

# Working in an overcrowded accident and emergency department: nurses' narratives

## AUTHORS

### Mary Kilcoyne

M.H.Sc (Advanced Nursing Practice), RGN, Higher Dip (AandE)  
Clinical Nurse Manager, Mayo General Hospital,  
Castlebar, County Mayo, Ireland

### Maura Dowling

PhD, MSc (Nursing), BNS, RNT, RGN, RM, Cert.  
Oncology  
Lecturer, School of Nursing and Midwifery, National  
University of Ireland, Galway, Ireland  
Maura.dowling@nuigalway.ie

## KEY WORDS

accident and emergency, overcrowding, access block,  
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## ABSTRACT

### Aim

The aim of this study was to highlight nursing issues associated with overcrowding (or access block) in the Accident and Emergency (A&E) department.

### Design

An interpretive phenomenological approach was adopted, with the utilisation of unstructured interviews.

### Setting

The A&E department of a general hospital situated in the West of Ireland.

### Participants

Eleven nurses working in the A&E department volunteered to be interviewed.

### Findings

Three central themes, with inter-related sub-themes, emerged from the data. The central themes identified were: lack of space, elusive care, and powerlessness, with sub-themes being health and safety issues, infection control issues, poor service delivery, lack of respect/dignity, nurses hovering, unmet basic human needs, not feeling valued, moral distress, and stress/burnout.

### Conclusions

The nurses in this study provide a distressing picture of nursing in an A&E department, as they pursue the provision of effective, holistic care of patients in overcrowded conditions.

## INTRODUCTION

Overcrowding and its associated problems have been highlighted since the late 1980s (Ardagh and Richardson 2004). The problem reflects an international trend, with commentary from Ireland (Department of Health and Children 2005), New Zealand (Richardson et al 2002), United States (Trzeciak and Rivers 2003), Canada (CAEP and NENA 2001), and Australia (Fatovich 2002).

Overcrowded emergency departments are portrayed as a high risk environment for medical errors and pose a threat for patient safety (Gorden et al 2001). In an effort to manage overcrowding, the Irish Health Service Executive recommends that no patient is to wait for more than 24 hours in an A&E department for admission; no A&E department is to have more than 10 patients waiting for admission; and while awaiting admission, patients will be guaranteed privacy and dignity (Health Service Executive 2006). In Australia, Fatovich et al (2005) reported that improving inpatient flow is the most likely intervention to directly reduce access block. Access block refers to "the situation where patients in the emergency department (ED) requiring inpatient care are unable to gain access to appropriate hospital beds within a reasonable time frame" (Fatovich et al 2005 p.351).

Specific measures aimed at addressing the issue of overcrowding in A&E departments have proven successful in the United Kingdom. In 2002, Sir George Alberti was appointed as National Clinical Director for Emergency Access, and given the responsibility for overseeing the implementation of the Reforming Emergency Care strategy. The Reforming Emergency Care strategy aim is that the patient's experience of emergency care is represented by shorter waiting times, with few if any waiting more than four hours from A&E arrival to admission, transfer or discharge; quicker ambulance response times with better training and equipment; more primary care based services for minor ailments; and finally, better integration within emergency and critical care (Hughes 2004). Others, too, report some success in

projects to manage operational delays in emergency departments (Bartlett et al 2002).

## METHODOLOGY AND METHODS

The philosophical views of Heidegger provided guidance for the study's methodology. Research guided by Heideggerian phenomenology is focused on ontological issues about what it means to be a person (Walters 1995). A purposive sample of 11 A&E nurses working in the A&E department of a regional hospital in the West of Ireland, participated in the study. The nurses had between two and 20 years experience of emergency nursing, and all grades of staff were included to obtain rich data. Approval was sought and granted from the hospital's ethics committee to undertake the study. Recruitment of participants was achieved through displaying an information leaflet on the nursing notice board in the A&E department, explaining study details, and requesting volunteers willing to be interviewed to contact the first author. Because the first author was well known to nurses in the department, a concern was the possibility that nurses might feel obliged to agree to be interviewed if they were approached. Therefore the volunteering approach was deemed appropriate. All eleven participants provided written consent.

Initial sampling decisions were purposive, that is, the selection of participants was made on the basis of their ability to provide significant data about the area under inquiry. However it was decided to also interview three nurses who had recently left the A&E department. These three nurses all volunteered at the beginning of the study, but it was initially decided against including them in data collection since they had already left the department. However, data emerging during the early interviews revealed that overcrowding in the A&E department had contributed to the attrition of A&E nurses in other hospitals. Therefore it was decided to include these three participants based on their experience of emergency nursing and to explore if overcrowding was a contributing factor in their decision to leave the A&E department. Evidence of the qualitative

researcher as bricoleur is therefore also evident in the study. According to Weinstein and Weinstein (1991), "...the *bricoleur* is practical and gets the job done" (p.161). Moreover, it is argued that the notion of researcher as a bricoleur may be a way of enlarging the landscape of the researcher's inquiry, offering a deeper and more comprehensive picture (Tobin and Begley 2004).

It was decided to use unstructured interviews, since the research method for this study is in keeping with the views of Heidegger and his position that the method should be uniquely suited to the particular question (Racher 2003). The first author conducted all the interviews and posed the following opening question to the study participants: "Can you tell me how you experience nursing in an overcrowded A&E department?"

With regard to the study's dependability, narrative studies do not have formal methods of reliability (Polkinghorne 1988). Instead, they "rely on the details of their procedures for procuring the best possible information, which evokes a sense of trustworthiness for the validity of the information used for study"

(Eberhart and Pieper 1994 p.46). Credibility was pursued by the first author maintaining a journal of experiences during interviewing and data analysis. Moreover each study participant was asked to confirm the interpreted findings. In addition, an external peer review was obtained from an experienced nurse researcher, based in New Zealand, with extensive emergency nursing experience, who validated the study findings.

Colaizzi's (1978) framework of seven procedural steps was used in the data analysis. Although some authors suggest this framework is usually used in descriptive phenomenology (Cohen and Omery 1994), this framework is also suitable for a study utilising a Heideggerian phenomenological framework (Flemming et al 2003).

## FINDINGS

Three themes with sub-themes emerged from the nurses' narratives (table 1). The nurses' narratives revealed that these themes overlapped and impacted reciprocally on each other.

**Table 1: Themes and sub themes arising from nurses' narratives**

Themes	Lack of space	Elusive care	Powerlessness
Sub themes	Poor service delivery	Lack of respect/dignity	Not feeling valued
	Health and safety	Unmet basic human needs	Moral distress
	Infection control issues	Hovering	Stress/burnout

### Theme: Lack of space

All the study participants clearly reflected lack of space in the emergency department, as a major obstacle to service delivery, patient care, health and safety, and infection control. This is clearly articulated in the narrative of Nurse (4) below.

Nurse 4: "The building wasn't designed when it was planned however many years ago; it wasn't designed to cater for people on trolleys. It was designed as a working Casualty Department with a minor and a majors area, and as it happens all our overnight

*stays, we try and accommodate them in the minor department, which therefore leaves us with reduced space for the doctors to see their patients which in turn causes longer delays for the patients that are waiting... Also we feel when the emergencies come in, sometimes number one their route is blocked, their actual way in to get into the department sometimes can be blocked because trolleys are put in every conceivable space available".*

The Emergency Department is not designed nor has the facilities to nurse patients for long periods

of time. The issues of infection control, and health and safety within the emergency department are articulated by Nurse (3).

Nurse 3: *"If you have two or three patients bundled into where there should only be a couple of patients then the facilities are being stretched. That surely is not right. And again you have people in a hurry to get things done and you know hand washing goes out the window in some instances. Health and safety issues, if there was a fire, God forbid and if there was a cardiac arrest and you had to push other patients out of the way to get to that patient who might be, as I said before sharing oxygen and suction"*.

#### **Theme: Elusive care**

In an overcrowded emergency department, there is an illusion of nursing care being provided to patients, which in reality is not the case. This is reflected in the narratives of the participants below.

Nurse (7) articulates emotionally a situation that highlights the dilemma for nursing staff in trying to ensure respect, dignity, privacy, and care for an elderly patient and her family in her final hours of life in an overcrowded emergency department. The nursing care provided for this patient was of good quality. However it was the environment where the care was carried out that compromised holistic care for the patient and her family.

Nurse 7: *"An incident that comes to mind is of a very elderly lady who came in, who you didn't have to be an Einstein to look at to know that this lady was dying and she was put on a trolley. Now she was given the privacy of taking up one of the cubicles that were to be used for the ordinary everyday patients that would be coming through the A&E. That was about four o'clock in the morning and by nine o'clock we knew that lady was dying and something as basic as a comfortable bed, privacy, her family able to be around her, quietness, just the simple peace and quiet of your family being able to sit comfortably around you with no noises, all that was denied to that woman and her family. She was in cubicle one, the major side, busy department, nine o'clock, public coming through, staff coming on duty and that to me*

*is what that woman's last sounds were; racket, public racket coming through. She didn't even have the sort of decency of a quiet peaceful death and her family crying, looking helplessly at us. I felt so helpless that day and I remember thinking to myself I don't think, I don't think things can get much worse or I don't think I have ever felt so helpless you know"*.

The sense of frustration that nurses feel in failing to provide quality care and their empathy for patients' lack of privacy and dignity is also reflected by the narratives below.

Nurse 1: *"I am sure they [patients] must sometimes look at the staff and say you know, why don't people spend a bit more time with me. Everything is so rushed when your overcrowded, because you are trying to get people through the system as fast as you can...Nursing was always the role, the one that had the time to talk to the patient, the one that spent a lot of time with the patient, And you were there to pick up the pieces and certainly that's not a role we are performing any more"*.

Nurse 2: *"You feel a lot of empathy for the patients on trolleys because they have no space, they have no dignity, they have no privacy...The patients on trolleys themselves they can't eat properly and they are not given a choice of their dietary foods or they are not given the opportunity to be free enough to walk around the Department, have visitors come and see them and it is just, it is not an appropriate environment for them. They have no space, no time. They see resuscitation [teams] moving, they see teams running past them, they are hearing children crying and they see a lot of sadness"*.

#### **Theme: Powerlessness**

The study participants expressed feelings of frustration, anger, not being valued, and stressed, and all felt powerless in their role as nurses in a working environment which they felt has become an accepted norm.

The three participants, who had taken the decision to leave the A&E department, eloquently expressed their frustration at working in this difficult situation.

Nurse 11: *"I have witnessed people sob quietly to themselves when they thought no one was looking. People who withdraw into themselves to protect themselves when from the chaotic environment that has been forced upon them because they became sick... In my own case I just couldn't endure the hardship that patients now have to endure. The feelings I had at the end of my shift that I hadn't done enough, even though I'd be worn out trying... At least now I can give my patients the time and consideration that they need and deserve".*

Nurse 9: *"You were always playing catch up, always dealing with the same problems, no solutions. For me I was always aware of these conditions for both staff and the patient. I did not want to continue working in an environment that was unhealthy."*

Nurse 8: *"You just felt you were sailing the ship alone literally [laughs]. Ah you would feel very demoralised. Because you know you wouldn't have felt that you had done your best for the day or given your best to people. Well I just feel that you, I just would rather not be there at all if I couldn't do the job that I wanted to do, you know".*

The study narratives reveal the difficulties for nurses working in overcrowded emergency departments. However because all the participants were female, the potential of gender bias is strongly evident. The perspective of male A&E nurses on this phenomenon may have resulted in different experiences. Moreover, the methodological weaknesses of studying one particular group of nurses are obvious, since not all nurses will associate with the experiences revealed here.

## DISCUSSION

The aim of this study was to highlight nursing issues associated with overcrowding in the A&E department. All the participants revealed lack of space as a significant barrier to the nursing role in the department. Anxiety, stress, fear, frustration, a poor sense of safety and security are just some of the aspects influenced by the physical environment. These factors all play a part in motivating quality and productivity in the functioning of the hospital staff

(Carver 1990). However Carver further contends that hospital staff adapt to their environment, learn to live with the problem and fit their patient care around the problems. This would appear relevant to nurses working in an overcrowded emergency department where nurses are continually moving patients and trolleys in and out of cubicles to enhance the functioning of the department and allowing new patients to be assessed and treated.

Care as context dependent, is evident in Byrne and Heyman's (1997) study which explored A&E nurses' perceptions of their work. They found that understanding how nurses in A&E interpreted their role was fundamental to understanding how they organised their work and interrelated with patients. These nurses saw their work as one that was mainly concerned with providing urgent physical care. Holistic individualised care was seen as being idealistic, and nurses often felt pressurised to complete tasks. When the department was busy, 'popping in' on patients was identified as one way of signifying to patients they had not been forgotten. A central theme was defined as 'keeping the department running smoothly'. The nurses felt it was important to give psychological support to patients, but that moving the patients through the department swiftly was a more pressing aim (Byrne and Heyman 1997).

All of the participants in this current study expressed that 'overnight stay' patients had unmet basic human needs while being nursed in the emergency department. This alludes to lack of privacy, dignity/respect, hygiene facilities, and space. Respecting privacy is a vital part of holistic care and meeting individual needs. Privacy in the hospital setting is considered broadly, to possibly include, the right to enjoy one's property, the right to safeguard the confidentiality of one's medical and personal information, the right to receive treatment with dignity during intimate care, and the right to control one's individual space and territory (Woogara 2001). Back and Wikbald (1998) reported that patients demonstrate a high preference for having access to a locked cupboard to keep their personal belongings

safe. This is very relevant to patients nursed on trolleys in an overcrowded emergency department, where they do not have access to their own space, to lockers, or to the normal ward environment that was their expectation on being admitted to the hospital. The provision of a bed in the health service means more than simply a physical structure. It implies an attempt to meet the total needs of the patient's period of care. Included in this, is a fitting environment where the patient's dignity, privacy, and family needs are safeguarded (Di Biasio and McClelland 2001).

The nurses in this study reveal their experience of moral conflict since they are unable to carry out their role due to factors beyond their control. As most patients are vulnerable, they need protection as well as skilled and appropriate care. Yet nurses may not always be able to protect patients or supply all their care needs, for a multiplicity of reasons. When the professional goals of nurses are hindered, they suffer moral distress (Corley 2002). Moral distress arises when one must act in a way that opposes personal beliefs and values. It is uneasiness about not doing all that one could do to satisfy one's moral obligation (Kelly 1998), and occurs when one knows what to do in a particular situation but is impeded by constraints (Jameton 1993). Moreover, Rodney and Strazomski (1993) contend that unresolved moral conflicts can lead to a reduction in quality of care and create burnout, with caregivers leaving their jobs.

In conclusion, the nurses' narratives reveal a rich, if somewhat, disturbing, interpretation of their experience of nursing in an overcrowded A&E department. The central issues of lack of space, a feeling of powerlessness and the inability to deliver quality care to patients, contribute to moral distress and burnout among nurses.

## RECOMMENDATIONS

If the delivery of patient focused quality care in the A&E department is to be achieved, it is imperative that nurses are listened to, their expertise acknowledged and they are involved in the decision-making process. Nurse managers play a central role with regard to supporting A&E nurses performing their role in a

climate created by factors beyond their control. The issues and difficulties associated with overcrowding in the emergency department are complex and multifaceted and it is imperative that A&E nurses, at constant risk of moral and emotional distress, are not forgotten in strategic attempts to manage this issue.

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