential participant, reviewed the criteria, and scheduled interviews with those who met the study criteria. Whether they refused or participated in the study, they were asked to refer potential participants. All participants were asked about referring another potential participant. Dates and locations were mutually agreed. Each interview was conducted in person in either at the participant’s home (n=4), at a diner during non-peak hours (n=3), and in a library (n=2). Consent for interview and digital audio recording was obtained from all participants prior to the interview. The digital audio recordings were sent electronically to a professional transcription service through secured provider site. All personal information: names of people, institution’s names, and locations were transcribed using initials as I had instructed the transcription service. Transcripts were electronically returned for review through the secured provider site. To further maintain the participants’ confidentiality in the
dissemination of the study findings, I coded all participants’ demographic information and each was assigned a pseudonym according to my designated coding system.

Description of the Participants’ Experiences

Abby

Abby was my first interview. Abby, a former ED RN colleague, worked the night shift (7 pm – 7 am) in a large inner city ED on the northeast coast. The interview took place in Abby’s home. We had had many conversations in her kitchen in the past and here was where we were going to conduct this interview. This was our place of comfort. Abby served coffee as we covered the consent form for the interview and auditory recording. Neither Abby nor I knew how we were going to react once the recorder was turned on.

As soon as the recorder was turned on, I felt my own anxiety pervade the interview. I felt awkward as though I wanted her to answer my specific question so we could be done with the interview. Abby, a kind and patient woman in her 40’s, has a gentle smile and a manner that would put the most anxious person at ease. Although I struggled with the beginning of the interview, we had gotten into a conversation of emergency nursing.

Abby’s initial response to the research question was focused on the staffing levels of emergency departments. She stated how being short staffed (not having enough nurses for the number of patients or the patient’s level of acuity) “probably brings people together more to work together as a team”. Abby described a team as, “working together, helping each other”. Additionally, Abby added, “Sometimes you don’t have the ability to have all the nurses needed to take care of a patient. And it takes—it delays care”. She offered delayed care examples of the ability “to go get medications” or “even to document in a timely fashion might be lacking.” Abby indicated that when the census rises and nurses help each other “it makes it more bearable, more tolerable.
Makes you able to continue on and work and be pleasant.” She added, “When you are stressed and not getting help, it can be very frustrating.” She feared that patients may be able to pick up on the frustration and it will affect their care. Abby was quite succinct in her explanation:

“It’s just a better feeling when you like the person to work with them than it is to— when—if you don’t care for them. Personality, as much as you try not to let it affect you, personalities absolutely affect working together. It makes it—if you like the person, whether it’s a friend or—whether it’s an outside friend—whether you’re friendly with them on the outside or just friendly with them at work, it—because it’s just a better rapport and you can even like make light of the work that needs to be done, like if you need to clean a patient, or if a patient is uncooperative, the chemistry you have with that person might help with—might even help the patient relax a little bit. Because working in an ER, as a patient, nobody wants to be—most people don’t want to be in the ER. You’re there because it’s not a planned surgery, it’s not because you’re having a baby, it’s because something bad has happened to you. Whether it’s a heart attack, a trauma, or a stubbed toe, something happened to you to make you go to the emergency room. And most people, I feel patient-wise, are at their worst when they are in the ER… patients and family. So, to have people that you like, just makes it so much easier to deal with unpleasantness.”

She admitted that when she is friendly with the people with whom she works; they can talk about other things rather than work.

“It’s a distraction from the patient care or the awfulness that you might see. Or the— when you’re at work, it’s a profession that you’re always giving; people always want something from you. And if you’re friendly with somebody, you can just sit down and talk without them wanting something from you. So it’s kind of—it’s kind of like a stress reliever.”

Abby used the term “let of steam” when discussing negative aspects of her position. She talked about not letting stressful work relationships affect her. She paused as she thought as if she did not want to say something bad. Abby described using humor with her colleagues to relieve stress:

“Like, just even laugh or joke about something. That’s kind of like a pressure valve, a little bit of a release. Many times, if I’m working with people that I don’t—or aren’t friendly with—it doesn’t even necessarily mean that I don’t like them, I just don’t know them—I call it my poker face, and I just go to work, do what I have to do, and I
come home. I interact with my patients. Maybe I’ll have—you always develop somewhat of a rapport with your patients, whether it’s good or bad, but I tend to keep to myself more if there’s people that I’m working with that I don’t know well or don’t care for.”

Abby quietly stated that there are some people that aren’t nice to others. She termed them “negative” and would not want to be around them or socialize with them in any way. At this point Abby became quiet. A family member had returned home and the recorder was turned off as we changed the subject. Once we relocated, she told a tale about a colleague and their change in behavior. Abby relayed that the colleague became “grumpy” and “less tolerant of things going wrong”. She found the behavior disheartening and didn’t want to see her colleague experience this. Abby stated, “it added to the stress level of everyone else” on the shift when the colleague was working.

“Clique” is another term she brought up. Abby smiled and told a tale about a clique of which she is not included. She neatly stated with a small smile on her face,

“It makes such a difference when it’s just people that work well together. The atmosphere of the ER, even if it’s busy, is less tense, it’s—you can actually joke more, and again relieve the stress, when the clique is there. And they may have the camaraderie and the de-stressing, but the people who are not part of that don’t have that de-stressing.”

Abby wondered out loud if people can pick up on lack of “de-stressing”. She stated, “the patient’s anxiety level can be higher when the nurse’s anxiety level is higher, whether they realize it or not that their anxiety level is high.” Abby felt, “When you’re more relaxed about things, the patient tends to be more relaxed and accepting of the cares that need to be done.”

As the interview moved to anxiety behaviors, I asked Abby if she could pick up on another nurse’s behavior. Her thoughts immediately moved to the In-charge nurse. In-charge nurses are assigned by shift and she stated, “the charge nurse is key to help keep things—keeping
everybody else’s anxiety levels low.” Abby further clarified, “it might be anxiety at trying to manage everything when the ER is really busy and you’re inundated with patients and acuity.”

Abby stated that one day an ED RN can work as staff and the next they are put In-charge. She paused as she reflected on what she wanted to say. The RN assigned to the In-charge role is her “supervisor” for that shift but her “peer” when they work together as staff on other days. When she is assigned to the In-charge position, Abby told me of how some people have “challenged” her and “not respected” her needs as a charge person because of not being assigned to the position every time she is working. She also told me of how nurse “friends” have “taken advantage” of her being In-charge but did not elaborate. Abby admitted, “They will do whatever I ask them to” and “I try not to take advantage of that because you want to be fair when you’re In-charge.”

As our interview began to wind down, Abby brought up the term, “areas”, which she described as specifically designated patient rooms. Abby didn’t smile when she talked about “areas”, but she said they aide in defining which nurse is assigned which patient. The ED RN cannot “pick and choose who you take.” Abby stated that with” the cooperation of the staff—there are people who are more motivated than others to take patients.” Abby firmly stated that assigning “areas” are “good because then it forces” nurses to take patients who otherwise would not.

This led Abby to speak of nursing experience. She adamantly declared, “ER nursing is very different from any other kind of nursing.” Her eyebrows furrowed as she told how to help other nurses during ED crises, “if they don’t know what they need to do, I try to direct them as far as what needs to be done” “...it varies depending upon who you’re working with. Years of
experience. I mean, experience is key.” Abby admitted that she is easier on the RNs that are new to the ED experience, “more tolerant of the new nurse than I am of nurses with more experience.” This was because she has the expectation that the more experienced ED RNs can do the work. Abby’s perspective on new ED RNs is, “... they haven’t seen things; they haven’t the experience.” Abby admitted to being more patient with the newer ED RNs because they need to be taught. She smiled as she said, “they are kinder”, “there’s more of a positive outlook” and “they’re still optimistic” in their learning of emergency nursing.

As we heard Abby’s family member strolling around the upstairs. We smiled at each other. Before I ended the interview, I asked Abby if she liked where she worked. She admitted that she liked where she works and the layout. She thought it could be a really great place. But she became quiet and softly said, “I find it frustrating because we’re focusing more on things that we need to be documenting and they’re looking more at statistics than I think looking at actual patients. It’s more—as computers are becoming more...” Abby’s voice trailed off as if she could not find the word she wanted to say. Once she composed her thoughts on computers, Abby stated: “They’re a necessity; it’s not optional. Documentation is needed to be done, and they (management) look at the documentation and they look at what the documentation shows versus what the patients—how well the patients are taken care of.” Abby disappointingly said, “I feel like it’s getting depersonalized.” “…it’s becoming more of a business. And to me, when you are taking care of people, it’s not a business, it’s very personal.”

We ended the interview and chatted for a few more minutes before I left to get into my car and drive home. I thought of nothing except “this first interview is over!” The next day Abby called to chat. She briefly brought up the interview and asked if I got everything that I
needed. I laughed and told her it was just the beginning. We both laughed and then our telephone conversation then moved to our natural chit chat about our lives.

**Betty**

Betty was an ED RN, who worked the “mid” or “swing” shift at a small community hospital in Connecticut. Betty was referred to me for the interview. Our conversation to arrange the interview was brief. When we spoke on the phone, she was quite enthused to participate in the study. The interview took place in Betty’s home. I was uncertain about going to a stranger’s home to interview. When I arrived to Betty’s home, I was greeted by two small friendly dogs. Betty, who was dressed in jeans and a t-shirt after having just finished exercising, welcomed me into her home with a smile. Her light brown hair was still slightly wet from the shower she told me. Betty led me into the kitchen/dining room area where we were going to interview and offered me coffee, which I declined after explaining I had two cups already. Betty introduced me to a family member, who left the room when began the research process. Once consent was obtained, the recorder turned on, and the research question posed, I was quite certain that I had made a good decision to interview Betty. She was cheerleader. Structured and organized in her thoughts. As she spoke, I thought about what it would be like to work alongside her.

As Betty reflected on the research question, her initial response was, “*everybody’s personality comes out under stress. Their background comes out under stress, their issues at home come out under stress or they don’t, depending on who the person is*”. She was referring to the ED environment’s ability to have the acuity and census levels changing at a moment’s notice. Betty continued:
“some nurses will bend over backwards to help you and therefore you’ll bend over backwards to help them. Other nurses you know that you can’t even approach because they won’t touch anything but their own stuff with a 10-foot pole. So, it’s, it’s, those people that don’t help others and just want to do their own thing and stay in their bubble…”

Betty admitted, “there are less of them and there’s more of the other people that help each other.” As she spoke, Betty’s eyes made contact. She had a story to tell. She spoke of one nurse in particular. She described the nurse as the type who had the reputation of “only looks at his own patients”, “if he covers you for lunch he doesn’t do anything for your patients” and “he’s a great nurse clinically”. Betty proceeded to say, “Personality-wise, you know, everybody knows, ‘Oh, you know, R., he’s not going to help you, he’s not going to do anything’.” She further described how she has worked with him:

“The only thing he will do and, and for me personally because I developed a relationship with him, is he’ll answer any question that I have. He has more experience than I do. So, he’ll answer any question that I have, especially medication. He loves to give his knowledge out because he knows everything, but he won’t help you with a bed pan, he won’t help you turn a position, he won’t help you boost, he won’t help you do anything.”

Betty stated that she found him fascinating because of his knowledge. She has learned to work with him to gain more of his knowledge.

Betty began to reflect back on how she first became and ED RN. She discussed how her position in the hospital would allow her to assist the ED RNs. As Betty put it, “I gain the favors of others by doing for others first.” She admitted, “I don’t have a problem with people helping because they jump to help me, because I jump to help them. I’ve established that. It’s part of my, the fabric of who I am.” When Betty became an ED RN, she felt that the ED RNs’ knowledge and of her and their knowledge of the specialty of emergency nursing was integral in her future performance, “everybody owed me something. And they knew who I was so I had the
support”. Because of this support, Betty felt comfortable when she first began in the ED and has been able to maintain her professionalism at all times while at work. She is constantly in motion to perform patient care.

Betty goes on to reflect back on an experience she had with nurse with whom she worked, who “gets flustered so easily”, “sucks her teeth a lot” and “is very verbal”. Betty felt that “you can turn those people around.” She does this by “helping her” as much as she can. Betty has noticed that this nurse “gets very flustered very quickly”. Betty’s concern was that when this nurse behaves in this manner, it “impacts patient care because they can hear her say these things” and it “makes them nervous”. Betty further stated that when patients are impacted the ED’s “Press Ganey’s are at stake because they’re like, “Well, I had this nurse who was just, you know, crazy.”

The Press Ganey reports are important to Betty’s institution, which aide in the hospital’s financial re-imbursement for patient care. Betty described her attempts to curb the nurse’s behavior by providing direction for her, intervening when necessary to “calm her down”, and “always watching out” for her. Betty stated that she has noticed the other nurse’s behavior from the day before, “I had an ICU patient for the first four hours of my shift that became one on one, she was all over my zone, helping me doing everything.” Betty felt that “pulling things” out of people instead of just talking about it works much better. Betty stated, “you don’t have to be a manager to be a leader.” I found myself wishing I could be a fly on the wall in her ED over the past several months to observe how this nurse transformed her behavior.

At this point in the interview, Betty stated that she was still “struggling” with her own ED but there are RNs where she works that have 25-35 years of ED experience and she “never
She stated, “even if the patient was a hot mess, I’d have support around me.” This thought brought her back to the male RN from the beginning of our interview. Betty was aware that other ED RNs are disgruntled with him, his work behavior, and its impact on the patients. Nonetheless she has tried to “develop a different kind of relationship” with him. “So the relationship that I’ve developed with him is I’ve turned him, he doesn’t even know it, but I’ve turned him into my mentor, clinically.” She approaches him with clinical questions and in return she assists his patients with the bedpan, urinal, ice chips, and etcetera. Betty has found that although this RN, who “will maybe (or maybe not) give a medication while he’s covering your patients for your lunch break”, has now begun to approach her with an interesting case and has offered her patients the occasional bedpan or boost up on the stretcher. She appreciated the “occasional giveback” and declared their relationship to be a good one even if “other nurses roll their eyes at him.”

The “buffer” was what Betty called herself when she described working with this male RN and any other RN that “butts heads” with him. She described it as the other ED RNs not being able to “hold back their feelings about, and their frustration with him, so it just brings it out even more got him pegged. So when you peg him like that he does it even more”. Betty felt as though this is “one more thing to manage” while she is working. However, if there is a crisis situation such as a code:

“All of that gets thrown off. Every, everybody’s in the one...” “so he’ll jump in and, and then the three of us will be there and any animosity or any friction goes right out the window and you’re focused and you are doing what your job is.” But once the code is over, “you’re right back to where you started from and, and, the other nurse will say something that maybe he did or didn’t do in the code and grumble, grumble. And I’ll just be like, ‘Alright, I’m the sounding board again. Here we go, you know, just tell me and hopefully we can move on.’ So I just have to keep everybody moving ‘cause you can get stuck in the mud with that frustration and you ruin the whole day.”
Betty began to recall a situation with another RN. It is apparent that the situation was frustrating for her. A “clinically weak” RN, who had “more years of experience than I” and was unfocused, socialized instead of working. Betty told a specific memory:

“We had a woman that, her blood sugar just kept on dropping and dropping. We must have done four amps of D50 and she just kept, you know, she would stay up there for a while and then bottom out, so you have... well, and she would become unresponsive. Well, this nurse was not paying attention each and every time. I mean, when you figure for the third time, you know, we’ve got a serious problem on our hands that we need, we need to get a hold of and I was, I found that I was the only one who was, you know, checking on her more frequently and testing her blood sugar and making sure because this, this chick was just, this nurse was just socializing. And it was baffling to me. I just can’t understand it.”

There was no mistaking Betty’s communication. She was frustrated and “baffled” by this ED RNs lack of care for the patient. Betty stated the other ED RN’s behavior of being “on the phone, socializing – flirting” as draining, “And then we made it through the shift. I was exhausted because you’re picking up so much slack.” Betty further stated that when you work with people on whom you cannot depend, “your faith is shaken and your trust is gone” and “when working with people that whole trust factor is so key.” She questioned, “Who am I with? Do I trust them to not only watch out for me but watch out for their own patients? And vice versa.” Betty declared herself the “never let them see you sweat” type and easily internalizes “the turmoil, the frustration, the tension, the stomach ache, the shoulder pain, the headache...” She told me she brings her “A game” every time she works a shift.

Betty suddenly recalled that she has not seen the RN that “baffled” her since that last shift. Betty works the swing shift, which is an 11 am – 11 pm. She knows all RNs from the day and night shifts. Her thoughts moved to the differences in shift work. She described the
day shift as a gradual increase in patient census and the biggest RN complaint most of the time is “*I didn’t get my break*” whereas the night shift “*never gets a break*”. Betty further described the night RNs: “*they have their own culture*”, “*they have to work with less*”, “*they work very well together*”, can be “*intimidated by the night crew because they are such strong personalities*”, “*very focused*”, “*no time for chit chat*”, and “*can appear unfriendly or abrasive*”. She declared the “*different dynamics create different people and different work environments*” and as a swing shift worker, she sees both environments. As a swing shift RN, Betty stated that she receives kudos from both day and night shift RNs. She always attempts to clear out her assignment before leaving for the day.

“I benefit from my own good conscience.” Betty hoped that her behavior as a worker is “*infectious*” and that “*other people follow my lead*”. She felt that “*leading by example*” may set the tone for the ED for her shift. This led her to recall another memory of an RN, who she was paired with in a work area and who liked to leave on time. Betty recalled that this RN had a very strong personality and Betty would want to continue to stay and work when the night crew was inundated with patients and needed help. With time, Betty noticed that the RN was staying later, “*softening up a bit*’ and “*is now getting thank you’s from the night staff.*”

“Thank you’s” are a part of the ED she told me. Her hospital has Magnet status “*so a lot of that push for management to recognize, we call it ‘kudos’*”. Betty felt that “*it does wonders*” “*for camaraderie, for morale, for letting other people know that other people are doing good*”. Betty added that she felt there is “*more camaraderie*” in the ED than “*I found
up on the floors.” Her last comment was that she is “is very happy to be there and very happy to have the crew that we do.”

As I thanked Betty for the interview and called out a “goodbye” to her family member, I was deep in thought. I wondered what it was like to work with Betty. Was her personality “infectious”? I certainly felt as though something was catching, but I couldn’t quite specify it. During my ride home, I thought of her experiences and my readings of Giorgi. She was an example that one participant can have several experiences of the phenomena under study.

Corey

Corey was referred to me by a colleague. We had spoken on the telephone several times attempting to arrange a mutual meeting date and time. Corey was one of those people told you exactly what he thought. Before I met Corey, I found him to be confident in his career. We arranged to meet at a local library for the interview. Corey was in his 50’s with silver colored hair. He was casually dressed in blue jeans and a tan sweater. He works the night shift in a large inner city ED on the northeast coast. He had a welcoming smile. We situated ourselves in a small conference room in the corner of the library and began our interview. He immediately responded with a question: “Do you work together as a team or not?” He further stated, “When there is a crisis, does everyone just jump right in to help or are there those individuals who have a different, I guess, work ethic that continue to take care of their patients and don’t get involved?” Corey provided a recent experience:

“A good example, last week, actually a couple days ago we had a patient who came in, elderly man complaining of chest pain, looked OK. He walked in. They triaged him, got the EKG immediately. He was having a STEMI, he was having an MI. It was – we put him in the acute zone. Two doctors, four nurses, one of the nurses’ aides all
came to the bedside. He was lined, labbed, medicated, on the monitor, vital signs done, EKG done within just a few minutes. The call was made by the doctor to transfer him and he was in and out of the ER in an hour. And there was no yelling, there was no screaming, there was no – everybody just did...without direction, to help. Everybody just worked. But it took the – like it took the village to take care of the patient. There have been other times when something like that will occur and you look around and some of the nurses...

Corey postulated “variables” may be the cause. He wondered out loud whether it is the RN’s “discomfort level”, “is not interested”, “not made to feel part of the team”, or “waiting for direction”? He believed there are “variables” that can make a shift’s assignment, “you can walk into the ER and look at the assignment and say, ‘No matter what happens today, it’ll be fine,’ because you know who you’re working with.” He admitted other days might not go as well because some people “just don’t work as a team”. Corey told me a “good team” can depend upon the day of the week. He explained that the staff are there, but sometimes “a critical incident” can occur and the RNs are “just uncomfortable with that kind of patient care, so they kind of back away from it.”

Corey provided another example:

“There was a patient in the critical zone that, that three of the nurses that were in the critical zone, only one of them went to the bedside. Where nurses from another zone came, but the other two nurses in the critical zone didn’t even acknowledge that there was anything going on kind of thing, you know? And again, maybe they were busy, but still, when there’s something critical, at least stick your head in and say, “I’m busy with my patient, but I’ll be right over,” or “Is there anything I can get you,” or “I’ll watch the other.” You know, some acknowledgement that there’s a crisis happening. And that, it happens rarely. But again, I think sometimes it’s comfort level or discomfort level of that person.”

He explained that the one RN involved who responded was uncomfortable with the lack of response from the other two RNs with whom they were working. Corey clarified the situation for me, “it’s the critical zone, not the non-acute zone”. In the “non-acute zone”, patients are sick
and care needs to be provided, but it’s different in the “critical zone”. As he said this, he made a face and I read it as, “unbelievable, huh?” and we were silent for a few minutes.

I asked Corey about the “non-acute” zone. He easily described it as having 8-10 patients and when the RN with whom you work in the zone goes on break, you are now covering 18-20 patients. He stressed that prioritization is vital. Corey told me of his own breaks and making requests of the covering RN to do something for your patients: “You’ve only asked the to do one thing and you come back an hour later, and it wasn’t done.” He wondered whether the RN was too busy to get to it or that they just didn’t do it. He declared, “That can be frustrating, when you leave patients in their care and you’ve only asked them to do one or two things, and you come back and it’s not done.” Corey felt it may be a “work ethic”. He questioned whether these RNs feel “responsible” and want “to get everything done”. Corey told me that he now tries to “reinforce” the specific things when he wants done for a patient while on break.

When probed about his covering the other RNs for their breaks and not getting things done for the patient, Corey’s response was quick: “I always feel a little guilty, but I always try and explain why it was I couldn’t get to it.” He admitted that even this doesn’t work with some RNs. “There are those people that want everything with a pink bow. Well, like at change of shift. I did this, but I just – I didn’t get this. ‘Oh, you didn’t?’ ‘No, I didn’t.’” He simplified the concept: “It can go over into the next shift as long as it’s not something life threatening.”

Corey took the interview into staffing and being in charge, “I think working short is becoming more and more the norm. I think people get very frustrated, and there are those people that get resentful.” He described RNs refusing to take additional patients because of being short staffed. Corey felt the resentment most when he is placed In-charge for the shift.
When he is In-charge and gets these responses from fellow RNs, his response was humble, “I really have no option. We have tried to get another nurse to come. The nurse manager is working on it. But right now I really need to give you this patient.” He added that he always acknowledges the RNs sense of being “overwhelmed” and assists in care by “dropping a line and getting labs”. Corey also documents the “initial assessment in the chart”. He does this to lessen the “burden” for the RN. He expressed hope that by “Showing that person that you are willing to care for someone who is not your patient and that you’re willing to help.” He cautioned, “You can be taken advantage of by doing that, also, but I think sometimes, I would hope, that with nurses that don’t do that, that maybe they will see that now when they’re in charge, that might not be a bad thing to do.” Corey was referring to teamwork and he further stated:

“I think it’s very hard to build a team. I think some of it can be, ‘This is what we’re going to do and this is how we’re going to do it.’ And some of it is just chemistry. It’s just how you relate to each other. You know, it’s – I think it’s difficult sometimes when you work with people, and we all have, that for whatever reason, they either dislike you, don’t like you, don’t want to communicate with you. And that I don’t – that’s very hard to change. I think that’s very difficult to change. And that makes life very difficult when you’re working. Because as far as I’m concerned, you can really dislike me all you like for whatever reason, but when I’m trying to endorse a patient to you, don’t walk away from me, don’t roll your eyes, and don’t wave your hands at me, put my name on it. And that behavior is very difficult to change.”

Corey told a story about two new ED RNs, who were new to nursing. He told me how he was in the “critical zone”, couldn’t leave the bedside of a critically ill patient and two new ED RNs helped him with his other patients without any prodding, without any direction. “It was great. It was – I thanked them profusely.” “They were just two younger nurses who were both very competent and assertive. And now are both in higher level management positions.” Corey smiled. “I think they were comfortable with their skills. They had an awareness of the situation,
which some people are just not. And I think that was just, that was just them. You know, that was their personalities, too. Take over, get things done and not everybody is like that.” I sat and thought that he was describing young leadership to me.

When people do for each other it makes multiple tasks that can seem overwhelming, doable. Corey described his hospital’s telemetry data sheet, an “annoying” but necessary aspect of the care when a client is admitted for cardiac monitoring. Transcribing the information from the computer onto the telemetry data form can help an ED RN as does calling to give report to the floor RN when the patient has a bed assignment. Corey told me this can sometimes backfire between ED RNs. When an ED RN wants to “hold onto their patients” so they don’t get more assigned to them, they may take it out on the RN that is attempting to help them with their patient tasks.

Corey told me that although the In-charge RN tries to keep track of the patients on their ED’s patient board, not every patient gets moved over to an RN’s zone in a timely manner. “Ambulances come in and you forget to move patients over.” He told me this is when the ED RNs begin to “patient count”: “And they’ll count. Well, she has five and I have…” “It can’t always be equal.” Corey explained, “There’s a reason. And we used to, with our 5-tier system, we used to a stable 3, an abdominal pain; it’s stable, could wait in the waiting room. Now, they want all the category 3’s in.” He told me that management is aware of staff’s concerns and the outcome was to simply put the name of the ED RN to whom the patient was endorsed whether they took the report or not. Corey told me the outcome of this:

“Or the other day I was trying to give an endorsement to a nurse, and she just kept walking, with her back towards me. So I stopped, I’m too old to follow people around. So I stopped, I planted my feet, and I kept talking. And she finally did sort of turn her
head, “Yeah, OK. Whatever.” That’s a personality thing. That’s a known entity. But still, it’s disrespectful to me or to whoever else is trying to give her a report.”

Corey recalled how things were done when he first started as an RN. He believed patients are sicker, but expressed frustration at all the other things that now needs to be done. In particular, he referred to “on the computer” “One of my co-workers calls it, ‘Computer care, not patient care.’” We both laugh out loud.

“…people are monitoring the computer. My assistant nurse manager – I guess shortly after we got the computerized system. And you know, the category, the triage category… are patients that need to be resuscitated or very critically ill or a 1 and it comes up red on the computer. So the, I don’t know who it was, if it was customer service. Someone called the assistant nurse manager to say that there was a patient that was a category 1 and they had been there an hour and there were no nurse’s notes on the patient. And the assistant nurse manager said, ‘Well, do you want to know where the nurse is? She’s at the bedside of the patient trying to save the patient’s life.’”

He further stated,

“…just all of the hoops that we have to jump through now, I think it’s become very frustrating. And working short staffed. And that whole aspect of nursing, how it’s become, that we’re so aware of that it’s business. It’s a big business. I think that’s made a lot of people a little disgruntled.”

Corey hoped that “it doesn’t impact patient care” but “definitely thinks it disrupts relationships” as he described the “extra work” that ED RNs must do: telemetry data sheets, completing every question on a triage form even if it’s not relevant to the patient’s care, “I was questioned about a patient who was in cardiac arrest and I didn’t fill in “N/A” for tetanus status.” Another example he gave was, asking clients whether they are homicidal or suicidal when they are not in the ED seeking mental health care, but medical care. Corey felt that irrelevant questions and tasks are “impacting our professional practice.” When he sought the rationales, Corey told me,
“...nobody says why. ‘This is new; we have to do this.’ So I think those are the kinds – when you talk about burnout.” “Let us do our job. It’s just, it just seems like there’s always more and more and more to be done. But still the bottom line is that we still have to take care of the patients. And we’ve been doing that for years and years and years without all these other things. But it can, it can make the relationship with other people difficult because you know, you see people that just – they just do the bare minimum. You know. They don’t do the above and beyond. And again, is that just their personality or is that something that all the wear and tear?”

We end our interview after 90 minutes. Corey had given me another insight into ED RNs workplace reciprocity. I appreciated his candor. I thanked him profusely as we left and headed towards our respective cars. It was during my car ride home, I began to feel there was current that was weaving through the interviews. It was with my interview with Corey that I began to feel protective over my participants. I immediately contacted a colleague to discuss my feelings.

Debby

Whenever I think of Debby, I smile. She touched soft spot in my heart. Debby was a 40 year old female, who has a BSN in Nursing and has greater than 25 years of ED nursing experience. She works the night shift in a large community hospital in rural New York. Debby was referred through another participant. She was eager to participate in the study. Debby wants her voice heard. The interview was scheduled to take place in a local diner near her home. We met outside the diner. I noticed that Debby’s hair and eyes were brown. She was dressed comfortably in blue jeans and a hooded sweatshirt. Debby smiled easily and giggled a little when we greeted each other and shook hands. We chose a table in the back of the diner. It was an off-time and the diner was quiet.

Debby told me how she began working as an ED RN. She described it a “close cohesive environment” where she received guidance and direction from the older or senior nurses. Debby’s story flowed into her current ED. “I’ve realized that it’s the best place to work because
of the interaction with the staff.” She described per diem and full time staff. The full time staff is invested in the institution; the per diem staff is “in it for the money”. The difference in the numbers of full time and per diem scheduled for a shift can impact on day. Debby is a dedicated employee with a positive attitude. Negative people are hard to be around, they “damper the situation.” Debby continued:

“But every day is unique based on who you’re working with. Not based on the day, not based on the patients, because the patients are going to come and go, but it is who you are working with. So if the majority of people in the unit are per diem and there’s one or two, which has happened, full-time people, you kind of know that you’re the anchor and they’re kind of around.”

Her ED is divided by districts. Each ED RN has a district. When nurses cover each other for breaks, they covered the district. Debby described her experience in covering breaks further. “They give you a good report about what needs to be done” and there are those “handful of people destroy the morale of the unit, when you go in and get report from them and they fluff it, they make it look nice” and then she “discovers” multiple things must be done for several patients including discharging a few of them. The patient turnover, she told me, leads to new patients being put in this RN’s district. The other RN returns from break and their district is in turmoil because of the turnover, but they tell the RN “my district was fine. I don’t know why it’s such a mess now. You didn’t do anything.” Debby told me, “you feel like you didn’t do what you needed to do for that hour.” These situations leave her frustrated, “you know the reason you feel that way is because they didn’t do what they needed to do before they even left.” Debby recalled a specific situation where a nurse “hasn’t spoken to me since” the day she covered them for break. Debby expressed frustration at the situation. She wondered why certain behaviors are tolerated. “They love a code.” “That’s what they want to take care of whether
they’re in that district or not.” “When they really have to do work and it is that busy, they are overwhelmed.” Debby told me that on days when this RN is not working it is “beautiful”; those days this RN is working the “negativity that comes into it and that drawback to it, that kills morale in any emergency room”.

Debby told me of how her ED sends out messages to the staff. They are open in their communication and when things are being done well, the RNs are congratulated for their work. She told of how bad behaviors impact the patients and that “patient complaints about an individual nurse the management takes that very seriously into consideration.” Debby segwayed into another story about a client and how the ED RN wasn’t taking the symptoms seriously and argued with the physician. Debby stated, “And, whether we knew it or not or got that feeling, ‘cause I feel like we always have that sixth sense anyway, you can’t blow people off. You can’t blow people off. And our job is just get stuff done.” Debby told me how other ED RNs will perform the care when other’s do not. “Personalities” are important to the ED. When the ED RN is “scattered” but a “good nurse”, Debby took the time to establish a “rapport” by providing friendship, gentle direction and guidance to this nurse when they worked a district together. She admitted, “not everybody wants to take the time to do that, to get to know their co-workers like that. And that is a sad piece, because we are a family” and described how she went to the night shift because there was a need for nurses.

Debby described the differences of the shifts: days, 7 am – 7 pm begin slower, the nurses ease into the shift; swing shift is 11 am- 11 pm and the ED is busy, the day nurses are grateful to see the swing nurses arrive; and the night shift 7 pm – 7 am “things are crazy”, they “begin overloaded and try to clean up the ER throughout their shift”. Debby loved working nights
because she was able to “develop relationships with the night crew” and “getting to know each other”. The shifts of the ED make sense to her now. When she worked days and things weren’t done by the night crew, she now understands why. Shifts and nurses have to be a good mix, Debby told me.

She related a story of a co-worker who worked the swing shift and was unable to manage the shift work. Reports to the night shift were “met with resistance”. Debby told me her colleague felt she “couldn’t even stay in emergency nursing”. After being encouraged to speak with management and subsequently being moved to the day shift, Debby reported her co-worker is doing much better:

The “change in the personality and the demeanor and just the, you know, vibe that you get from her is huge. She is so much happier, she—and not because it fit her life any better, it was working fine, but she feels like she fits into something. She wants to. She tries harder.”

Debby described the importance of colleague interactions and told me “how nice it is to be in crisis and pull together and do and save somebody’s life”. As she said this, I thought in my head, the purpose of an ED RN’s career. Debby continued with her story. A critical patient arrived. All the ED RNs pulled together to care for the patient and the critical care RNs took their lead. The patient was in the intensive care unit (ICU) bed within 2 hours of ED admission. Although the ED RNs (and the patient’s family members) knew the patient would not likely survive the night, Debby stated, “the team work that got that going was just, and everybody felt so good” and the “The family experience was phenomenal. They were so happy that all of this, it just all fell into place so nicely.” Debby eloquently puts it, “what we do today as a group or even as an individual within that group is going to benefit more than just today, more than just
that patient. And what can we do or what can we learn from what we’re doing to do it different
the next time?”

When the pieces do not come together, sometimes it’s the RN. Debby described another
experience for me. The new ED RN who likes “chatting instead of taking care of the patient”.
Even though this ED RN had an extended orientation, she was problematic. Debby told me,

“when you have to think about staffing and not everybody is equal, that’s not fair. If
somebody’s new and green and stuff like that, fine. I get that. But when they’re
supposedly an ER nurse that we’ve given them plenty of time to know, they should be
able to go anywhere and work like everybody else does.”

Debby was concerned, “She’s not a personality for the emergency room.” Debby stated that this
RN’s sick calls have increased and this, too, affects, the other ED RNs. Debby has come to
realized that she cannot “change” new ED RNs. Everyone comes with their own set of “values”
and “attitudes”. Debby felt that these aspects “either fit or doesn’t fit”. Senior ED RNs don’t
like “defensive” and “insecure” attitudes. “I do believe that certain personalities are not cut out
for nursing and not cut out for ER nursing.”

When RNs are put into a position where the “unit leader or charge person knows that
you’re the nurse that gets the job done so therefore you get more sometimes than others, it can
be frustrating”. Debby stated:

“There always has to be at least an equal mix if not have the scales tilted on the hard
workers or the good workers or the real ER nurses over the people that really
shouldn’t be there. Because when the scales balance the other way is when you lose
those good people.”

We discussed losing good nurses. I can see this made her sad. Debby told me several senior
nurses have left her ED because they “couldn’t adapt to the computers” and all the “added pages
of documents” that must be completed before the patient leaves the ED.
The diner had become busy. As we both realized our interview time was almost done, Debby exclaimed, “We don’t have a vision and a mission in our nursing department!” Debby stated that a value system should be presented in the interview process and the prospective new RN should be told, “This is what we are and if you are this and if you can agree with this, if you can work with this, if you can live with this, then you can work in this emergency room.” As Debby said this, I had thought “she is on to something with the vision and mission statements. We walked to our cars and I thanked Debby for her time. During my car ride home I thought about Debby’s experiences and began to feel as though I wanted to return to the ED as an RN. I immediately wrote my feelings in my journal and debriefed with a colleague. My purpose was not to return to the ED, but to research the ED RNs experiences.

**Eddie**

Referred to me by another participant, Eddie is a 50 year old male with a BSN. He had greater than 20 years in ED nursing and works nights in a large inner city hospital on the northeast coast, where patients are brought directly in for care after triage. We planned our interview in a diner local to his home. I had a feeling that this would be a very frank interview. Our telephone conversations were always brief. I arrived to the diner early and took a booth by the window. There were three other tables with two patrons each. A few minutes later a tall male with light blonde hair and blue eyes walked in, approached the booth, and sat down upon confirmation of who I was. He was wearing dark blue jeans and grey colored sweater. As I had first thought, Eddie was quite frank with his responses. We ordered our food and began our interview.
Eddie told me that he thought he works with the better half of the staff due to the way weekends are set up. He described every other weekend RNs are assigned to work. His weekend has “a lot of good team players” and told me this is important because in nursing “I don’t think is about just you doing it and I doing it, you always need somebody else. And sometimes you need more than somebody else.” He clarified, “everyplace does it different. But we know how we are set up here.” Eddie began to describe behaviors of some of the RNs with whom he works. The ED RNs that “always has the worst patients”, “they kick up a storm no matter where they are assigned”, “jump down your throat” and “attack you” when you assign a patient to them, those that “play deaf”, and those that “sit and watch” when other RNs are busy. He recalled an experience with “sit and watch” RN. Eddie told me this nurse was from another shift, “played the game instead of assisting”, and was In-charge. Instead of assisting, the RN was “socializing”. Eddie described the RN as “a winner” upon arrival to the night shift. He clarified, “very lazy” and “not helpful”. He recalled another experience when he was In-charge and a notification of a sick client by ambulance was coming into the ED. Eddie described avoidance behavior by the other RN. Not wanting to help in the arrival and stabilization of the patient, documenting on the patient’s chart and “taking credit for everything” the other ED RNs did for the patient, then not wanting to take the patient into the RN’s assigned zone. “Finished” and angry, Eddie assigned the patient anyway. This action had brought a visit from nursing management at a later date. Eddie clarified the situation, “Everyone here is acting like babies. Everybody knows the deal.” “Nobody looks at how busy somebody is sometimes. They look at numbers.” The other RN was looking at numbers, he said. Eddie does “not hold a grudge” against this nurse. The RN “wouldn’t talk to me” but that “doesn’t mean I’m not going to help
him.” Now, there is no longer any “problems” with the RN. “I’ve helped them out a couple of times.” “They know I don’t sit by and watch.” Eddie told me when he first arrived in the ED he realized, “Nobody’s going to help you unless you do something for them”. He told me that those who have noticed how he works “do a lot of things for me” even if they are the type that “likes to sit around”. “You have to kind of build relationships.”

Sometimes the attempt at building relationships is futile. Eddie told me about being “frustrated” with the “deaf ear” nurse. The nurse ignores being assigned patients by the In-charge RN and receiving prescriptive treatment orders from physicians. Because this ED RN “doesn’t care what’s going on” and is “only going to do one thing at a time”, they will no longer be assigned to the “front zone”, which is a busy area. Eddie told me, “everybody gets frustrated with her” and it’s not alright for the RN to “have an easier assignment all of the time.” Avoidance behavior is not the norm during critical situations. “People always come to the notifications. It’s very rare people are not going to jump up to them.” Eddie described another ED RN to me. Although this RN is the “first one there to help out” in a critical situation, every time the RN “comes in. It’s drama, drama, drama. It’s always some sort of drama.”

The thoughts of drama bring out another experience from Eddie. Two nurses who have “personality” issues. They “hate each other” and “do not talk to each other”. Yet, they were assigned to the same zone and were to cover each other for breaks. Eddie, who was In-charge that night, told them to cover each other. The two ED RNs avoided each other and breaks were messed up, which caused one of them to go to nursing management. This action had circumvented Eddie’s In-charge role. The next shift they worked together, Eddie confronted the
RN: “I spoke to her professionally. You have to work with each other. You have personality conflicts… that is not what this is about. We have to get the job done.” He told me the conflicts:

“just make the night harder. I went home, not exhausted from the job. Exhausted from listening. Making comments and complaining about everything, that to me is the most stressful thing. The most stressful thing. And now I don’t even want to help you. Because you’ve been complaining since – I don’t even know if you’re busy or not busy.”

Eddie recalled another night when “Everybody took a patient and shut their mouth.”

“Nobody said anything. You don’t know how much easier that makes the night when you don’t have people snapping!” Eddie continued: “The basic think is team playing. I don’t care if you hate me or not. This isn’t about me or you. This is about: let’s get through this night; let’s help this patient.”

He had taken a few minutes to eat the food he had ordered, cheeseburger and French fries. His thoughts wandered to “new parameters” and “Paths”. He stated, “They want you to do things faster and they just keep slowing us down.” We discussed this a little until he said, “They’re always trying to – everything gets blamed on nursing.” He described an incident where a nurse was triaging a patient, the nursing supervisor walked into the ED, and the physician reported the nurse to the supervisor that the patient’s vitals hadn’t been done. Eddie made a face and declared incredibly, “The nurse was still triaging the patient! Unbelievable!”

As he finished his meal, we realized we had gone over our interview time allotted. Eddie told me another experience. It was his way to finish off his story.

“One night it was so bad. I think we were snapping at each other all night. It was one night; it was horrible. So in the morning we were laughing. It was 7:10 am and we’re all sitting, laughing. The night is over and we can be friends again. That’s what it’s all about. You do get mad with each other. But when it’s over, the whole thing is over.”
Our interview ended. I thanked Eddie for his participation and we walked to our cars. He joked that he would think of 20 more ED stories when he got home. We laugh and parted our ways. During the car ride home, I was excited. Although I wanted to protect them and advocate for them, ED RNs are a distinct breed that can handle themselves. I was here to only study workplace reciprocity of the ED RNs. Eddie had given me some valuable insight into ED RNs relationships.

Fay

Fay, an ED RN in her 30s, has been an ED RN for over 10 years. She works the night shift at a small community hospital in Connecticut. I found that Fay was a kindred spirit upon meeting her. She, too, had started her nursing career as an emergency nurse. She has a compassionate way about her. Our interview took place in her home, a small cozy apartment near her job. Fay, like many ED RNs, has a full time job and a per diem job. As we chat, she admitted that she loves school and is thinking about furthering her education.

After overcoming our amazement that we began our careers the same way, Fay told me her perspectives of emergency nursing. She began with describing the night shift. “The culture’s totally different. I think on the night shift there’s less administration, less support, so we kind of count more on each other; it’s more of a team work effort.” Fay described the day shift as having a tendency to get “argumentative” and “nit pick”. “There’s a lot of cattiness I see during day shift. You know, ‘this is not my patient, this is not my patient,’ and at nights you don’t have that choice. This is what it is and we’re going to get through this.” On nights, we “rely on each other, definitely.” “There’s no administration where I work” on nights so they pull together as a team to get patient care done.
Fay told me that where she works they are seeing more patients, “almost double” than 10 years prior. She stated, “We’ve gone from working with four nurses, one tech, one doctor, to working with six nurses, two to three techs, two doctors.” The nurses are of “different levels” of experience so the “stress level is totally different”. She told me that in addition to some new ED RNs, there are those per diem (part time) RNs that work in other EDs, too. Some of them work in the In-charge position frequently at their full time positions. As she thought about the nurses and their “different levels” of experience, she began to tell me a story:

“Recently we had carbon monoxide poisoning at [a retail store] and we got like six patients, and we were so busy. And everybody just worked together. We’re like, ‘OK, let’s put a stretcher here, let’s do this, let’s do that,’ and we knocked these patients—I’ll do triage, the doctor was on board with us, we knew exactly what we had to do, the carbon monoxide levels... we got these patients out like in an hour and a half, ‘cause they weren’t really sick, so that demonstrated a lot of teamwork.”

Fay told me the members of that team were of “different levels”. The new RN “who was soaking it all in...” “We are very good with our newer nurses.” Fay told me how they pull the new ED RNs to see new cases and “debrief them” because “When I first became a nurse, that wasn’t so much the case.” “I had a lot of support from the older nurses, but the dynamic of the new nurses coming out...” She trailed off reflecting about the dynamic then said:

“For instance we have a couple of nurses that want to be the float nurse. ‘How come I’m never the float nurse? I’m new?’ And we’re like, ‘you need to get your experience first, you need to be in a zone, manage that, because in order to be a float, you need to be strong. You need to be able to do this, do that, and move on to the next thing’ because they cover breaks and things like that. So they like want to jump right into it, they don’t want to sit and wait or—how can I explain it to you? You know, ‘get your years of experience.’ They want to jump into leadership right away...”
Fay didn’t begrudge them. She told me “they can also teach us; I’m always willing to learn.”
She told me, “… it’s so weird just because I’ve always felt like I was the novice and then I started precepting and now I’m like a leader, now people look at me as a mentor…”

Fay described leadership as being able to take charge and be placed In-charge of the ED. To be In-charge for the shift, that nurse “sets the tone for the ER.” “If you’re calm in a situation, everyone else is gonna be calm” and the RNs will “take your lead. If you’re up in an uproar, then everyone’s gonna act like that.” Fay believed this goes for the physicians, too. Their behavior affects the tone of the ED. She told me, “We know what we have to do” and stressed behaviors “leads more way for error”.

This leads Fay to tell me of an experience that she witnessed between a physician and an RN during a code; it was an argument over correct code protocol. She told me of how they went “tit for tat” at each other and how it was “uncomfortable” for the RNs in the room. Fay told me she’s seen RNs do this to each other, too. One RN may feel that she knows more than another; the other feels as though she’s being put down and fights back. The result: “they stay clear of”, “work around” and “avoid” each other. Fay told me that because she knows “the personalities” when she is In-charge “I try to steer them clear of each other.” Fay has never seen them “take it out on a patient”. “If there is a code, we pull it together.” Fay began to tell me another story about a pediatric code:

“One thing I must say, though, like working for a small community hospital, when you have cases like children dying and stuff, we really don’t debrief, which is something we’re trying to work on. Oh, it affects the whole tone of the whole ER. We are like, you know, something like that happens, we’re all devastated.”
Fay believed the RNs are “probably even closer because they shared that experience”. They “…still talk about it till this day”. Fay thought “once you have those experiences, there’s a link between the nurses, no matter what level you’re at”.

We paused. There was non-verbal communication between us. Fay expressed to me that she has had very good experiences in her career. She is a self-declared “fair” “hard worker”. Fay admitted that when RNs are wrong, she has corrected them. It makes her uncomfortable because she’s concerned with their feelings. However, if has to do with “compromising patient safety and care, I tell them.” Our interview ended early due to company at her apartment door. We thanked each other for the time spent. After parting, I wanted to maintain contact with Fay. She had a distinct leadership quality about her that I felt was missing in clinical nursing.

Gigi

The interview with Gigi, an ED RN in her 50s with 8 years of ED experience, took place in her home. Gigi has dark brown hair and eyes. The first thing I noticed was her eyes. I could tell her smile is genuine by her eyes; the smile lines around her eyes told me she smiled a lot. Her whole face reacts when she smiled. Nursing was Betty’s second career. She graduated with an Associate’s degree in Nursing, had worked on medical surgical floors and in intensive care units, and works nights at a small community hospital in rural New York. Betty had two dogs that greeted me as welcoming as she did. Gigi led me to the kitchen with the yellow painted walls for our interview. Gigi offered me a beverage as she got one for herself. I declined. Gigi was in blue scrubs. She wanted to be part of the study and could fit me in before she had to go to work. I worried that I was rushing her. She assured me that I was not.
When I asked the research question, Gigi immediately responded with personality traits. She told me that there are “personnel that move in and out of the department because the type of personality that it takes to be an emergency room nurse.” She further described it, “First of all you have to be a little bit of a junkie. You know, you have to be up for the adrenaline rush and not let it bother you. Like some nurses do not like – they get very unraveled.” “But the emergency room as a whole different flavor to it.” Gigi’s critical care experiences have helped her adjust to the ED experience and felt it is very similar to ED nursing. She described her perspective:

“You are used to things going bad fast and having to make decisions, sometimes independently, before doctors can come to your aid. So you rely on a team of people that you work with. And so, there are those who, in the emergency room, are more helpers and there are those who are, maybe you might call them ‘assist staff’ and those who are drivers. And so those of us that have driving personalities of which is normally my place. I’m a person that goes right up front. I’m a spearheaded individual, and I start giving directions and telling people, ‘You do this, you do this, you do this.’ People take their roles and do it.”

Gigi told me that due to the nature of the ED, nurses do not stay long and “we have rotated through more staff than in any other areas that I’ve ever worked.” She succinctly stated it:

“People just rotate out because sometimes it’s too much stress and sometimes it’s maybe just not to their liking. But the bottom line is that you’re working with new people a lot. As well, you have your core of people who stay. And that core is a core that you become so dependent on and they become dependent on you to do your part.”

Gigi instantaneously reflected on a recent patient case, a trauma. She described how some ED RNs stayed outside the room and how newer ED RNs “jumped in and took their place” in the trauma code. Gigi further described it:

“There was a few moments of tension where you actually had to yell at somebody, ‘Do this,’ and they didn’t hear you or they were focused on something else, and you had to say it to them firmly again, repeat it. And the beauty of working in that kind of a setting and having that kind of a personality that works for this, you don’t take it to
heart. You, you say to yourself, ‘Hey, I got to be part of the team, and I should have been paying attention.’ Or listen, ‘He wasn’t directing at me. He was directing at the situation.’

The patient went to the operating room immediately. She recalled this “incredible let down” but not being able to “hash things out” because a cardiac arrest had just arrived immediately after this case left the ED. “You move from one stressful situation to the next stress situation to the next stressful situation.” ED RNs must “have the kind of personality that can, not brush things off, but in your own way analyze them”.

Gigi began to discuss another stressor for her, “the stressor of the requirements of JCAHO and the new requirements of Magnet.” The paperwork, the committees, the group activities that must be done frustrated her. She made a puzzled face as she said, “it almost is contraindicated for the personality of the emergency room nurse.” We both laughed at her remark. She spoke of nurses, who spent more time on the computer “ticking boxes” than caring for the patients.

Gigi swung immediately into two more stories. She spoke of nurses’ “personalities”: “strong”, “rather aggressive” and those who are “feeling their way through the nursing system” to determine whether ED nursing is for them. Those aggressive nurses that jump into critical situations and taken charge are assertive in their patient care. Noticing that a client during a cardiac arrest needed “more effective compressions”, a nurse Gigi worked with moved “from triaging and actually pushed the person away who was doing compressions” in order to provide effective care. The volume of the situation turns into “yelling”; dialogue become “orders”. Some staff nurses take “offense” of this type of communication. Gigi does not. In fact, she had a tendency to accept this behavior: “I remember sitting down at the desk and everybody was kind
of decompressing a little bit and this particular RN actually apologized.” Gigi told the RN that she didn’t have to apologize although “a lot of people felt like she did need to apologize”. This behavior she attributed to the protective nature of others, it “is interesting because you have this tight knit group of people who do work together, sometimes they take up the offenses of others”. “The bottom line is the patient lived.”

The puppies began to bark at the kitchen door. “Puppy potty break”, she said with a smile as she got up to let the dogs out. She looked back at me as she expressed concern about others taking being offended by this type of behavior. Gigi attempts to “draw them in, bring them into the middle of the situation” to “make sure that they have an opportunity to have a physical participation. And it will help them to… I don’t want to say get over it, but it will help them to work their way through it”. She felt that “getting them involved” and “directing them” in patient care in critical situations is a good way to foster teamwork. For Gigi, teamwork is “being part of a good team player is giving everybody a sense of autonomy and authority” that “not only are they part of the situation but part of the whole team”. She judged strengths and weaknesses and “weave them together” to figure out what aspects a person does or does not do well. Gigi told me she is constantly searching for something new to learn and encourages others to do the same to strengthen the weaknesses. She attributed her first career in this method. It’s a way to “develop a great team”.

“You are sad when those people go…” Gigi referred back to the JCAHO and Magnet status requirements. In critical situations “you depend on individuals and prefer to be surrounded by people like you”. She attributed the status requirements of affecting the team and the way they are “able to interact with each other in responsible ways”. Gigi frowned as she
said, “and now for us to be graded…” She let the dogs back in. “Re-imbursement based on the Press Ganey scores... so if you don’t play nice nice”. Without breaking eye contact Gigi stated, “Our focus is the patient. Our focus is them recovering. Our focus is them surviving.” There is no mistaking her comment. In the last couple of years, several senior, experience ED RNs have left Gigi’s ED. She told me, “we have lost a lot of great senior nurses in the last few years” and it “has been a real detriment”. Gigi expressed concern that it will “change the face of emergency room medicine. It could be very traumatic because those senior people were also the people who are great under pressure and move so fluidly”.

Those that don’t work well under pressure or move so fluidly can be tricky. Again, Gigi referred to the “dynamics of personality”; however, she will not let anything slide when it comes to patient care. “I depend on the people I work with to do what they’re supposed to do.” “I’m all about confrontation.” If something wasn’t done for her patient, Gigi confronts the other RN. “… Some people blow it off and some take it seriously”, she told me. A particular RN comes to mind and Gigi stated, “she has no intention of changing her ways”. She referred to ED RNs with this behavior, “they’re lazy” and “they do what they have to do to get by”. In a code situation, she found it difficult dealing with them: “all of a sudden, they want to jump into the middle of what’s going on, but they don’t want to take care of the stuff that quote/unquote ‘Isn’t all that important, doesn’t matter.’” Gigi described further,

“These people are like meticulous in their charting and meticulous in their computer work and meticulous in, doing all these crazy little requirements, but they’re not meticulous in what they do as a nurse. Patient care, patient needs to survive.”

These RNs “just look the other way” and “shrug their shoulders” and Gigi found it “tough” to “have to deal with them in the next critical situation”.

When she is covering the breaks of RNs that exhibit this type of behavior, Gigi makes “a point of going the extra mile when I take care of their patients. Maybe try and guilt them into doing better when they take care of mine.” She admitted to me that it works for her patients but not for other RNs. Several times a shift she can encounter this type of behavior. It “lends towards, you know, you having to suck it up a lot and say, “You know, I’m going to do what’s – I’ll just keep doing what I’m supposed to do.”

We realized that our time was almost up and Gigi had to go to work. Her husband came quietly into the kitchen. Gigi introduced us. We chatted for a few minutes as I turned off the recorder. I expressed my gratefulness for her time and she wished me luck on my research. As I approached my car, I smiled to myself. “Multiple experiences of the concept” ran through my head. Then I began to think, “I have themes...”

Holly

Holly, an ED RN in her 30s, has been an ED RN for over 10 years and has started a Master’s in Nursing program. She had worked in numerous EDs and explained that she wanted to gain as much as she could in ED nursing. She works the day shift at a large inner city hospital on the northeast coast and was referred by a prior participant. Holly and I had spoken several times before we sat down for our interview. She made me laugh out loud in our phone conversations. Her stories were humorous. Each time I would tell her to save her stories for the interview. Our interview took place in at the dining room table in her home. When she greeted me at the door, I noticed a tall, thin woman with short blonde hair and blue eyes. Holly brought two glasses of water over to the table and we began our interview.
Holly described each ED that she has worked as being “very different” and believed that “a lot of it has to do with institutional culture; I think institutional culture plays a very big role.”

She described further:

“I think institutional culture and how it promotes the profession of nursing also affects greatly how nurses treat each other and what they do for each other when working together. That’s been my experience, that unfortunately—I don’t know if it’s unfortunate, but you would hope that people individually decide what it is that they want to be, how they want to be, in terms of professionalism and everything, but you can be whatever you want to be, but if the forces are working against you, and that’s the culture of the institution, then you either choose to submit yourself to that culture or leave.”

I had begun to think that Holly did not understand my research question, but she continued and reflected on her first ED RN experience. She described herself as having “no reference point”, “nothing to compare it to” and “much more than I could handle”. Holly told me that she “worked with some awesome people” and although they have all moved on to different things, they have all kept in contact. “We are so tight. We’re in different parts of the country, but we stay so tight, that if one person gets ill, we all like fundraise or go to that person or offer assistance.” She laughed as she described it as:

“We had the abused child syndrome—you know, the siblings that suffered abuse from their parents that grew up like super close to each other because they had to take care of each other because they knew that there was nobody else to take care of them, and that’s the way we were.”

Holly admitted, “...on the flip side, the professionalism, and the expectation that we were given as nurses at this hospital was unmatched anywhere else that I’ve been.” A new ED RN, unprepared for the role, dealing with other ED RNs who had similar experiences and caring for each other. I began to think Holly understood my research question. Holly continued:

“We were elevated, basically. We were expected to do what it is that we’ve been trained to do, and we were expected to make decisions and do that. And I think that
that sort of culture was healthy, even though the actual work condition was unbelievably difficult”

She did not fault the hospital for the work conditions. Holly described it as “a moment of growth that was just unpredicted, and the growth was just so great that it was impossible—nobody knew how to keep up with it.” Incredulously, she told me, “We could actually argue, ‘I can’t take another patient!’ ‘How come this one’s not triaged? This one doesn’t even have vital signs! What’s going on over here?’” But the arguments would cease at the end of the shift, “then go to breakfast in the morning together, and that was it.” This was doable because she stated, “it was expected that we’d be professional”.

Holly told me that nursing management was united: “There was not a manager that was splitting one against the other.” “We weren’t made to feel like every decision is made for us through some sort of preplanned algorithm.” This fostered the expectation “to think” “be professional” and “use the knowledge that we have through education, through experience, to deliver the best possible quality care to the patients and uphold the name of the institution”.

Quality improvement is important to Holly. “Quality improvement sometimes has to be brutal, because we deal with some very difficult things.” If RNs are not going to fully embrace quality improvement, Holly felt, “you’re doing an injustice to your institution, to yourself as a professional, to the profession, and moreover, to the very people that we are supposed to be taking care of, and that’s the patients.” She equated it to a basic phrase often mentioned in nursing programs, “cover your ass” or “CYA”. Those RNs that don’t seek improvement have the CYA “mentality”. If the institutional culture fosters quality improvement, Holly felt that it will make “how well we’re going to work together and how well we’re going to take care of our
patients”. It dawned on me that all of the participants are mentioning the same thing: “patient
care”.

Holly spent a little time speaking of hiring the “key people” “to foster that sort of
ambience” of those that find something wrong and “offer a solution” for the problem. She spoke
of the right “balance”. She recalled a recent situation and the banter that occurred between her
and another ED RN. They were picking on each other after caring for a critical patient. Neither
RN took it seriously. But she added:

“I’ve worked in places where any slightest bit of something considered offensive and
you’ve just declared war on somebody. I mean, now you’re going to spend two years
never talking to this person, avoiding this person, scheduling yourself away from this
person...”

She attributed this type of behavior to the “level of expectation of the professionalism” of the
nurse and the tone of the behavior is “often set by the culture of the institution”.

“Sometimes you don’t want to work with certain people...” She wondered aloud whether
RNs form their opinions off of one experience or a pattern of experiences. “It’s easy to be in a
position and look down on what somebody else isn’t doing than it is remembering how hard it is
to juggle when you have to do it yourself.” Holly began to talk about rotating charge positions.
She added:

“When you have a rotating charge position, and if you see somebody struggling, use
your ability in that position to help them out instead of judge them. Instead of
wondering how are they deficient, because they can’t possibly keep up with what you
feel that you yourself can do. Because you yourself can do so much, but you’re not the
one doing it.”
Holly told me her first In-charge rotation story. She had wanted to make things better and be the best charge RN that she could be. She admitted to making demands on the ED RNs that she, herself, wouldn’t be able to perform if she were not In-charge:

“The very first few times I was in charge, I wanted to change the world, you know? And I remember this... one of my nurse mentors; she brought me outside for a cigarette—yes, a cigarette! —and she said, ‘Let me tell you something that you need to learn really quick. You’re in charge today, tomorrow I’m in charge.’”

Our interview time had ended. We said goodbye and I thanked her for her help. Holly smiled and I was at ease. As I walked to the train to get home, I thought about what Holly had said. I got the feeling it is more abstract than concrete. Her perspective of working with ED RNs had to do with institutional culture paving the professional way for RNs. If ED RNs are professional and continue to improve the quality of their performances, the outcome of their professional relationships will be affected, which is patient care. On the train ride home, I reflected on my previous participants. Patient care is discussed with each recollection of ED RN interaction.

Ivy

Ivy was referred to me by a prior participant. She was soft spoken ED RN in her 30s with a BSN. Before ED nursing she worked the medical surgical floors and had been an ED RN for over 5 year working the night shift at a large community hospital in rural New York. Ivy and I arranged for our interview to take place at a diner local to her home. The day was a little chilly and became colder as the sun was setting. Ivy and I met each other outside the diner. I immediately noticed her smile. She had round cheeks surrounded by dark brown hair. She wore blue jeans and a green sweater. We had grabbed a table at the back of the diner and ordered French fries and cola. Our interview began after formalizing the confidentiality agreement.
Ivy answered the research question by describing her beginning as an ED RN. She described herself as a “go-getter” and “I wasn’t afraid to do”. Ivy told me that she “felt there was more camaraderie with our ER that I worked in, and I had great support. And I had nurses that had been there for a long period of time and it was kind of a close cohesive environment.” Ivy further clarified, “there are rifts between people”, but in recalling an experience with a sick patient, Ivy told me she felt “cohesiveness” and “great supportive network” while providing patient care. Ivy told me things have changed since she first started. She attributed it to the renovation of the emergency department environment.

“It is state of the art”, but the “team nursing” method used previously doesn’t work in this new ED. She described being able to “bounce off of each other” and “get what needed to be done” completed. Ivy told me the teams would “intertwine” and “communicate”. This made her feel that sense of “cohesiveness”. At time of the interview, the ED she worked in has “districts” and “we’re very separated”. She further stated, that RNs “will come in to help each other” if there is a critical patient in the district, but attributed the amount of help to “depend upon the personalities”. Ivy attempted to clarify her perspective, “personalities can be clashy” and “it depends on how you work”.

Ivy told me that sometimes how RNs work can depend upon how their patient load is assigned: “Getting a heavier district” because “you are the harder worker” and “you get heavier patients”. She described this as being “very difficult”:

“You want to be able to help out your peeps. I don’t like to feel like I’m drowning, and then when I’m drowning some people will help me, or they won’t help me, and I want to try and help others out, then I feel like I can’t help others because I have my own boatload going on…”
This led Ivy into a story about a colleague. She “was trying to help him out” by “picking up the slack”. Ivy stated the RN told her “Don’t ever touch my patients again, don’t ever help me again.” She told me that she felt “relieved” when the RN told her this, but “was feeling the guilt of the for the patient, because it’s about the patient”. I had made a mental note at this point. All the participants are mentioning the patient as the focus. Ivy questioned herself out loud “Why am I supposed to feel responsible?” “…but also then I felt bad for the patient”. Ivy described “getting pissed” and being “yelled at” by the other RN. She told me it affects the way the ED runs because “I don’t want to put a patient in that zone, because I don’t want to subject them to this person.”

Ivy told me “At the moment, I don’t feel the cohesiveness with our team players, our nurses.” Ivy had approached other ED RNs “to figure out what we could do to make the place better and feel cohesive and not feel so alone”. Ivy had gone to her unit manager to discuss the issue. She used the terms “support” and “group” as she described what she wants for her ED, “supporting us and telling us that we’re doing a bit of a good job” and possibly searching out ways “to make it a little easier” or to help “feel like a group”. Unfortunately, the “mandatories” and “numbers” are working against the group. Ivy described Press Ganey patient surveys and the effect on ED RNs:

“What matters is patient satisfaction and how we treat patients, and that’s eventually how hospitals are being reimbursed. And we have to figure something out to still keep our staff happy so we can make our patients happy and not have… throwing numbers at us.”

Ivy stated, “one survey changes everything” and the focus will stay on the one and not the “the other 10 patients I had who were very happy and cared for, or satisfied”. She offered different advice for management, instead of “we have to work on this” maybe “say good things that we do
such as call backs. We do a lot of patient call backs to make sure they’re okay.” She reflected back on “cohesiveness” and reminisced about the “crew”.

Ivy told me the “crew” was also friends. They “encouraged” each other and had “outside relationships”. She attributed this to working together for so many years it “ kinda becomes your life”. The “experiences” brought the RNs together and “they liked each other” Ivy stated, “I feel like you weren’t left alone as much then” “they would help you.” She reflected on a colleague who was feeling alone on her assigned shift. Ivy described her as “ miserable”, “ not feeling supported or helped” when she needed it, and not confident that she could approach the ED manager with the issue. Ivy told me that she was going to leave the ED. Fortunately, she discussed the issue with nursing management and was reassigned to another shift. Ivy told me, “she’s just like a new person. She’s so happy. And she feels so much more supported.” Ivy began to tell me how she felt supported.

Another ED RN on the unit is Ivy’s “guru”, “mentor” and “friend”. “I go to her for everything”, she told me. Ivy described her, “positive about everything and... very calming, and tries to work things out in a calm way.” When this RN is assigned In-charge, Ivy told me that sometimes it’s “hard” because “she’s a mothering hen, so she wants to take care of me”. This can cause a little “friend conflict” when Ivy wants to “break loose sometimes” and “take care of my own stuff”. Ivy clarified it. Her friend in an In-charge position trying to help her is different from when she’s not In-charge. She described “unit leaders” as her “so called bosses”. These are the people she goes to for “work related stuff”. She described a “work friend” who has taken a management position. Ivy told me the RN is “trying to find herself” in this new position. She told a recent experience about schedules. Ivy’s was not correct and she was told by this RN to
“figure it out”. Ivy told me, “I felt like I was kicked.” This episode left her feeling angry and upset. The interview was quiet for a couple of minutes. Ivy focused on the French fries.

Ivy began again. She told me about how being too helpful can be “annoying”. Those ED RNs who want to help you and do everything for you. Ivy said, “You feel like you want to be up to their speed, but you can’t.” She described the ED “drive” as an “adrenaline rush to get things done.” She further told of another RN with whom she works. She found this RN “obnoxious” and “thinks they know everything”. When that RN is present for critical situations, it becomes “chaos” due to the “barking orders” when we should be “working together” on the case. Ivy contrasted this behavior with another RN with whom she works. She described the RN as “brilliant” and in “code situations it is comfortable” to work with them. Ivy told me, “When everyone wants to be the chef, it doesn’t work.” This led her to another recent experience. A recent unsuccessful code situation:

“We worked this person for two hours and the group of people that were in the room and the group of people that we got done just worked so well, and it felt good. As much for the sadness of losing the person in the end, we know that we worked hard and everybody that was in the room worked together as a team, and knew what to do, and even if we didn’t know what to do directly, we figured it out and we all worked together with this, and it was—there’s a sadness of the loss, but there’s also like, ‘OK.’ We felt good. We felt a good camaraderie.”

Ivy contrasted it to a “chaotic, crazy code” with a “vibe” due to the police involvement and going back to her “six new patients” that all need work-ups. She spoke of the abandonment, “we’re together and then everybody scatters.” If ED RNs took care of her patients in her district while she was away helping in critical situations in other districts, she was grateful and always expressed her thanks. Ivy felt it is important to acknowledge when others do for you. But she felt “unsupported” and “uncomfortable” when she cannot locate anyone to help when she needs
it. When “they’re really sick and you feel like they’re going to crap out on you and plus you have all these other patients” the heavy load affects her. “You don't feel helped, you feel overwhelmed.” “Everybody is doing something and you don’t have enough staff, or the acuity’s too high, or you have enough staff but the acuity’s so high that everybody’s doing something and you have to figure it out yourself.”

Our time had finished and I turned off the audio recorder. I had found myself wanting to make a protective cocoon around Ivy. I had this urge to hug her and tell her everything would be alright. Instead we chatted a little about education. She wanted to return to school. I encouraged her to do the best she can at whatever she chooses. The plate was empty and the fries are all gone. We realized that it was time to go as the diner began to get busy. We walked to our cars and I thanked her for the interview. I wished her the best. I drove home with the cocoon is still in my mind. Everything she had mentioned was valuable. I wanted to help them somehow and to make their workplaces better. After journaling and discussing my feelings with a colleague, I found myself realigned: my study will help the profession of nursing and ED RNs.

**Data Analysis**

Using Giorgi’s method, I began analysis with the first interview. I listened to the audio recording and upon receiving transcripts, re-listened and read the transcripts simultaneously. Any personal notations from the time of interview were added to the transcript. The transcript was then re-read again for a sense of the whole. Upon re-reading the transcripts again, meaning units were identified and documented on the side of the transcript. Once interviews were completed, each interview review was conducted the same way. Additionally, each transcript was reviewed both individually with the previous transcripts. When saturation appeared among the participants, three more interviews were completed to confirm the findings. Transcripts
were then color coded to confirm the meaning units derived upon review. This was done a third time with colored highlighters when documenting research findings. Initially, more than 100 individualized meaning units were identified among all participants. Table 2 identifies the meaning units that were identified to have similarities in words, tone, and sentence structure of the participants.

**Table 2**: Giorgi’s Method: Individual Meaning Units

<table>
<thead>
<tr>
<th>Meaning Units</th>
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</thead>
<tbody>
<tr>
<td>Working together as a team; helping each other makes it more bearable</td>
</tr>
<tr>
<td>Being friendly at work and talk without them wanting something from you; joking relieves stress</td>
</tr>
<tr>
<td>Developing positive relationships with workers who only look after their own</td>
</tr>
<tr>
<td>ED RNs are like a family; getting to know each other; establishing rapport with new nurses getting them involved to feel a sense of team; build relationships</td>
</tr>
<tr>
<td>Weave them together, camaraderie, great supportive network, close cohesive environment</td>
</tr>
<tr>
<td>Needing somebody else; care for each other, because nobody else was there</td>
</tr>
<tr>
<td>Lack of nursing staff delays care</td>
</tr>
<tr>
<td>RNs behavior impact patient care; patients’ pick up on anxiety</td>
</tr>
<tr>
<td>Compromising patient safety is unacceptable</td>
</tr>
<tr>
<td>Our focus is the patient; them recovering; their survival</td>
</tr>
<tr>
<td>Working together to take care of the patients</td>
</tr>
<tr>
<td>Increased stress can cause frustration</td>
</tr>
<tr>
<td>Working short is the norm; people get frustrated and resentful at staffing levels and increased documentation</td>
</tr>
<tr>
<td>Covering messy people and discovering lots of work needs to be done is frustrating</td>
</tr>
</tbody>
</table>
• Frustration, exhaustion and stress at dealing with other’s behaviors or having to be a buffer between nurses
• Working harder can get you a heavier district, heavier patient loads
• Dynamics of personality affect how people work together; personalities come out under stress, personality issues and conflicts create problems
• Hiring key people to create a balance
• Offense to communication; lack of offense to communication
• Outside relationships: friendships help
• Personality to be an emergency nurse, Certain personalities are not cut out for the ED
• Personality traits are required: Professionalism and intuition are important
• Cliques, not necessarily a good thing for outsiders of that clique
• Some nurses bend over backwards to help; others don’t
• Gain favors by doing favors first
• Nobody’s gonna help you unless you help them
• Charge nurses are the key to help keep things going, set the tone for the shift
• Charge nurse is supervisor during shift and peer the next day; being rotated to In-charge gives a different perspective; can cause conflict with those peers that are friends
• Leadership comes in many forms. Showing that you are willing to care for a patient that is not yours sets an example. Lead by example
• Creating mentor relationships; developing positive relationships with workers who only look after their own
• Support from older, more experienced nurses; losing them due to changes in ED structure, detriment as they work under great pressure and move fluidly
• Management needs to support staff and tell them what they’re doing well
• When friendly colleagues are promoted and schedule issues, “felt kicked”
• Areas, zones, districts, don’t allow nurses to pick and choose who they take, motivates staff, forces others who don’t want patients to work; they also separate teams

• Patient trackers: forgetting to move patients over causes problems among staff

• Although computers are necessary it is now computer care, not patient care; care is depersonalized, caring for people is very personal

• Lack of vision and mission statements

• Mandatories, patient surveys (being graded on care), and numbers are being focused upon by management, no longer patient focused

• Disgruntled behavior about increased documentation

• Crisis all RNs pull together, jump in to help, work together in a crisis, direct each other, support, being thankful for the help

• We can learn from what we are doing

• Move from one stressful situation to the next

• Best place to work because of staff interaction

• ER has a different flavor to it, Every place does it different, All EDs are very different

• ER nursing is differed from any other kind of nursing

• Shift cultures are different, nights has its own culture; less administration, less support; they rely on each other because they have to work more with less

• Institutional cultures have huge influence

• Negative people damper the situation and kills morale in any ED

• Baffled by another RNs behavior: socializing, flirting, unfocused

• RNs who don’t want to communicate, walk away and roll eyes, look the other way, shrug their shoulders

• Resistance of other staff members: Overly helpful can be annoying; Obnoxious, knowing everything, and barking orders can cause chaos
After the meaning units were identified, I spent time reviewing the transcripts and reflecting further. I assessed for meaning units in two ways. First, I blocked off each meaning unit into table format and compared and contrasted to all the other meaning units (Appendix D). When meaning units were recognized to be similar in nature, I listed them in the same location on the table format. I then asked two colleagues, who were nurse educators, to look at the tables to assess if there were any words/phrases that were similar. The instructions to my colleagues were to look at the words/phrases listed in the tables and if they noticed any similarities in the words/phrases, to draw arrows to where the words/phrases are similar. The second way I performed thematic assessment was to list all the meaning units, use color highlighting according to meaning, and then clustered all of the participants’ the meaning units (Appendix E). Both of these methods for meaning units assessment delivered the same intonations. Table 3 illustrates the essential meaning units of all of the participants’ experiences of workplace reciprocity.

Table 3: Giorgi’s Method: Meaning Units

| Institutional cultures have huge influence |
| ER nursing is differed from any other kind of nursing |
| Shift cultures are different |
Creating a balance in ED RN staff
Harder workers get the harder patient loads
Personality traits are important; not everyone has the personality to be an ED RN
Areas, zones, and districts are two-fold: they motivate staff to take patients; but they also separate teams.
Computer care, not patient care.
Focus on numbers, not patients

| Patients are the sole focus     |
| Teamwork is vital to take care of patients |
| Establishes a sense of family   |
| Crisis pulls the ED RNs together |

Lead by example
The In-charge RN sets the behavior for the shift
Creating mentor relationships

Negative people can damper the situation and kills morale in any ED
Feeling of disappointment at not being able to help others
Feeling of being overwhelmed and alone when everyone scatters

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### Essences

Once the meaning units emerged, preliminary essences were identified. After a thorough review of the data, six categorical essences were identified. Throughout the essences the phenomenon of interest, reciprocity, was interwoven. As stated in earlier chapters, reciprocity is the mutual exchange of tangible items or symbolic gestures either directly or indirectly with a positive or negative aspect (Malinowski, 1922; Mauss, 1950). The essences were identified and categorically classified in order. Table 4 identifies the essences with the emerged essential meaning units of all the participants.

**Table 4:** Giorgi’s Method: Essences

| Institutional cultures have huge influence |
| ED nursing is differed from any other kind of nursing |
| Shift cultures are different |
| **ED Culture** |
Creating a balance in ED RN staff
Harder workers get the harder patient loads
Personality traits are important; not everyone has the personality to be an ED RN

Areas, zones, and districts are two-fold: they motivate staff to take patients; but they also separate teams.
Computer care, not patient care.
Focus on numbers, not patients

Patients are the sole focus
Teamwork is vital to take care of patients
Establishes a sense of family
Crisis pulls the ED RNs together

Lead by example
The In-charge RN sets the behavior for the shift
Creating mentor relationships

Negative people can damper the situation and kills morale in any ED
Feeling of disappointment at not being able to help others
Feeling of being overwhelmed and alone when everyone scatters

Each of the essences will be described and discussed. The six essences were: ED culture, balancing, technology, caring, bridging, and connection.

**ED Culture**

In this study the ED culture was identified as one of the integral components of which the participants’ spoke. Culture is the norms of behaviors exhibited by groups. The ED is an unpredictable fast paced environment where change can occur unpredictably. Historically, EDs are designed to provide priority care for the sickest patients first (Sheehy & Newberry, 2003). The ED RNs are on the front line to provide care for patients as soon as they enter into ED system, during interventional care, and are pivotal for disposition of patient care; specifically, admission into the healthcare institution or discharge from the healthcare institution and providing education related to the condition for their ED visit (Sheehy & Newberry, 2003). The ED culture can, with its unpredictable patient census and acuity levels and the norms of RN
behavior, affect how RNs reciprocally work together as they described in this study. Whether institutional, ED or shift-based each participant described a degree of culture that impacted the ED and their experiences with each other. Additionally, full time or per diem status was also described as a cultural characteristic that impacted the workplace reciprocity.

Holly talked about the EDs she has worked in as “very different”. She described, “a lot of it has to do with institutional culture, I think institutional culture plays a very big role.” “I think institutional culture and how it promotes the profession of nursing also affects greatly how nurses treat each other and what they do for each other when working together.” Holly further described how she was expected to behave in a professional manner, “We were expected to do what it is that we’ve been trained to do, and we were expected to make decisions and do that. And I think that that sort of culture was healthy, even though the actual work condition was unbelievable difficult.” If the institutional culture fosters quality improvement, it will guide “how well we’re going to work together and how well we’re going to take care of our patients”. (Holly)

According to Abby, “ER nursing is very different from any other kind of nursing.” She goes on to say that nursing is its own culture. At any point nurses may provide care for a client in a life or death situation. Or the nurses may care for a client that feels whatever has happened to them is the worst thing in the world. As Abby described it:

“…as a patient, nobody wants to be—most people don’t want to be in the ER. You’re there because it’s not a planned surgery, it’s not because you’re having a baby, it’s because something bad has happened to you. Whether it’s a heart attack, a trauma, or a stubbed toe, something happened to you to make you go to the emergency room. And most people, I feel patient-wise, are at their worst when they are in the ER... patients and family.”
Because of the unpredictability of the patients, their presenting situation, and the ED, in general, ED RNs can be affected by the unpredictable culture of the ED. Abby stated, “So, to have people that you like, just makes it so much easier to deal with unpleasantness.”

Shifts are a sub-sub culture. The order of cultures is described as institutional culture, ED subculture and then shift sub-sub culture. The availability of resources, personnel, equipment, and etcetera can vary depending upon shifts worked in the ED. Several of the participants described shift cultural differences. Betty further described the night ED RNs: “they have their own culture”, “they have to work with less”, and “they work very well together”. Each work shift has a different dynamic Betty declared, “different dynamics create different people and different work environments.” Fay provided more insight into the night shift dynamic, “The culture’s totally different. I think on the night shift there’s less administration, less support, so we kind of count more on each other; it’s more of a team work effort.” On nights, we “rely on each other, definitely.” Fay further stated, “There’s no administration where I work” on nights so they pull together as a team to get patient care done.

Debby described the cultural difference between full time and per diem ED RNs. In her experience Debby stated that the full time ED RN is invested in the institution; the per diem ED RN is “in it for the money”. The number of full time versus per diem ED RNs on any given shift can impact on workplace reciprocity of the ED RNs’ relationships. She described it:

“But every day is unique based on who you’re working with. Not based on the day, not based on the patients, because the patients are going to come and go, but it is who you are working with. So if the majority of people in the unit are per diem and there’s one or two, which has happened, full-time people, you kind of know that you’re the anchor and they’re kind of around.”
Balancing

“I’ve realized that it’s the best place to work because of the interaction with the staff.”

(Betty)

The essence of balancing in this study is the attempt of the ED RNs to maintain equilibrium in the presence of excessive behavior in one direction or another. In this case, the excess was evidenced by personalities of those who work in the ED and being assigned the rotating In-charge responsibility, respectively. The ED RN participants of this study identified how reciprocal staff interactions depended upon balancing in their workplace relationships. To maintain the equilibrium, or balancing, the ED RNs dealt personality/personality conflicts and being In-charge on one shift and performing as staff the next, respectively.

Liking with whom they work is important to ED RNs. Abby indicated, quite succinctly, that it also impacts patient care:

“It’s just a better feeling when you like the person to work with them than it is to—when—if you don’t care for them. Personality, as much as you try not to let it affect you, personalities absolutely affect working together. It makes it—if you like the person, whether it’s a friend or—whether it’s an outside friend—whether you’re friendly with them on the outside or just friendly with them at work, it—because it’s just a better rapport and you can even like make light of the work that needs to be done, like if you need to clean a patient, or if a patient is uncooperative, the chemistry you have with that person might help with—might even help the patient relax a little bit.”

If there is a lack of rapport, it makes the reciprocal behavior of workplace relationships difficult. Fay described knowing “the personalities” of her co-workers and when she is In-charge “I try to steer them clear of each other.” Eddie also spoke of two nurses that have “personality” issues. They “hate each other”, “do not talk to each other”, and have gone to nursing management to complain. Eddie was forced to confront a workplace issue on the next shift she worked with the
nurse to maintain the balance of the workplace relationships: “I spoke to her professionally. You have to work with each other. You have personality conflicts... that is not what this is about. We have to get the job done.”

The feeling of frustration occurred when those In-charge were aware of who the “harder workers are” that can get the “job done so therefore you get more sometimes” (Debby) and get “a heavier district” (Ivy) and “heavier patients” (Ivy) than other ED RNs. “There always has to be at least an equal mix if not have the scales tilted on the hard workers or the good workers or the real ER nurses over the people that really shouldn’t be there.” Debby further stated, “Because when the scales balance the other way is when you lose those good people.” Without that balance the ED RNs could be working with new ED RNs all the time, “People just rotate out because sometimes it’s too much stress and sometimes it’s maybe just not to their liking”.

(Gigi) Lack of balance affects the way the ED RNs work with each other. Ivy stated:

“You want to be able to help out your peeps. I don’t like to feel like I’m drowning, and then when I’m drowning some people will help me, or they won’t help me, and I want to try and help others out, then I feel like I can’t help others because I have my own boatload going on…”

Betty described:

“some nurses will bend over backwards to help you and therefore you’ll bend over backwards to help them. Other nurses you know that you can’t even approach because they won’t touch anything but their own stuff with a 10-foot pole. So, it’s, it’s, those people that don’t help others and just want to do their own thing and stay in their bubble…”

Corey attributed the behavior of these ED RNs to “I think sometimes it’s comfort level or discomfort level of that person” while working in the ED environment. Gigi described this as leading to a situation where “core of people who stay. And that core is a core that you become so dependent on and they become dependent on you to do your part.” Gigi referred to
maintaining a core group of ED RNs for balancing the staff in order to accomplish reciprocal workplace activity.

Rotating work shifts as staff and then assigned In-charge the next can also create turmoil in the balance of workplace reciprocity. Constant complaining of those nurses with personality conflicts is exhausting. As Eddie stated, “just make the night harder. I went home, not exhausted from the job. Exhausted from listening. Making comments and complaining about everything, that to me is the most stressful thing.” Eddie further described how it affected his workplace behavior with these ED RNs, “And now I don’t even want to help you. Because you’ve been complaining since – I don’t even know if you’re busy or not busy.” When she was assigned to the In-charge position, Abby told how some people have “challenged” her and “not respected” her needs as a charge person because of not being assigned to the position every time she is working. She also told of how nurse “friends” have “taken advantage” of her being In-charge but did not elaborate. Abby admitted, “They will do whatever I ask them to” and “I try not to take advantage of that because you want to be fair when you’re In-charge.” Holly described her first In-charge rotation story. She wanted to make things better and be the best charge RN that she could be. She admitted to making demands on the ED RNs that she, herself, wouldn’t be able to perform:

“The very first few times I was in charge, I wanted to change the world, you know? And I remember this... one of my nurse mentors; she brought me outside for a cigarette—yes, a cigarette! —and she said, ‘Let me tell you something that you need to learn really quick. You’re in charge today, tomorrow I’m in charge.’”

Holly described the need to hire the “key people” “to foster that sort of ambience” that will make the ED RNs work together to their highest ability. She spoke of the right “balance”.
Technology

“Computer care, not patient care…” (Corey) “…they’re looking more at statistics than I think looking at actual patients.” (Abby)

Technology is the use of computers or machines to enhance how work is done. Technology in the healthcare workplace was instituted to assist in the care of patients. It has a reciprocal nature in such that technology was provided for (to give) nurses to create an ease of functional work to better care for patients (to receive). The essence of technology and its impact on workplace reciprocal relationships was described by the participants of this study. The ED RNs work together for patient care, yet the electronic documentation requirements and the patient surveys are affecting how they work with each other. Abby told me that technology is “a necessity; it’s not optional.” Gigi described how some ED RNs are “…meticulous in their charting and meticulous in their computer work and meticulous in, doing all these crazy little requirements, but they’re not meticulous in what they do as a nurse. Patient care, patient needs to survive.” Abby further stated that although the documentation needs to be done, management needs to review “…what the documentation shows versus what the patients—how well the patients are taken care of.”

The concern for technology and patient care resonated with all the participants. “I feel like it’s getting depersonalized.” “…it’s becoming more of a business. And to me, when you are taking care of people, it’s not a business, it’s very personal.” (Abby) Eddie described an incident where a nurse was triaging a patient on the computer, the nursing supervisor walked into the ED, and the physician reported the nurse to the supervisor that the patient’s vital signs (blood
pressure, pulse, respirations, temperature, and pain scale) hadn’t been done. Eddie incredulously declared, “The nurse was still triaging the patient! Unbelievable!” Corey told me:

“…people are monitoring the computer. My assistant nurse manager – I guess shortly after we got the computerized system. And you know, the category, the triage category… are patients that need to be resuscitated or very critically ill or a 1 and it comes up red on the computer. So the, I don’t know who it was, if it was customer service. Someone called the assistant nurse manager to say that there was a patient that was a category 1 and they had been there an hour and there were no nurse’s notes on the patient. And the assistant nurse manager said, ‘Well, do you want to know where the nurse is? She’s at the bedside of the patient trying to save the patient’s life.’”

Debby told me several senior nurses have left her ED because they “couldn’t adapt to the computers” and all the “added pages of documents” that must be completed before the patient leaves the ED. The issue of technology affected the way the ED RNs work with each other to care for their patients. If the ED RNs cannot adapt to the changing technology, experienced RNs leave the ED; thus affecting the ED RN work environment.

Caring

“Our focus is the patient. Our focus is them recovering. Our focus is them surviving.”

(Gigi)

The essence of caring in this study was exhibited through each participant’s recollection of patient care as the focus of the workplace reciprocity in their relationships. The phenomenon of reciprocity was weaved throughout their stories as they described pulling together as a team to provide patient care. For ED RNs, workplace reciprocity is inherent to their workplace relationships because of “how nice it is to be in crisis and pull together and do and save somebody’s life” (Debby). “The bottom line is the patient lived.” (Gigi)
The camaraderie is important for the nurses to pull together and work as a team to attempt to save someone’s life:

“We worked this person for two hours and the group of people that were in the room and the group of people that we got done just worked so well, and it felt good. As much for the sadness of losing the person in the end, we know that we worked hard and everybody that was in the room worked together as a team, and knew what to do, and even if we didn’t know what to do directly, we figured it out and we all worked together with this, and it was—there’s a sadness of the loss, but there’s also like, ‘OK.’ We felt good. We felt a good camaraderie.” (Ivy)

Even if ED RNs don’t collegially get along, Fay has never seen them “take it out on a patient”. “If there is a code, we pull it together.” Being a team player and patient care are interchangeable terms for ED RNs. “The basic think is team playing. I don’t care if you hate me or not. This isn’t about me or you. This is about: let’s get through this night; let’s help this patient.” (Eddie)

There is concern that nurses’ behaviors can affect patients. Betty described an ED RN who “gets flustered so easily”, “sucks her teeth a lot” and “is very verbal”. Betty’s concern is that when this nurse behaves in this manner, it “impacts patient care because they can hear her say these things” and it “makes them nervous”. Ivy described an ED RNs behavior and how she felt it affected the way the ED functioned, “I don’t want to put a patient in that zone, because I don’t want to subject them to this person.”

Holly told me this fostered the expectation “to think” “be professional” and “use the knowledge that we have through education, through experience, to deliver the best possible quality care to the patients and uphold the name of the institution”.

**Bridging**

“Showing that person that you are willing to care for someone who is not your patient and that you’re willing to help.” (Corey)
The essence of bridging was evidenced by the ED RNs doing for other ED RNs to establish relationships. Work was performed with the patient as the focus and with the behaviors being returned, reciprocally, at another point in time. The way ED RNs behave, the way the exhibit themselves to their co-workers, in an environment that has the potential to change at any moment, creates bridges to the others’ behaviors; thus, bridging. Betty declared herself the “never let them see you sweat” type and easily internalizes “the turmoil, the frustration, the tension, the stomach ache, the shoulder pain, the headache…” She brings her “A game” every time she works a shift. “I benefit from my own good conscience.” Betty hoped that her behavior as a worker was “infectious” and that “other people follow my lead”. Fay described her behavior when she is In-charge for the shift, she “sets the tone for the ER.” “If you’re calm in a situation, everyone else is gonna be calm” and the RNs will “take your lead. If you’re up in an uproar, then everyone’s gonna act like that.”

Some nurses will use bridging behavior when covering breaks and caring for other ED RNs’ patients. Gigi makes “a point of going the extra mile when I take care of their patients. Maybe try and guilt them into doing better when they take care of mine.” Debby took the time to establish a “rapport” by providing friendship, gentle direction and guidance to another ED RN who was “scattered” but a “good nurse”. She admitted, “not everybody wants to take the time to do that, to get to know their co-workers like that”. Betty, who also worked with an ED RN that was “distracted”, described her attempts to curb the nurse’s behavior by providing direction for her, intervening when necessary to “calm her down”, and “always watching out” for her. Betty stated that she noticed the other nurse’s behavior, “I had an ICU patient for the first four hours of my shift that became one on one, she was all over my zone, helping me doing everything.”
Betty feels that “pulling things” out of people instead of just talking about it works much better. Betty stated, “you don’t have to be a manager to be a leader.”

The essence of bridging for Abby was that for the ED “Experience is key.” When working with new ED RNs she describes having more patience with them than experienced ED RNs because, “... they haven’t seen things; they haven’t the experience.” Fay told me, “I’m always willing to learn.” She further described the role transition she experienced, “… it’s so weird just because I’ve always felt like I was the novice and then I started precepting and now I’m like a leader, now people look at me as a mentor…”

Connection

“What we do today as a group or even as an individual within that group is going to benefit more than just today, more than just that patient. And what can we do or what can we learn from what we’re doing to do it different the next time…” (Debby)

The essence of connection (or lack of connection) with workplace reciprocity impacts on the relationship behaviors they experience. The participants of this study described having relationships, interactions, or associations with other ED RNs. This is the essence of connection that the ED RNs experienced. Connection is deeper than the essence of bridging. Connections, if made, required nurturing in order to maintain them.

The experience of lack of connection was identified by several participants. Corey described an experience of attempting to give a patient report to another nurse:

“Or the other day I was trying to give an endorsement to a nurse, and she just kept walking, with her back towards me. So I stopped, I’m too old to follow people around. So I stopped, I planted my feet, and I kept talking. And she finally did sort of turn her head, “Yeah, OK. Whatever.” That’s a personality thing. That’s a known entity. But still, it’s disrespectful to me or to whoever else is trying to give her a report.”
Abby relayed that an ED RN that she worked with had become “grumpy” and “less tolerant of things going wrong” in the ED. She found the behavior disheartening and didn’t want to see her colleague experience this. Abby stated, “it added to the stress level of everyone else” on the shift when the colleague was working. The other ED RN was disconnecting. Ivy described “getting pissed” and being “yelled at” by another ED RN. She told me the lack of connection affected the way the ED runs because “I don’t want to put a patient in that zone, because I don’t want to subject them to this person.”

There are times when a lack of connection converts itself into a connection. Betty described an ED RN with whom she worked. She told me how other ED RNs do not want to work with this RN. Betty worked directly with this RN frequently and she described, “So the relationship that I’ve developed with him is I’ve turned him, he doesn’t even know it, but I’ve turned him into my mentor, clinically.” She created a connection where one did not exist.

Debby loved working nights because she was able to “develop relationships with the night crew” and “getting to know each other”. Eddie told me, “You have to kind of build relationships.” He described an experience:

“One night it was so bad. I think we were snapping at each other all night. It was one night; it was horrible. So in the morning we were laughing. It was 7:10 am and we’re all sitting, laughing. The night is over and we can be friends again. That’s what it’s all about. You do get mad with each other. But when it’s over, the whole thing is over.”

Gigi found it “is interesting because you have this tight knit group of people who do work together, sometimes they take up the offenses of others”. She described how another ED RN apologized after a critical code situation, “I remember sitting down at the desk and everybody was kind of decompressing a little bit and this particular RN actually apologized.” Gigi told the
RN that she didn’t have to apologize although “a lot of people felt like she did need to apologize”. This she attributed to the protective nature of others.

When a connection exists, the experience is resonating among the ED RNs. Fay described the connection felt among the ED RNs after a pediatric code:

“One thing I must say, though, like working for a small community hospital, when you have cases like children dying and stuff, we really don’t debrief, which is something we’re trying to work on. Oh, it affects the whole tone of the whole ER. We are like, you know, something like that happens, we’re all devastated.”

Gigi told me that when ED RNs leave and the connection is severed it affects the ED environment. She told me, “we have lost a lot of great senior nurses in the last few years” and it “has been a real detriment”. Gigi expresses concern that it will “change the face of emergency room medicine. It could be very traumatic because those senior people were also the people who are great under pressure and move so fluidly”.

**Summary**

This chapter discussed the study findings of the nine participants. The participants’ descriptions included selected quotations that represented each participant’s experience of workplace reciprocity. Meaning units were identified and six essential meaning units were identified and clustered categorically. Essences emerged and participants’ responses were used to support the essences, which provided rigor to the study. The essences were synthesized using Giorgi’s method to describe the experience of workplace reciprocity of emergency nurses.

The participants in this study shared their experiences of working with other emergency nurses to better understand workplace reciprocity. The final step in Giorgi’s method is synthesis of the essences. Caring is essential to the profession of nursing. For any nurse, the focus is caring for patients. The ED RNs’ identified that although patient care is the focus, caring for the
other ED RN is also important in their workplace relationships. Caring to perform as a reciprocal experience, bridging relationships to gain a sense of connection and to enhance the workplace relationship and how nurses work together (workplace reciprocity). Three aspects impact on caring and workplace reciprocity: technology, balancing, and the ED culture. The technology used in an ED setting affect feelings of caring among ED nurses; thus affecting workplace reciprocity. To have a good team takes a specific balance of nurses, who have personalities and experience that can enhance or hinder the ability to create connections and to allow for bridging of relationships of ED RNs’ to foster workplace reciprocity. The culture of the ED, each work shift and the impact that the institution sets forth can affect workplace reciprocity.

The concept of study, workplace reciprocity, was woven throughout all of the essences and when synthesized it identified itself to be an integral part of workplace relationships of ED RNs. Workplace reciprocity between and among ED RNs is influenced by the ED environment, balancing, and technology on caring for patients and each other as seen in the bridging and connection for the purpose of creating and maintaining workplace relationships. Figure 1 displays the free imaginative variation of links of the essences.
Figure 1: Essence Links
Chapter 6: Discussion of Findings, Implications, and Recommendations

Introduction

This study was conducted to understand the lived experience of workplace reciprocity of emergency nurses. The participants interviewed for this study were nurses with greater than three years of emergency nursing experience. Using Giorgi’s Phenomenological Method, the data was collected, analyzed and interpreted. Six essential essences were identified. The essences were synthesized into one statement which identified the meaning of workplace reciprocity of emergency nurses. This chapter provides a discussion of the findings, the implications for nursing practice, and recommendations for future research.

Discussion of Findings

The phenomenon of reciprocity, the direct or indirect mutual exchange of tangible items or symbolic gestures with a positive or negative aspect, was woven throughout the essences identified in this study. The essences: ED culture, balancing, technology, caring, bridging and connection are discussed in this section.

ED Culture

It is the cultural norms that establish relationships and how work is done. In this study, the data identified the several aspects of ED culture: the impact of the culture of the healthcare institution on the ED, the ED culture as a fast paced, unpredictable environment, differences in work shift culture, and the cultural differences of those RNs who work full time versus per diem. Although the literature on ED culture is sparse, the available literature was evaluated for application to this study.
This study identified how the culture of healthcare institutions affects the ED culture. The data identified the reciprocal nature of institutional culture on the profession of nursing as evidenced in the description of support of the ED RNs and their decisions in the clinical environment to provide care for their patients. Parsons, Cornett, and Burns’ (2005) described the staff initiatives from three Methodist Healthcare System’s ED. The purpose of their study was to identify aspects of a healthy ED workplace from the staffs’ point of view. The model framework, Health Promoting Organizations, was provided. The key concepts of this model were shared leadership, participatory management, and empowerment. These also are the basic characteristics of Magnet™ designated hospitals. Using these key concepts, the ED staff collaborated to discover ways to create a systemic way to solve specific problems. This collaborative technique is described by the participants in this study. Seven themes emerged from the Parsons et al research: excellence in patient care; excellence in patient care processes and systems; workable, safe environment; effective provider staffing systems; interprofessional relationships and collaboration; educational development; and teamwork behavioral norms. The themes discovered in Parsons, et al, have a similar finding to this study’s essences.

Literature relevant to the ED environment is scarce. The ED environment is fast paced and unpredictable. The experiences as described by the participants identified caring for clients in health related situations that range from life and or death situations to minor injuries. Pang (2005) researched the influence of the work environment on the living quality of nurses. The quantitative study compared nurses working in EDs to other nursing departments. Pang’s results identified the living quality of nurses working in EDs for longer periods of time were lower than those RNs in other nursing departments (Pang, 2005). Although the results of Pang’s study were
not descriptively replicated in this study, there are indications that without reciprocal workplace relationships the quality of the culture would be impacted negatively.

ED shift work culture was identified in this study. The ED RNs described the different dynamics of each shift including, administrative and staffing support, resources, and teamwork. There is a paucity of existent literature on ED shift work. DeCordova, Phibbs, and Stone (2013) completed exploratory qualitative research on RN perceptions of off shift work. Of the themes that emerged from the DeCordova et al research, collaboration among night RNs resounded most closely to the findings of this study, specifically, the revelation of the night ED RNs culture. Other themes that emerged from the DeCordova, et al, study included completing tasks, mixture of nursing personnel, and the RN perception of being under appreciated.

In this current study ED RNs employed full time expressed a personal investment in the ED where they worked as opposed to the per diem ED RNs. The data identified that when there were more per diems working than full time ED RNs, the culture and the workplace relationships were different. The full time ED RNs were the anchor of the ED culture because they understood the norms and behaviors expected of their role. Muse, Harris, Giles, & Field (2008) described that when workers feel that they are part of a culture that values them and they value that culture, they assimilate the cultural norm and create reciprocal trusting bonds with co-workers. This may account for the experience of full time ED RNs versus per diem ED RNs as described in this current study. The full time ED RNs are part of a culture that values them and in return, they value the culture.
Balancing

In this study, the ED RNs described how the reciprocal interactions between and among the ED RNs depended upon the balancing of their workplace relationships. The essence of balancing was identified to be the ED RNs’ attempt to maintain equilibrium in the presence of excessive behavior in one direction or another as evidenced by the personalities of other ED RNs and being assigned the rotating In-charge responsibility, respectively.

The participants of this study described working with other ED RNs and how personalities can impact on workplace reciprocity and the workplace relationship. Eley and Eley (2011) researched personality traits of Australian nurses and doctors. Their study detected a difference between personality traits of temperament and character. Temperament, a stable personality trait, could be predictive of professional behaviors; character, a developmental personality trait, could be useful in training from professional behaviors. Additionally, their research suggests that understanding of professional role, workplace function of that role, and how the role is integral to other professions through the awareness of one’s own personal temperament and character traits may lead to foster mutual understanding and improve professional practice (Eley & Eley, 2011). Whereas Eley and Eley’s research delved into comparative nature of personality traits on the interprofessional relationships of nurses and doctors, the current study looked at the intrapersonal relationships of ED RNs and workplace reciprocity within the nature of those relationships.

There is suggestion in the literature that personality traits impact on job satisfaction. Chang, Li, Wu, and Wang’s (2010) research suggests taking personality traits into account when assessing job satisfaction. They further declared a positive, proactive personality buffered
against potential stress, thus creating a more satisfactory work environment. Additionally, Chang et al (2010) indicated a negative affect could unconsciously contribute to detrimental job outcomes. Although Chang’s study did not address personality traits of ED RNs, it was evident from the participants’ responses of the current study that personalities of ED RNs are integral in workplace reciprocity and relationships. Thus, balancing those personality traits can lead to formation of a core group of ED RNs or the dissolution of the ED RN staff.

There is a paucity of research in the literature on rotating in charge positions. Through a literature search, the literature describes the In-charge position in relation to orientation to the role and managing patient care and In-charge as a leadership role versus a managerial role, respectively (Yee & Swillum, 2003; Arzoomanian & Keys, 2008; McCallin & Frankson, 2010). Yee and Swillum’s (2003) work described the development and implementation of an eight hour program to prepare ED RNs to function in the rotating In-charge nurse role in an ED on the west coast. Experienced ED RNs were recruited to brainstorm in the program development, which included the charge nurse role, communication, administration/legal issues: Health Insurance Portability and Accountability Act (HIPPA) and Emergency Medical Treatment and Active Labor Act (EMTALA), and ED policies. Four ED RNs, with no In-charge experience, completed the program successfully. Performance evaluations of these four ED RNs were positive and included references to increased communication ability and knowledge base of the ED and institutional policies.

Arzoomanian and Keys’ (2008) article described a similar program development and implementation in an ED on the northeast coast that utilizes permanent In-charge nurses. These nurses are In-charge whenever they work. The program developed out of a need for formalized
education plan for permanent In-charge nurses. The program topics included: In-charge role and responsibilities; communication; Press Ganey and patient care; conflict management; legal issues/EMTALA, and electronic charting. Performance evaluation of the permanent In-charge nurses included increased effective communication and Press Ganey scores related to patient care.

Yee and Swillum’s and Arzoomanian and Keys’, respectively, work discussed orientation and development of ED In-charge nurse educational programs for inexperienced and experienced nurses to the In-charge role. Although the current study identified the issues with rotating In-charge responsibilities and workplace reciprocity, the formal development of an In-charge educational training program should always be considered for all EDs to aide in the workplace relationship of nurses.

However, some literature questions whether the In-charge responsibility should be a permanent versus rotating role. McCallin and Frankson’s (2010) exploratory descriptive study investigated twelve in-charge nurses’ experiences in an acute care hospital in New Zealand. Participants were interviewed in a structured question format that identified specific issues related to the in-charge role. The findings of the study were role ambiguity due to a lack of clarity in the in-charge RN role, business management deficit due to a lack of basic management skills, role overload due to the multitasking: too many people requesting too many things in too little time, and role stress due to the above listed findings. McCallin and Frankson (2010) recommended clear role guidelines, implementing the In-charge nurse as a permanent, not rotating, leadership and management role, and basic business management skills should be considered before appointing any nurse to the in-charge role. The participants of the current
study identified how rotating in and out of the In-charge position per work shift impacted on their relationships and workplace reciprocity. Implementing a permanent in-charge ED RN position could lessen the potentially negative impact on the workplace relationships and enhance workplace reciprocity among ED RNs.

Technology

In the current study, the essence of technology, which is the use of computers or machines to enhance ED RNs patient care, was identified to impact on the reciprocal nature of workplace relationships. When administration or another ED RNs’ focus was on the computer and not on the patient, the ED RNs in the current study described a disturbance in workplace reciprocity, thus affecting their workplace relationships. Kossman and Scheidenhelm (2008) performed a descriptive qualitative study that addressed nurses’ perceptions of an electronic health record (EHR) on job performance and patient outcomes. For their study, Kossman and Scheidenhelm (2008) used interviews, surveys and observations of nurses in convenience sample (n=46) of two Midwestern hospital settings: one medical/surgical floor and the other an intensive care unit (ICU). The study identified that the nurses felt the EHR was extensive and time consuming. Nurses reported that 56.6% of their time was spent on the EHR (Kossman & Scheidenhelm, 2008). Negative and positive aspects of the technology were identified by the nurses. The negative aspects included decrease in effective patient care and work outcomes, nurses had to keep lists since all documentation was on the computer, decreased time with patients, and nurses and physicians did not read the computerized notes documenting patient care. The positive aspects included improved efficiency of patient care, increased access to pertinent patient information, and improved organization. The nurses in the study preferred
electronic charting over paper charting due to increased patient safety and overall quality of care. The current study identified findings that although the technology is necessary, the nurses felt a hindrance of critical thinking with more of a focus on numbers and the computer rather than on the patient.

An ethnographic study by Bennett (2011) describes technology and patient care in a different perspective. Bennett’s (2011) study setting/population was a hemodialysis unit and the nurses on the unit. Hemodialysis (HD), an external filtration technology, is used on patients whose kidneys no longer function. Patients who receive HD treatments are scheduled for certain days of the week and length of time as designated by a physician. The HD nurses develop long term relationships with their patients due to the frequency of visits and the length of time associated with those visits. Bennett (2011) identified technology intimacy with the care of long term HD patients. Technology intimacy is physical touching and self disclosure that occurs with the use of technology for long-term care patients (Bennett, 2011). Although the healthcare setting of a HD unit is different from an ED, as identified in the current study, it encourages the possibility of technology intimacy in the ED setting.

Caring

In the current study, the essence of caring was identified. Workplace reciprocity and workplace relationships of ED RNs were patient care focused. Although the ED RNs in the current study did not describe what caring is, workplace reciprocity in their relationships was embedded within caring, for the patient and for each other to accomplish the patient care, in a hectic, unpredictable environment. Adam and Sharp’s (2013) literature on reciprocity and caring of nurses reflects the finding in the current study. The authors identified the term, “professional
reciprocity” (Adam & Sharp, 2013). “Professional reciprocity” is positive reciprocity that is deliberately initiated by the nurse while providing care (Adam & Sharp, 2013). Adam and Sharp (2013) further identified that “professional reciprocity” requires paid nurses to perform skilled work that requires training and workplace environment can constrain or facilitate the formation of “professional reciprocity”. The authors argued the importance of “professional reciprocity” in building relationships not only to gain trust and cooperation but also to increased job satisfaction of the nurse (Adam & Sharp, 2013). The current study did not address job satisfaction; however, it does indicate further research on the concept.

Burtson and Stichler’s (2010) quantitative research addressed nurse caring and the relationship among nurse job satisfaction, stress, compassion fatigue, burnout and compassion satisfaction. Nurses (n=126) at an academic medical center were recruited for the correlational study (Burtson & Stichler, 2010). The researchers disclosed the study had several limitations due to confounding variables such as the individuality of each patient and organizational change in relation to nurse caring. However, they were able to explain that a variance of 28.7% in nurse caring was related to compassion satisfaction (Burtson & Stichler, 2010). The authors correlate this finding with interaction opportunities among nurses are significantly related to nurse caring (p=0.032) and can impact patient care (Burtson & Stichler, 2010). The authors recommended fostering social contact and belonging among nurses to enhance patient care and patient satisfaction. Although these findings were not described in the current study, it suggests need for further research on the concepts.
Bridging

The essence of bridging was evidenced by the ED RNs talked about doing for other ED RNs to establish relationships. Work was performed with the patient as the focus and with the behaviors being returned, reciprocally, at another point in time. The way ED RNs behave, the way the exhibit themselves to other ED RNs, creates bridges to the others’ behaviors; thus, bridging.

DiCicco-Bloom, Frederickson, O’Malley, Shaw, Crosson and Looney (2007) performed a secondary data analysis of a previous ethnographic study using a model of social capital they had developed. The aim of their secondary analysis was to apply their model to the data that was based in a primary care practice setting that included physicians, nurses, medical assistants, an office manager, and receptionists. Their model of social capital included attributes of bonding, bridging, fluid alliances, reciprocating, cooperating, trusting and transformative shared understanding (DiCicco-Bloom et al, 2007). Table 5 describes the operational definitions of the attributes of the model of social capital as defined by DiCicco-Bloom et al, 2007.

Table 5: Model of Social Capital Attributes and Operational Definitions

<table>
<thead>
<tr>
<th>Attributes</th>
<th>Operational Definitions</th>
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<tbody>
<tr>
<td>Bonding</td>
<td>connectivity of the individuals with similar job responsibilities of the organization</td>
</tr>
<tr>
<td>Bridging</td>
<td>links individuals of different positions of the organization</td>
</tr>
<tr>
<td>Fluid Alliances</td>
<td>shared leadership not based on role or title, based on task and changing conditions</td>
</tr>
<tr>
<td>Reciprocating</td>
<td>an exchange, not based in task orientation or requiring equal value</td>
</tr>
<tr>
<td>Cooperating</td>
<td>task oriented, pulling together</td>
</tr>
<tr>
<td>Trusting</td>
<td>relying on the integrity and reliability of the other</td>
</tr>
<tr>
<td>Transformative Shared Understanding</td>
<td>newly expanded awareness based on the input of the group</td>
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The application of their model of social capital for the secondary data analysis study, the researchers identified each attribute and the actions demonstrated by the practice participants. Bonding was demonstrated by the nurse and medical assistants in caring for the patients and supporting the physician role. Bridging was demonstrated by the problem solving teamwork of the nurse, physician, and office manager. Fluid alliances were demonstrated in the practice’s group spontaneity to change how patients were cared for in the practice. Reciprocating was demonstrated by the nurse including the medical assistant in a presentation. Cooperating was demonstrated by the nurses and medical assistants working together to complete the patient care before the end of the work day. Trusting was demonstrated by the medical assistant in correcting errors related to specimen collection by the physicians and nurses. Transformative shared understanding was demonstrated by the group members agreeing that changing the structure of patient care was successful.

In DiCicco-Bloom et al’s (2007) secondary analysis study, bridging was defined as linking individuals of different positions of the organization. In the current study, the essence of bridging was identified as the establishing relationships between the ED RNs, creating a bridge to a future reciprocal workplace relationship. Whereas Newell, Tansley and Huang’s (2004) assessed the knowledge integration of information technology (IT) workers through case study research. Their research highlighted two aspects of the concept of social capital, bridging and bonding of relationships. Bridging, which was as external, was required to create links to bridge relationships and disperse information when relationship ties were weak (Newell, et al, 2004). Bonding, which is discussed further under the essence of connection in the current study, is described as an internal relationship trait (Newell, et al, 2004). Newell et al’s findings were
supportive the essence of bridging identified in this study as the ED RNs’ attempts were at bridging relationships with other ED RNs.

**Connection**

The essence of connection was identified in the current study as the link between ED RNs workplace relationships. Once established, connections are required to nurture and maintain the workplace relationship. As with the other essences identified in this study, workplace reciprocity is intertwined in the essence of connection. ED RNs will do for other ED RNs with whom they have a connection as they expect that same to be done for them.

In a review of the literature, it was noted that there is scarcity of research on the essence of connection. Yet, it was noted that the term “bonding” is used in the social capital literature to describe workplace connections. In their research, DiCicco Bloom et al (2007) described the bonding as the connections between individuals of similar positions in an organization. Newell et al, described bonding, as an internal relationship trait, which was evident to nurture the strong, cohesive links to bond relationships to create teams and share knowledge among groups (Newell et al, 2004). Both of these studies speak to the essence of connection.

After performing a thorough literature search, Duddle and Boughton’s (2007) provided a case study of Australian nurses. The researchers described three themes of their study which focused on negative aspects of intraprofessional nurse relationships: difficult interactions of the nurses, negotiating the workplace territory, and resilience as a way of coping in and with the relationship (Duddle & Boughton, 2007). Duddle and Boughton (2007) concluded that understanding workplace environment by fostering cohesive workplace relationships by assisting nurses in comprehending and appreciating their own behaviors and how it affects others and
contributes to the workplace atmosphere. Although their research does not support the specific essence of connection in this study, their research conclusion lends familiarity with the overall synthesis of the essences of this study.

**Reflections from a Nursing Model Perspective**

The resounding experience of the ED RN’s, as derived from the data identified in this study, is the phenomenon of workplace reciprocity between and among ED RNs in their workplace relationships. The reciprocal nature of their workplace relationships are not only influenced by but also influences the ED environment, balancing, and technology on caring for patients and each other as seen in the bridging and connection for the purpose of establishing and nurturing workplace relationships. In reviewing the literature and synthesis of the essences, I used Paterson and Zderad’s Humanistic Nursing Theory to illuminate the essential findings.

Humanistic nursing is experienced in the real world. Humanistic Nursing Theory is characterized by existential, transactional, intersubjective, and nurturing between nurses and patients (Paterson & Zderad, 1976). Humanistic nursing aims at the development of human potential through intersubjective relationships. It is these intersubjective relationships that extend Humanistic Nursing Theory to this study.

To explain how Humanistic Nursing Theory applies to this study, its theoretical framework requires discussion. Humanistic Nursing Theory is the incarnate man meeting in goal directed intersubjective transactions that occur in time and space in a world of man and things (Paterson & Zderad, 1976). The theorists further expanded upon the meanings of this framework. Incarnate man is the patient and the nurse. Meeting allows for those being and becoming to occur between the patient and nurse. With each meeting, the individuals bring with
them their past experiences to accomplish a goal. The goal directed behavior requires nurturing to promote well being and more being. The goal is accomplished through intersubjective behavior. The individuals bring themselves and their experiences to do and to care for. This intersubjective transaction occurs with a specific time and space as designated and lived by the individuals’ involved. As well as the culture of the world of men and things in which this intersubjective transaction occurs.

This phenomenological study illuminated the workplace reciprocity experiences of ED RNs, which is influenced by the ED environment, balancing, and technology on caring for patients and each other as seen in the bridging and connection for the purpose of establishing and nurturing workplace relationships. Humanistic Nursing Theory can be applied to this study as the essences can be applied to the theoretical framework and its meanings. Table 6 identifies the association of the essences of the study and Humanistic Nursing Theory.

**Table 6: Essences and Humanistic Nursing Theory**

<table>
<thead>
<tr>
<th>Essentials</th>
<th>Humanistic Nursing Theory</th>
<th>Humanistic Nursing Theory Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balancing</td>
<td>Incarnate man</td>
<td>patient and nurse</td>
</tr>
<tr>
<td>Bridging</td>
<td>Meeting</td>
<td>being and becoming</td>
</tr>
<tr>
<td>Connection</td>
<td>Goal directed</td>
<td>nurturing well being and more being</td>
</tr>
<tr>
<td>Caring</td>
<td>Intersubjective transaction</td>
<td>being with; doing with</td>
</tr>
<tr>
<td>Technology</td>
<td>Occurring in time and space</td>
<td>measured as lived by patient and nurse</td>
</tr>
<tr>
<td>Culture</td>
<td>In a world of men and things</td>
<td>culture</td>
</tr>
</tbody>
</table>

Paterson and Zderad’s (1976) approach to humanistic nursing resonates with the phenomenon and the essences identified in this study. In this context, ED RNs, as their own existential beings with their own experiences, bring themselves to each encounter. Workplace
reciprocity and the relationships, the ED RNs using bridging and create connections to be able to care for each other as well as for patients when influenced by technology, balancing and ED culture. To further clarify in the Humanistic Nursing Theory framework order, the incarnate man is the people in the interaction. For this study, it is the ED RNs balancing who they are and what they bring to the workplace relationship. Bridging is the meeting of the ED RNs and being in the moment to establish a relationship, to become. Connections are nurtured for well-being and to maintain more being in a goal directed aspect of the workplace relationship. Although the patient is the focus of caring for the ED RNs, they care for each other by being with and doing with in an intersubjective transaction, the workplace relationship. Technology is part of the lived experience of the ED RNs that occurs over space and time and is a reciprocal part of workplace relationships. In this study, the world of men and things was the ED culture and its influence of workplace relationships.

In summary, Humanistic Nursing Theory emerged as one what to explain the ED RN’s lived experiences of reciprocity in workplace relationships. The participants were incarnate beings that meet for goal directed intersubjective transactions occurring in the time and space of the world and man or ED RNs’ whose workplace relationships are influenced by the ED environment, balancing, and technology on caring for patients and each other as seen in the bridging and connection for the purpose of establishing and nurturing workplace relationships.

**Researcher Expectations**

Before embarking on this research, I had expected more insight into the details of what makes good and/or bad reciprocal workplace relationships of ED RNs. What was discovered was the patient was the focus of the ED RNs’ workplace relationships. The reciprocal
relationships of ED RNs are based in caring. The primary focus of the care is the patient; however, they care for each other in creating a team approach to provide the patient care. To have the team, a sense of connection needs to be established and a bridging behaviors to give or receive in the relationship. The essence of caring can be impacted by the ED culture, the technology the ED RNs must use in providing their patient care, and the balance of ED RNs.

**Study Strengths and Limitations**

This research offered insight into emergency nurses’ experiences with workplace reciprocity. Although I attempted to bracket my prior knowledge and experiences by maintaining a journaling, my own experience as an emergency nurse may be considered a strength as well as a limitation. During the research process, I continued to recall that my experiences were not being explored. However, my professional experience afforded additional insight into the emergency nurses’ experiences. This allowed for me to probe further in my interview process to gain more in-depth subjective information. When those being interviewed have a sense that they are understood by someone who has been in similar situations, a certain level of trust can emerge (Oakley, 1981; Warren & Hackney, 2000). Thus, interviews rich in data were possible.

Another dual strength/limitation issue lies in the sampling technique. Purpose sampling allowed for participants with the desired criteria to be interviewed. However, the results of this study may not be generalizable to other healthcare specialties and personnel. Another sampling limitation could be the first eligible participant was a former colleague. The limitation lies in the existence of a prior relationship before this study; specifically, due to the potential in the honesty of the storytelling.
A drawback of the research technique, qualitative phenomenology, limits the study. Qualitative research findings cannot be generalized. Phenomenologically, the findings of this study can only be applied to the nine ED RN participants and their telling their stories at the time of the interview. Methodologically, if the participants were re-interviewed at a later date, they could add, remove, embellish, or push aside some of their experiences and choose another on which to reflect (Giorgi, 1985). Additionally, although I, as the researcher and former ED RN, attempted to thoroughly bracket my biases and assumptions through journaling and debriefing, my own experiences and the esteem that I hold for ED RNs may have tainted the interpretation of the data. Finally, if another were to simply read the transcripts, they would not have been an integral part of the research experience and could reconstruct the phenomena in an alternate way (Giorgi, 1985; Maxwell, 2005).

**Implications for Nursing Practice**

Understanding workplace relationships can provide insight into ED culture, balance, and technology impact on the essential essence of caring that nurses possess, which affect the bridging and connections that ED RNs require for workplace relationships. Allowing ED RNs to have control over their environment may yield better outcomes, which are always patient related. To provide balance, assessing ED RN personalities and performance at frequent intervals may aide in retention of staff and prevent burnout of ED RNs. Technology is in place to support nursing practice, not to impede on workplace relationships and care of patient. Recognizing and remembering that the patient, not the computer, is the priority is essential to nursing practice regardless of specialty. Although patient care is primary focus, the business of healthcare is employee focused as to improve consumer outcomes. Take care of the employees
and they will take care of the consumer, the patient. Workplace relationships need to be established and nurtured for efficient, productive and effective outcomes. Those outcomes are always patient related for the ED RN.

**Recommendations for Further Research**

Two further studies are recommended to examine workplace relationships of ED RNs. An ethnographic study to explore the culture of ED nursing could enlighten the essence of ED Culture identified in this current study. As previously discussed, ED culture affects the caring essence in which the ED RN workplace relationship exits. The second study recommended is a phenomenological study to gain insight into the experience of being an ED RN. Gaining insight into the perspective of being an ED RN may enlighten the essence of balance identified in this study. Individually and jointly, these two proposed studies could not only add to the literature of nursing workplace relationships but also provide understanding of providing quality patient care in a rapidly changing environment.

**Summary**

Emergency nurses work with other health care providers under uncertain conditions to provide care to patients with all kinds of illnesses and afflictions from all walks of life. Despite implications that they must work together to accomplish their tasks, there are few studies that explore the relationships among emergency department personnel. Furthermore, there are even fewer that focus on the way emergency nurses work together to provide care to their patients. The purpose of the study was to understand the lived experience of workplace reciprocity of emergency nurses through the use of a qualitative phenomenological method. Nurses with three or more years of current emergency nursing experience were recruited using a purposive
technique to obtain a convenient sample. Each participant was interviewed. The data was analyzed and interpreted using Giorgi’s Phenomenological Method. Findings from this study identified six essential essences. These essential essences were synthesized into one statement which identified the meaning of workplace reciprocity of emergency nurses. Paterson and Zderad’s Humanistic Nursing Theory emerged as a way to reflect on the findings in a way that was meaningful to nursing. Implications for nursing practice and recommendations for future research are identified.
Appendix A

[Image of the City University of New York logo]

Human Research Protections Program
Herbert H. Lehman College (CUNY) HRPP Office

DATE: March 6, 2012

TO: Christine Corcoran
FROM: Herbert H. Lehman College (CUNY) HRPP Office

PROJECT TITLE: [289960-2] Understanding Reciprocity of Emergency Nurses: A Qualitative Study

SUBMISSION TYPE: Response/Follow-Up

ACTION: APPROVED

APPROVAL DATE: March 2, 2012

EXPIRATION DATE: March 1, 2013

RISK LEVEL: Minimal Risk

REVIEW TYPE: Expedited Review

REVIEW CATEGORY: Expedited review category # 7

Thank you for your submission of Response/Follow-Up materials for this project. The University Integrated IRB has APPROVED your research. This approval is based on an appropriate risk/benefit ratio and a project design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

Please remember that informed consent is a process beginning with a description of the project and assurance of the participant’s understanding, followed by a signed consent form(s). Informed consent must continue throughout the project via a dialogue between the researcher and research participant. Federal regulations require that each participant receives a copy of the consent document.

Please note that any modifications/changes to the approved materials must be approved by this IRB prior to implementation. Please use the appropriate modification submission form for this request.

All UNANTICIPATED PROBLEMS (UPS) involving risks to subjects or others, NON-COMPLIANCE issues, and SUBJECT COMPLAINTS must be reported promptly to this office. All sponsor reporting requirements must also be followed. Please use the appropriate submission form for this report.

This research must receive continuing review and final IRB approval before the expiration date of March 1, 2013. Your documentation for continuing review must be received with sufficient time for the IRB to conduct its review and obtain final IRB approval by that expiration date. Please use the appropriate continuation submission forms for this procedure. PLEASE NOTE: The regulations do not allow for any grace period or extension of approvals.

If you have any questions, please contact Lissy Wassaff at (212) 794-5772 or lissy.wassaff@mail.cuny.edu. Please include your project title and reference number in all correspondence with this committee.
Appendix B

Human Research Protections Program
Herbert H. Lehman College (CUNY) HRPP Office

DATE: February 28, 2013
TO: Christine Corcoran
FROM: Herbert H. Lehman College (CUNY) HRPP Office
PROJECT TITLE: [289980-2] Understanding Reciprocity of Emergency Nurses: A Qualitative Study
SUBMISSION TYPE: Continuing Review/Progress Report
ACTION: APPROVED
APPROVAL DATE: February 28, 2013
EXPIRATION DATE: February 27, 2014
RISK LEVEL: Minimal Risk
REVIEW TYPE: Expedited Review
REVIEW CATEGORY: Expedited review category # 7

Thank you for your submission of Continuing Review/Progress Report materials for this project. The University Integrated IRB has APPROVED continuation of your research. This approval is based on an appropriate risk/benefit ratio and a project design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

Please remember that informed consent is a process beginning with a description of the project and assurance of the participant’s understanding, followed by a signed consent form(s). Informed consent must continue throughout the project via a dialogue between the researcher and research participant. Federal regulations require that each participant receives a copy of the consent document.

Please note that any modifications/changes to the approved materials must be approved by this IRB prior to implementation. Please use the appropriate modification submission form for this request.

All UNANTICIPATED PROBLEMS (UPS) involving risks to subjects or others, NON-COMPLIANCE issues, and SUBJECT COMPLAINTS must be reported promptly to this office. All sponsor reporting requirements must also be followed. Please use the appropriate submission form for this report.

This research must receive continuing review and final IRB approval before the expiration date of February 27, 2014. Your documentation for continuing review must be received with sufficient time for the IRB to conduct its review and obtain final IRB approval by that expiration date. Please use the appropriate continuation submission forms for this procedure. PLEASE NOTE: The regulations do not allow for any grace period or extension of approvals.

If you have any questions, please contact Tara Prairie at (718) 960-8960 or tara.prairie@lehman.cuny.edu. Please include your project title and reference number in all correspondence with this committee.
CITY UNIVERSITY OF NEW YORK
Graduate Center
Department of Nursing

INFORMED CONSENT FORM TO PARTICIPATE IN RESEARCH
Investigator: Christine Corcoran, RN, MS, PMC, FNP-BC, DNS (candidate)

TITLE OF RESEARCH STUDY:
Understanding Reciprocity of Emergency Nurses: A Qualitative Study

A. PURPOSE OF THE STUDY:
You are being asked to volunteer in a research study. This consent form includes information about this study. The purpose of this study is to understand reciprocity of emergency nurses. Emergency nurses work with other health care providers under uncertain conditions to provide care to patients from all walks of life with all kinds of illnesses and afflictions. Despite implications that they must work together to accomplish their tasks, there are few studies that explore the relationships among emergency department personnel. Furthermore, there are even fewer that focus on the way emergency nurses work together to provide care to their patients. The purpose of the study is to understand reciprocity of emergency nurses and how this process can influence patient care. The findings of the study will provide an understanding of reciprocity among emergency nurses and insight into this aspect of relationships amongst healthcare personnel. It will also inform the process of attracting and retaining active practicing emergency nurses as well as quality care for patients. You are being asked to participate in this study because your emergency nursing experiences and opinions will contribute to the success of this work. Your participation in this research is voluntary and you can stop participating at any time.

B. SUBJECT PARTICIPATION:
Approximately 3-10 participants will be interviewed. Participants must have greater than three years of current emergency nursing experience. Participants are interviewed only once. The interview will take about 60-90 minutes. Interview setting, time, date, and location will be at a neutral, private location determined by participant.

CUNY UI - Institutional Review Board
Approval Date: March 2, 2012
Expiration Date: March 1, 2013
Coordinator Initials: lw
C. DESCRIPTION OF THE RESEARCH:

A descriptive qualitative research approach will be used to collect and analyze the data for this study of the reciprocity of emergency nurses. This will be done in order to gain understanding of the concept of reciprocity. It will allow individual perceptions to emerge. Upon completion of the interview, the interview will be sent to a secured service for transcription. The transcription analysis will commence upon return receipt of the transcripts.

D. COSTS/REIMBURSEMENTS:

There will be no costs incurred by the participants in this study. If you choose not to participate in this study by not signing the consent form, there will be no consequences to you. Coffee and a light meal may be provided during the interview process at no cost to the participant.

E. POTENTIAL RISKS AND DISCOMFORTS:

The following risks or discomforts may occur by being in this research study. Subjects may be anxious that their privacy will be violated since personal and professional information may be disclosed during interviews. To protect the participants, all interviews will be conducted in a private space. Additionally, all data including written and electronic notes, audio recorded interviews, and transcripts will be stored in a safe and secure place that only the researcher will be able to access. As part of the process involved in obtaining written informed consent, all participants are reminded that their responses are confidential and that they may refuse to participate in the project or withdraw at any time without explanation and without repercussions. To protect the identity of subjects, the names of interview participants will be changed. Although the risk of participation in this study is no more than activities undertaken on a daily basis, some emergency nurses may experience anxiety when discussing work related issues. In discussing their experiences, the investigator will reassure participants about the normal responses to expressing feelings about work issues.

F. POTENTIAL BENEFITS:

Reciprocity has been researched in the past in human sciences, specifically, in anthropology and sociology literature. Minimal research on this concept exists in the healthcare literature, particularly the nursing literature. The findings of the study will provide a valuable understanding of reciprocity among emergency nurses and insight into this aspect of relationships amongst healthcare personnel. It will also inform the process of attracting and retaining active practicing emergency nurses as well as quality care for patients.

CUNY UI - Institutional Review Board
Approval Date: March 2, 2012
Expiration Date: March 1, 2013
Coordinator Initials: Iw
G. CONFIDENTIALITY:

All information collected will remain confidential. Any papers or articles that result from this research will report summaries of the data and not reflect only one person’s opinion or statement. The investigator will not share any information that they collect. When the results of the research are published or discussed in conferences, no information will be included that would reveal your identity. The audio recordings will be transcribed into word documents and the recording will be transferred to a digital voice program and kept on a computer in an encrypted file. No person other than investigator from the Graduate Center/City University of New York will have access to the audio recordings or any other data. You have a right to review the audio recording of the interview at its completion. The audio recordings will not be used for any other purpose other than data analysis nor will they be heard by anyone other than the Graduate Center/City University of New York investigator. Excerpts from the transcribed interviews may be used for educational purposes, written reports, and/or presentation at conferences. However, pseudonyms will be used to ensure participant anonymity.

H. CONTACT PERSON(S):

You can ask questions about this study at any time and you are encouraged to do so. If you have questions about your rights as a participant, or if you are not satisfied with the manner in which this study is being conducted and would like to discuss your participation with a representative from the Graduate Center/City University of New York, please contact Director of the Doctor of Nursing Sciences program, Keville Frederickson, telephone number 212-817-7985.

If you have any questions during the course of the research, please contact the investigator, Christine Corcoran, at the following telephone number: 914-522-8538.

I. WITHDRAWAL FROM THE STUDY:

You may withdraw from participation at any time without penalty.

J. AGREEMENT TO PARTICIPATE:

☐ I have read this consent form

Any questions I had were answered by: ____________________________.

I voluntarily agree to participate in this research study:

Signature ____________________________________________________________________________

CUNY UI - Institutional Review Board

Approval Date: March 2, 2012
Expiration Date: March 1, 2013
Coordinator Initials: lw
K. CONSENT FOR AUDIO RECORDING:

I hereby authorize audio recording of the interview for the research study: Understanding Reciprocity of Emergency Nurses: A Qualitative Study. I also authorize the investigator to play the audio recordings and review transcriptions of my interview in their analysis of data for the purpose of research. I understand that I will not be identified in any publication using the data from this audio recorded interview.

The foregoing authorizations are given subject to the condition that:

1. I will not be identified in any publication using data from this audio recorded interview.
2. I understand the making of the audio recordings are subject to approval and supervision of the study investigator, and the Institutional Review Board at the Graduate Center/City University of New York. I understand that all audio recordings taken shall be shown to the undersigned if he/she requests at the time he/she signs this consent. All recordings will be destroyed at the request of the undersigned.
3. I understand the audio recording of this interview will not be used for commercial or public media purposes without my written consent.

I consent to having my interview audio recorded.

I understand that I am entitled to and will be given a copy of this signed Consent Form.

Print Name of Participant  
Signature of Participant  
Date Signed

Print Name of the Investigator Obtaining Consent  
Signature of the Investigator Obtaining Consent  
Date Signed

CUNY UI - Institutional Review Board
Approval Date: March 2, 2012
Expiration Date: March 1, 2013
Coordinator Initials: lw
Appendix D

- Working together as a team
- Helping each other
- Lack of nursing staff delays care
- Helping each other makes it more bearable
- Increased stress can cause frustration
- Personality affects working together
- Being friendly at work and talk without them wanting something from you
- Joking relieves stress
- Negative, grumpy, less tolerant of things going wrong
- Cliques, not necessarily a good thing for outsiders of that clique
- Patients' pick up on anxiety
- Charge nurses are the key to help keep things going
- Charge nurse is supervisor during shift and peer the next day
- Areas, zones, districts, don't allow nurses to pick and choose who they take, motivates staff, forces others who don't want patients to work
- ER nursing is different from any other kind of nursing
- New nurses and tolerance
- Changing environment
- Looking more at statistics instead of patients
- Computer necessity
- Care is depersonalized
- Caring for people is very personal
- Personality and stress
- Some nurses bend over backwards to help, others don't
- Developing positive relationships with workers who only look after their own
- Gain favors by doing favors first
- I will jump to help
- I had support
- Behavior impact patient care: flustered quickly
- Leadership comes in many forms
- Creating mentor relationships
- Being a buffer
- Frustration
- Socialization, flirting
- Unfocused
- Baffled by another RNs behavior
- Night shift has its own culture
- Work more with less
- We can learn from what we are doing
- Not a personality for the ER
- Attitudes
- Defensiveness
- Insecure
- Certain personalities are not cut out for the ER
- Getting the job done and being given heavier patient loads because of it
- Losing good senior nurses because of changes in emergency nursing
- Lack of vision and mission statements
- Good team players
- Needing somebody else
- Every place does it different
- Always has the worst patients
- Attack you
- Play deaf
- Sit and watch
- Play the game
- Socialize
- Lazy
- Act like babies
- Looking at numbers instead of patients
- Build relationships
- Nobody's gonna help you unless you help them
- Critical; it's very rare people are not going to jump in
- Frustrated at other nurses' behaviors
- First one to help
- Drama, drama, drama
- Personality issues; personality conflicts
- Exhaustion and stress at dealing with other's behaviors
- Snapping; lack of snapping
- Team playing
- Let's help the patient
- Friends again at the end of the shift
- Shift cultures are different
- Less administration, less support
- Argumentative ins who nitpick
- Gattiness
- Night shift rely on each other
- Institutional cultures have huge influence
- Professionalism
- Worked with awesome people, so tight, super close to each other
- Care for each other, because nobody else was there
- Changing environment: Growth of the ER
- Managers were split just against each other; unity; allowed RNs to think
- Working together to take care of the patients
- Hiring key people to create a balance
- Being rotated to In-Charge gives a different perspective
- Not being afraid to do
- A go-getter
- Camaraderie
- Great supportive network
- Close cohesive environment
- Team nursing
- Changing environments affect the team
- Districts separate
- Critical situations: will come in to help
- Personalities can be clashy
- Working harder can get you a heavier district
- Feeling like you're drowning and not being able to help others
- Being yelled at for helping another nurse
- Feeling bad for the patient placed in bad nurses' districts
- Working with others to try to make the ER more cohesive
- Management needs to support staff and tell them what they're doing well
- Mandatory and numbers are being focused upon by management
- Patient surveys are frustrating
- Outside relationships: friendships
- When friends are In-Charge, it can cause conflict in the friendship
- When friendly colleagues are promoted and schedule issues, "felt kicked"
- Overly helpful can be annoying
- Obnoxious, knowing everything, and barking orders can cause chaos
- Being comfortable in code situations are, even unsuccessful ones, are rewarding. Create good camaraderie, teamwork.
- Feeling overwhelmed and alone when everyone scatters
- Work together in a crisis
- Support from older nurses
- Newer nurses wanting to take leadership positions
- Teaching and learning
- Mentoring
- In-Charge sets the tone for the ER
- People take your lead
  - Tit for tat behavior is uncomfortable
  - Avoidance behavior of RNs who don’t like each other
  - Never take it out on a patient
  - Compromising patient safety is unacceptable
- Personality to be an emergency nurse
- Adrenaline rush is required
- Not let things bother you
- Nurses that get unraveled... not for them
- ER has a different flavor to it
- Work independently
- Team of people to work with
  - Spearhead individual
  - Give directions
  - Turnover of staff
- Crisis: jumped in and took their place
- Move from one stressful situation to the next
  - Brush things off?
  - Personalities
    - Strong aggressive
    - Feeling their way through the system
    - Offense to communication; lack of offense to communication
  - Drawing new nurses in to get them involved and feel a sense of team
  - Weave them together
- Being graded on care
  - Our focus is the patient; them recovering; their survival
  - Department to lose senior nurses who work under great pressure and move fluidly
- Changing environment
- Dynamics of personality
- Confrontation of behaviors
  - Those that look the other way and shrug their shoulders
  - All ERs are very different
• May appear unfriendly or abrasive: strong personalities, focused
  • Lead by example
  • Thanking others
• Crisis, everybody jumps in
  • Work ethic to care for patients
  • Smooth work, no yelling, no screaming, work without direction, to help
  • Discomfort levels, not interested, or made to feel like team, waiting for direction
• Zones and patient assignments
  • Covering for breaks and things not being done is frustrating
  • Working short is the norm; people get frustrated and resentful at staffing levels
  • Showing that you are willing to care for a patient that is not yours sets an example
• Teambuilding is hard
  • RNs who don’t want to communicate
  • Walk away and roll eyes
  • Being overwhelmed in patient care
• Personalities: Being comfortable with skills and taking charge
  • Patient trackers: forgetting to move patients over
  • Being disrespected
• Computer care, not patient care
  • Frustration at working short staffing and increased extra work, documentation
  • Disgruntled behavior about increased documentation
• Close cohesive environments in past
  • Best place to work because of staff interaction
  • Negative people damper the situation
  • Covering messy people and discovering lots of work needs to be done
  • “Hasn’t spoke to me since”
  • Loves a good code
  • Negativity kills morale in any ER
• Patient complaints are taken seriously
• Intuition is important in ER nursing
• Personalities are important
  • Establish a rapport with new nurses
  • ER RNs are like a family
  • Get to know each other
  • Resistance of other staff members
  • Change in behavior due to shift and cohesiveness
• Crisis all RNs pull together
• Teamwork feels good
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