

Emergency Nurse Retention: Understanding Success Factors  
for the Retention of Emergency Department Nurses Employed by a  
New Zealand District Health Board

**Leslie Kistan**

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School of Clinical Sciences

Faculty of Health and Environmental Sciences

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## Abstract

Nursing retention is a growing concern for the health workforce, especially in high-acuity and pressurised areas, such as emergency departments (EDs). For the emergency nurse workforce, there is pressure from higher patient: nurse ratios, staff shortages, and complex, acutely presenting co-morbidities. The New Zealand (NZ) media have been regularly reporting overcrowding, escalating presentations, long waits, incidents of violence, and, most concerning, preventable patient deaths within EDs. The recent COVID-19 pandemic has exacerbated these issues.

This research aimed to examine the key factors contributing to successful retention of ED nurses employed by a NZ district health board (DHB). The research questions were, firstly, “What are the perceptions of ED nurses in relation to retention?” and, secondly, “What are the success factors contributing to retention?”

Qualitative interpretive description (ID) methodology was employed. The participants included 13 ED nurses who were purposively sampled and interviewed. The findings were thematically analysed using Braun and Clarke’s (2022) approach. The demographic characteristics of participants were: 1 male nurse, 12 female nurses; 1 nurse who identified as Māori, 1 Asian nurse and 11 European nurses. The average age was 35 years and nursing experience ranged from 18 months to 40 years.

Six themes were constructed. Theme one, personal satisfaction from being an ED nurse, captured reasons for taking the role. Theme two, using ways of coping, captured positive ways nurses coped in the ED. The third theme, workplace tensions, captured nurses’ experiences, struggles, and challenges while working in ED. Theme four, professional development is important, captured the importance of training and education for all ED nurses. Theme five, “we all chip in,” captured supportive relationships between team members in ED. Theme six, dissatisfaction with organisational structures, processes, and systems centred on the negative effect of existing systems, processes and structures within the organisation.

The study concluded that pull (positive) and push (negative) factors operated simultaneously to inform personal, professional, interpersonal, and organisational factors that led to retention decisions. Key recommendations for nursing practice include consistently valuing and acknowledging ED nurses through positive organisational cultures, healthy workplaces, incentives, regular professional development, and career progression. Furthermore, improved infrastructures, processes and systems to protect staff from violence and aggression is recommended. In addition, support for both senior ED and early career nurses is needed. In terms of nursing education, it is imperative to provide courses on stress, coping, teamwork, communication and leadership. Future research using mixed methods research approaches with large population samples across several hospitals is recommended.

## **Dedication**

I dedicate my thesis to my parents, grandparents, all children born and unborn in my family, humankind, and many ancestors, in-laws and relatives who made significant sacrifices to provide education for us. Without these people, mentors (RNs in SA), good wishes and encouragement, I would not have done it. I took on a massive project while working, but I learned so much. I hope to meet their expectations and contribute to nursing. Lastly, to people working and providing for me, their families past, present, and future all over the world, especially nurses, doctors, teachers, lecturers, academics, cleaners, orderlies, healthcare assistants, chefs, community service providers and missionaries.

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## **Attestation of Authorship**

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor used artificial intelligence tools or generative artificial intelligence tools (unless it is clearly stated, and referenced, along with the purpose of use), nor material which, to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

**Signed:**

A grey rectangular box redacting the signature of the author.

**Dated:** 15.05.2025

## **Chapter One: Introduction**

### **Background**

Nurse retention is a key workforce issue impacting nurses' work globally and a particular issue for the acute care workforce in areas such as the ED. Many studies to date have examined nurse retention, commonly highlighting job satisfaction concerns (Almost & Mildon, 2022; Efendi et al., 2019; Lasater, 2024; Lee et al., 2021; Loft & Jensen, 2020). Key factors that influence nursing retention are supportive leadership, peer support, teamwork, a positive environment (Tang & Hudson, 2019; Twigg & McCullough, 2014), professional development, and work–life balance (Loft & Jensen, 2020). Studies refer to these key factors as the 'pull' factors attracting nurses which are linked to intention to stay and, ultimately, retention (Roth et al., 2022; Sasso et al., 2019). Conversely, 'push' factors stem from unhealthy workplaces and stressed nurses (de Wijn et al., 2022; Wubetie et al., 2020) resulting in job dissatisfaction and intention to leave (ITL) (Alharbi et al., 2022; Roth et al., 2022; Sasso et al., 2019). These factors in a workplace reduce the retention of nurses.

This rest of this chapter introduces the issue of emergency nurse retention, the rationale and purpose of this research, the NZ context, the research approach and design, the ID methodology, the research aim and questions, the organisational framework, research positionality, and key terminology. The objective of the research was to understand the key factors for ED nurse retention in NZ. An outline of the thesis structure is presented at the end of this chapter.

### **ED Nurse Retention**

Nursing retention is a global concern, but it is heightened for nurses working in fast-paced, time-pressured, and high-acuity areas like EDs. Studies on ED nurse retention place importance on nurses feeling supported and valued by an organisation. Feeling valued means working in a positive culture (Adams et al., 2019), incentives such as career opportunities (Dawood & Gamston, 2019; Evans et al., 2017), preparation of junior nurses (Li et al., 2019), and transition to practice pathways for inexperienced nurses (Lee, 2024). In addition, personal and professional factors influence ED nurse retention, for example, the nature of the work (Francis-Wenger, 2024; O'Callaghan et al., 2020; Van Osch et al., 2018), work–life balance (Van Osch et al., 2018), peer support, teamwork (Lapierre et al., 2019; Zaheer et al., 2021), supportive leadership (Enns & Sawatzky, 2016; Van Osch et al., 2018), effective communication, positive attitude, and positive coping skills (Elder et al., 2019; Power et al., 2022).

Retaining ED nurses is significant because ED is the first point of call at any public hospital. The public are reliant on an ED that is adequately resourced with the appropriate number of trained and experienced ED nurses. Emergency nurses face added pressures from an increased volume of ED presentations, patient complexity, constant changes in patients' conditions, lack of

time, overcrowding (Jones & Van der Werf, 2021), gridlocks, ambulance ramping (Bialostocki, 2021; Cain et al., 2023; Crilly et al., 2020) and limited numbers of experienced staff, not to mention health targets, time pressures, shift work, interruptions during care, limited staff numbers, violence and aggression (Alomari et al., 2021; McIntyre et al., 2024). The COVID-19 pandemic caused another layer of stress for nurses because of uncertainty, anxiety, unpreparedness, fear, and patient and family hostility (Ahorsu et al., 2022; Brigo et al., 2022; Cinar et al., 2021; Ghanbari et al., 2022; Yang et al., 2022). A few studies have commented on the effect of stress on the professional role of ED nurses, comparing them with doctors and other general nurses. ED nurses report higher levels of stress and burnout than doctors (McCormick et al., 2023). There is often no downtime to recuperate or debrief (Barleycorn, 2019; Ratrout & Hamdan-Mansour, 2020), adding to stress. There is much to be researched in this context, and the next section explains more about the rationale and purpose of the research presented in this thesis.

## **Rationale and Purpose of the Research**

The current research aims to identify and understand the success factors in retaining emergency nurses in a DHB<sup>1</sup> region in NZ, specifically in terms of the perceptions of nurses. There is a paucity of research on ED nurse retention in NZ. Interpretive description, as outlined by Sally Thorne (2016), was chosen as a research approach that provides insight into the lives of ED nurses and the clinical environment in which they work. The findings from this research will provide evidence for managers which may help identify success factors, support policy development, and help future workforce planning to support ED nurse retention. What is needed are strategies to support and successfully retain ED nurses.

Retention of nurses is important because a country's health needs can only be met by an adequately resourced nursing workforce (Efendi et al., 2019; World Health Organization [WHO], 2016). Equally, retention of nurses is crucial for patient outcomes such as lowered mortality rates (Aiken et al., 2014). The *Global Strategy on Human Resources for Health: Workforce 2030* (WHO, 2016) stressed the need to invest in recruiting and retaining well-trained and adequate nurses (WHO, 2016) for a healthy nation. Nurse retention has direct and indirect economic or financial implications for an organisation. Some studies have found that nurse retention saves money for an organisation (Efendi et al., 2019; Helbing, 2017), whilst other studies conclude that losing one nurse can double costs for an organisation (Shaffer & Curtin, 2020; Wubetie et al., 2020). Organisational strategies implemented to retain nurses leads to better nurse mental health and well-being, team cohesion, productivity, and patient satisfaction (Bae, 2022).

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<sup>1</sup> DHB stands for district health board which was publicly funded for the provision of healthcare to specific parts of NZ. The DHBs started on January 1<sup>st</sup>, 2001, under the New Zealand Public and Disability Act 2000 and was disestablished in 2022 to form Te Whatu Ora (Health New Zealand) and Te Aka Wai Ora (Māori Health Authority).

Statistics on global workforce development regarding nurse recruitment and retention indicate the challenges. Research in the United States of America (USA) has found that it takes three months, or 59 to 109 days, to recruit one registered nurse (RN) (Nursing Solutions, Inc [NSI], 2024). Governmental cost-cutting by reducing nursing staff numbers in hospitals only exacerbates the problem. A universal experience is having to ‘do more with less.’ Therefore, organisations must now carefully look at how to recruit, train and retain nurses (motivate, inspire and support nurses mentally and physically) while keeping to a budget and ensuring all inpatients are kept safe (NSI, 2024). In January 2024, *The National Healthcare Retention and RN Staffing Report 2024* reported on a survey of 400 hospitals involving 111 nurses across 36 states in the USA which found that, since 2020, EDs had the highest staff turnover rate; in five years, there was a 112.1% increase in nurse turnover (NSI, 2024). When looking at the hospital, the mean cost for an RN leaving was US\$53,600, a 7.5% increase from the previous year, translating to an average organisation in the USA losing US\$3.9 to 5.8 million annually. The report showed that, in contrast, for each percentage point shift in nurse turnover, an organisation will save US\$262,500 (NSI, 2024).

Nursing retention is challenged by the nurse shortage, underscoring a major global concern. The WHO estimated that there will be a shortage of 5.9 million nurses by 2035 (WHO, 2020b). In the United Kingdom (UK), 26,755 nurses left the Nursing and Midwifery Council Register from the start of March 2022 to February 2023 (Nursing & Midwifery Council [NMC], 2023). It is noteworthy that 52% of registered nurses leave earlier than expected, whilst a quarter leave “a lot earlier” (NMC, 2023). In the USA, the US Bureau of Labour Statistics has anticipated nursing vacancies will increase by 6% annually from 2020 to 2032 and, by 2032, 3,349,900 more nurses will be needed to meet the demands of the health system (Bureau of Labor Statistics, 2024). The National Council of State Boards of Nursing [NCSBN] and the National Forum of State Nursing Workforce Centers forecast that 800,000 American nurses will resign by 2027 (NCSBN, 2024). The projection statistics are from a national survey conducted by Martin et al. (2023).

Nursing retention is commonly further impacted because nurses are a mobile workforce (Al Zamel et al., 2020; Ayalew et al., 2019; Jilani, 2019; Min et al., 2023; Weninger Henderson, 2020; Winkelmann-Gleed et al., 2022). There is strong evidence that nurses are attracted to better remuneration packages (higher salary, higher superannuation rates, relocation allowance, career progression, work–life job fit or work–life balance) and better working conditions (manageable workloads, suitable rosters, and team support) (Al Sabei et al., 2019).

Early career nurses or newly qualified nurses (NQNs) are pivotal to the future nursing workforce. Continued support for NQNs, early career nurses, or novice nurses leads to job satisfaction and retention (McIntyre et al., 2024). One of the key elements for nurse retention is respect for nurses (Almost & Mildon, 2022). As explained earlier, respected, valued, and appreciated nurses are happier and continue working. NQNs finding their way in a new

environment need professional and social connections to feel included, which leads to retention (Ke & Stocker, 2019). The initial months are important for NQNs because positive experiences, recognition of work done, a sense of accomplishment, and positive encouragement will inspire them to remain. Conversely, negative experiences such as shock, not feeling part of the team, and ongoing stress will lead to ITL and turnover (Almost & Mildon, 2022; Ke & Stocker, 2019).

## **NZ Context**

In NZ there is a constant movement of NZ-trained RNs to Australia, where RNs receive a better pay package and standard of living (Howell, 2024; Thornber, 2024). This is attractive to all nurses, especially early career nurses. The loss of RNs to Australia puts pressure on the NZ health system as the NZ population increases, and the health sector cannot support the growth. Statistics NZ-Tatauranga Aotearoa (2024) data show that NZ's population has grown to 5,338,900, a 2.5% increase from 2023. Australian nursing recruitment agencies are consistently recruiting NZ nurses and, to date, there are no mandates from the NZ Government to control this situation, despite our health system now being referred to by New Zealand Nurses Organisation [NZNO] Chief Executive Paul Goulter as an "improvised, ineffectual health system" (NZNO, 2024). Mr Goulter again raised concerns over the government's cost cuts on staffing and the lack of response to the growing nurse shortage due to burnout, poor wages, and unhealthy working conditions (NZNO, 2024). Australia is also facing a nurse shortage despite higher wages in Australia, and Health Workforce Australia [HWA] predicts a shortfall of 100,000 nurses by 2025 and over 123,000 by 2030 (HWA, 2014).

In NZ in 2013, the Nursing Council of New Zealand (NCNZ) forecasted a shortfall of 15,000 registered nurses by 2035 (NCNZ, 2013). Data from the NCNZ *Annual Report* in 2023 showed an increase in nursing registration from 57,833 in 2018–2019 to 69,621 at the end of March 2023 (NCNZ, 2023). Despite the growth in nursing numbers, mostly from internationally qualified nurses (IQNs), the NCNZ acknowledged the nursing shortage nationwide (NCNZ, 2023). In NZ, Te Whatu Ora's *Health Workforce Plan* published in July 2023 referred to nurses as the "foundational workforce" (Te Whatu Ora, 2023, p. 32) which was under pressure, needing 4,800 nurses at the time of the report, and demand was projected to rise above 8,000 nurses by 2032 (Te Whatu Ora, 2023d).

Nursing retention is impacted by factors like government reduction in expenditure by freezing staff hiring to save money, care demands from an ageing comorbid population, population growth, global migration pathways, the changing workforce, demand and supply issues (International Council of Nurses [ICN], 2023), nurses close to retiring, and increased patient acuity and volume. The ICN's (2020) report found that, pre-COVID-19, many nurses were already under intense pressure from working with low staff numbers, and during COVID-19, many nurses died or left; nurses are currently reconsidering their career options. The ICN research

shows that more than 1,000 nurses have died of COVID-19 in 44 countries, but the actual figure is much higher due to underreporting by some countries (ICN, 2020). In response to the post-COVID-19 pandemic situation, the ICN's 2023 report, *Recover to Rebuild*, has labelled the state of the health workforce as a "global health emergency" (ICN, 2023), reiterating the further pressure on burnt-out nurses post-COVID-19 to fill vacancies (ICN, 2023). The report called for urgent action, government policy changes, and nurse retention investment.

Furthermore, the implications of turnover are huge demands placed on stretched nurses leading to occupational stress. Studies have confirmed that occupational stress leads to burnout, missed care (Ball et al., 2018; Cho et al., 2020; Nantsupawat et al., 2022), decreased work engagement, job intention dissatisfaction, ITL, increased risk of nosocomial infection, and sentinel events and increased mortality rates (Aiken et al., 2002; Aiken et al., 2009; Aiken et al., 2014; Javanmardnejad et al., 2021; Tourangeau et al., 2007; Yu et al., 2021). Ensuring there are plenty of nurses in an ED results in happiness and job satisfaction among nurses, which improves the quality of nursing care, encourages teamwork, and minimises the risk of errors (Anderson et al., 2021; Javanmardnejad et al., 2021).

Unless immediate government investment in nurse retention is undertaken to address these problems and implement retention strategies (WHO, 2020), nursing turnover globally will continue to increase. Therefore, strategies to retain nurses are crucial.

The next three sections, significant media reports are discussed, a timeline of key events is presented, and tensions between policy and practice in NZ are considered. The period covered by the selection of media reports is from November 2, 2019, to December 5, 2024.

### ***Summary of NZ media reports on ED nurse staffing***

In New Zealand, media reports have highlighted concerns about ED staffing and ongoing risks to healthcare in EDs. New Zealand EDs are under pressure due to population increases, ageing, increasing complex patient presentations, under-resourced medical teams (Jones & Jackson, 2023), ambulance ramping, long wait times, lack of space, and, often, 95–100% bed occupancy (Daalder, 2023; Quill, 2024; Quinn, 2024). The Shorter Stay in ED (SSED) six-hour target was introduced to improve flow because there is compelling evidence that patients who stay longer in ED have poor outcomes. Looking at NZ EDs, for the quarter July 1 to September 30, 2023, (compared to July to September 2022), there was a 4.7% decrease in patients staying in ED under six hours, from 72.35% to 67.6%. The lack of beds and high patient occupancy rate negatively impacted the SSED six-hour target. Hospitals in smaller rural areas achieved their target compared to busy metropolitan hospitals/significant trauma centres (Te Whatu Ora, 2023a). In NZ, a press statement released on September 7, 2023, stated that there were 1.2 million patient presentations to ED with patients waiting longer than six hours, five times more than previously reported (Hickman, 2023). Data for ED nurse turnover in each hospital is unavailable, but on

March 28, 2023, the National Party's Health spokesperson Shane Reti (subsequently the Minister of Health from November 2023 until January 2025) (Reti, 2023) was concerned that data regarding the number of vacancies in EDs was unobtainable even after an expenditure of half a billion dollars (Reti, 2023). On December 6, 2022, a press release by Shane Reti indicated there were 230 ED nursing vacancies, and 4,000 nurses short across the country with provincial areas suffering the most (Reti, 2022). This shortage meant more pressure on EDs with major trauma centres, significantly those EDs in the rural parts of NZ. This is a problem because rural areas with EDs have no high-tech equipment, intensive care units (ICUs), or theatres like significant trauma centres, not to mention that there are fewer nursing staff (Reti, 2022). Another impact of nursing vacancies is delays in patients being assessed and treated, longer wait times (sometimes up to 24 hours), and patients leaving ED without being seen by a nurse or doctor (Reti, 2022). The Clinical Performance Metrics statistics for July 1 to September 30, 2023, show that ED presentations increased by 6.3% from 317,051 to 336,999 in the last quarter (Te Whatu Ora, 2023a). Despite unions such as the Association of Salaried Medical Specialists (ASMS), the New Zealand Nurses Organisation (NZNO) and College of Emergency Nurses New Zealand (CENNZ) releasing several policy statements raising concerns about patient: nurse ratios, burnt-out medical and nursing staff, overcrowding, ambulance ramping, and unsafe staffing, and calling for the government to address staffing shortages in EDs, there is still significant concern. Currently, no definitive action has been taken to eliminate the staffing shortage. The media continues to report issues such as visas for overseas-trained nurses and ongoing mass exodus to other countries for better working conditions. No practical solutions to ED nurse retention are currently in place.

### ***Timeline of key events in NZ EDs***

In this section key events linked to ED workforce reported in the media are summarised in chronological order. The date range is from 2019, pre-COVID-19, to December 2024.

**November 2, 2019:** a report called *Hospitals on Edge* was released by the Association of Salaried Medical Specialists (ASMS, 2019). The report contained verbatim comments from concerned ED staff about the inability to provide person-centred care because of an inefficient health system and the fact that there were more ED presentations than the rate of population growth. In addition, there were comments about high bed occupancy rates, lack of space, overcrowding, increased number of patients with life threatening illnesses, patients waiting, at times, 16 hours for a bed, low nursing levels, morally distressed and burnt-out staff. It was also reported on **August 29, 2019**, that ambulance staff were instructed to keep sick patients up to two hours outside EDs because of overcrowding (Russell, 2019).

**February 28, 2020:** a sentinel event was a patient death in which a junior doctor was caring for 50 patients by himself and could not attend to an elderly patient at Gisborne Hospital (Quinn, 2024).

On the same date, the first COVID-19 case was reported, and the first COVID-19-related death was on March 29, 2020.

**March 25, 2020:** a State of National Emergency was declared until May 13, 2020. In Auckland, the COVID-19 lockdown of over 100 days resulted in a reduction in ED presentations, but there was anxiety and fear amongst medical doctors and pathology labs that patients would not seek help from EDs (Newton & Espiner, 2020). Media coverage reported that the public felt hospitals were only for COVID-19 and feared they might catch diseases.

**April 22, 2021:** a patient collapsed and died in the ED toilet of Middlemore Hospital (MMH). The coroner's report stated delays in assessment and treatment, ambulance transfer, overcrowded ED and ED being in 'code red' were factors leading to his death (Morrah, 2024b). 'Code red' is when the demand for patient care is more than the capacity of nursing staff at a given time within the organisation. Hospitals often colour their status red when reporting, indicating overcapacity and the need for planning and action.

**June 9, 2021:** nurses went on strike. Nurses, as members of the NZNO, rejected the DHBs' pay equity offer of 1.38% pay increase because they wanted a 17% increase instead (Wait, 2021). Consequently, more than 30,000 nurses went on a strike on June 9, 2021, which led to the cancellation of elective surgeries (Trigger, 2021a). The news media (*NZ Herald* and *Radio New Zealand*) reported nurses were angry and frustrated from working in unsafe conditions and therefore unable to offer quality nursing care (Quinn, 2021). In addition, it was reported that nurses sacrificed much during the COVID-19 pandemic to ensure all New Zealanders were safe (Quinn, 2021), and that the proposed pay offer did not meet their expectations, or cover the rising cost of living and inflation (Quinn, 2021; Russell, 2021).

**July 8, 2021:** Wellington Hospital ED was issued with a Provisional Improvement Notice (PIN), and, on July 23, it was reported that 11 nurses had resigned within 10 days (Trigger, 2021b). ED nurses felt unsafe working in a crowded ED with long wait times and increased volume of patients. Under the Health and Safety at Work Act 2015 (HSWA) or regulations, the Health and Safety Representative (HSR) can issue a formal notice when there are health and safety concerns within a workplace. This notice is commonly called a PIN, and the organisation must act upon it within a set timeframe to ensure a safe workplace (Trigger, 2021b).

**January 24, 2022:** the ASMS chairperson, Sarah Dalton, called for a declaration of a health workforce emergency akin to a civil defence emergency because of concerns regarding the shortage of doctors and nurses. She was concerned about the arrival of the Omicron variant of COVID-19 and most EDs were working at 120% capacity while being

understaffed. Several PIN notices and ‘code reds’ were issued to EDs because of long patient waiting times, ambulance ramping, and poor care of mental health patients. COVID-19 and the flu caused an increase in the number of patients and overcrowding, resulting in ambulance staff spending an additional 3,000 hours in transferring patients in May 2022 (Dalton, 2022).

**June 15, 2022:** three PIN notices were issued by HSRs supported by NZNO to Palmerston North ED, which urged the hospital and government to look at overcrowding, lack of staff, stress, unachievable workloads, sick leave, burnout and resignations (Rankin, 2022).

**June 16, 2022:** a patient at MMH died after presenting to ED and leaving due to long wait times. It was reported that 94 patients were still waiting to be seen the next morning in ED (Harris, 2022).

**July 5, 2022:** winter and COVID-19 led to a patient surge, and again, there was apprehension about the arrival of the new BA.2.75 COVID-19 Omicron variant from India (Martin, 2022).

**October 20, 2022:** *Newshub* revealed that, according to Te Whatu Ora, there were 112 ED nurses needed across Auckland, Waikato, Wellington and Christchurch. Patients reported to *Newshub* about long waiting hours and six-hour delays in EDs (Truebridge, 2022).

**October 24, 2023:** a significant event occurred when 150 staff at Auckland ED complained to Te Whatu Ora-Health New Zealand about ED and called for safe patient: nurse ratios (Spence, 2023).

**May 2, 2024:** another report following *Hospitals on Edge*, called *Anatomy of a Crisis*, was released by the ASMS. The report aligns with media coverage, which described unwell patients presenting to ED who cannot afford GPs, staff burnout, access blocks, lack of space in hospitals and an increase in the number of unwell mental health patients (ASMS, 2024). Ambulance ramping was also reported (Keene et al., 2024).

**July 31, 2024:** Thames Hospital staff reported that they were short of 20 ED nurses and there was a hiring freeze (Quill, 2024). Nurses in Thames Hospital estimated the shortage of 20 nurses using the Care Capacity Demand Management programme calculation. No advertising for vacancies was allowed. Consequently, nurses and members of the public picketed on July 30, 2024, outside Thames Hospital. ED nurses were stressed because of poor staffing and increased patient numbers and acuity and early closure of Accident and Emergency Departments. Nurses were exhausted from working on their days off. Thames Hospital was not alone in having staff pressures and poor quality of care. At Tauranga

Hospital, a patient with chest pain and breathing problems waited for 11 hours and left without being seen by a nurse or doctor and, similarly, a gas explosion patient with facial cuts waited for nine hours. Likewise, Waikato Hospital was described as, “a third world country,” while Health NZ-Waitemata advised patients to attend ED only if they had life-threatening conditions or else, they would experience long wait times. Pressures were also felt at Whakatāne Hospital. The public responded, citing the unaffordability of GPs and early closure of the after-hours A&E services and the increase in respiratory illnesses led to them seeking help at EDs (Quill, 2024).

The College of Emergency Medicine deputy chair and Clinical Director of Emergency Medicine, Dr Kate Allen, acknowledged that EDs were experiencing unprecedented stress and not coping, and the situations were dangerous.

**August 22, 2024:** a patient died in the waiting room of a busy and understaffed ED in Rotorua Hospital (Hill, 2024).

**August 28, 2024:** patients in the Waikato ED waited for 10-12 hours despite having serious presentations; one patient waited 16 hours with internal bleeding and was discharged to the care of her GP. It was reported that the ED has lost many experienced nurses who are burnt-out from increased numbers of patients, and the lack of beds preventing nurses from attending to new admissions (Akoorie, 2024).

**December 5, 2024:** all EDs in NZ were at 90% bed occupancy with many critically unwell patients waiting to be seen. Dr Peter Jones told the *NZ Herald* that EDs were not meeting targets, and the lack of beds was in the worst state ever. He said that the ED Health Target is important but 80% is more realistic than the 95% (Morrah, 2024a).

In summary, several frustrated and angry nurses and doctors lodged complaints to Te Whatu Ora-Health NZ, informing management of the impact of the ongoing staffing crisis, lack of space, access blocks, understaffing, ambulance ramping, long wait times, patients leaving without being seen, mental health patients going untreated, incidents of violence, and overworked nurses, doctors and diagnostic laboratory therapists and technicians. This scenario repeated itself in 2025, with all EDs not meeting targets and grappling with nurse shortages and stress.

### ***Policy and practice tensions***

NZ media reports suggest that patients receive substandard care because nursing staff cannot perform their duties. This reality violates patient rights, as all patients using services within the DHBs, whether in ED or on an acute ward, have legal rights, such as respect and high medical and nursing care standards, as outlined in the Health and Disability Commissioner [HDC] (Code of Health and Disability Services Consumers' Rights) Regulations 1996. In addition, public health and well-being are safeguarded by the Health Act 1956, which ensures optimal health for patients.

Parallel to this, the legislation provides that all New Zealanders receive high-quality care by competent nurses regulated by the NCNZ. The NCNZ sets out professional standards, guidelines and expectations of all RNs in NZ to provide safe and competent nursing care (NCNZ, 2024). All RNs are regulated under the Health Practitioners Competence Assurance Act 2003. Both nurses and doctors work under the Health and Safety in Employment Act 1992 – aligned with the WHO statement (WHO, 2020), ensuring that all staff within the DHB work in a safe and stable environment (Burgess, 2008). From what has been highlighted, ED nurses and doctors are working in complex, problematic environments, which leads to stress, burnout, and ITL, and they are unable to provide adequate and competent care to patients. ITL leads to job dissatisfaction and turnover. Therefore, factors contributing to NZ ED nurse retention must be addressed.

### **Research Approach and Design**

ID was chosen as a research approach because it provided insight into the lives of ED nurses and the clinical environment in which ED nurses work. Thorne developed the ID methodology, previously called non-categorical ID (Thorne et al., 1997; Thorne et al., 2016). ID is relevant to a professional discipline, such as nursing, in research intended to probe and understand human experiences. This approach aligns well with nursing as it describes phenomena, answers research questions, appreciates existing the knowledge to be built on, and extends and applies knowledge for clinical applications (Thorne, 2014, 2016). ID is a methodology that allows researchers to share their clinical experiences and knowledge, and it appealed to me because of my prior ED nursing experience. ID adopts a clinically based approach to research that has implications for clinical practice, for example, ED nurse retention (Thorne, 2016; Thorne et al., 2004; Thorne et al., 1997). This advantage forms a theoretical scaffolding for beginning the research (Hunt, 2009).

### **Research Aims and Questions**

This research aimed to examine the key factors contributing to successful retention of ED nurses employed by a DHB in New Zealand. The research questions were, firstly, “What are the perceptions of ED nurses in relation to retention?” and, secondly, “What are the success factors contributing to retention?”

The following section briefly outlines Bronfenbrenner’s theory, which was used as the literature review framework.

### **Organisational Framework**

#### ***Bronfenbrenner ecological systems theory***

Bronfenbrenner's sociological theory was selected to help frame this research. The theory identified three levels of society, micro, meso and macro, and has been employed widely in public health and nursing as an organisational framework (Bronfenbrenner, 1981; Bronfenbrenner,

1996). This theoretical framework was chosen because the three-level approach helped frame and organise the literature review, findings and discussion points.

### **Research Positionality**

As a doctoral candidate, I must acknowledge my position within the research. It is essential because the candidate or scholar is accountable for assumptions and values brought to the area studied (Thorne et al., 2016). Therefore, in this section, I briefly cover my previous experience and current role.

### ***Prior to New Zealand***

I have lived and worked in Auckland for 26 years after migrating from a small town called Tongaat, which sits along the Natal coast in South Africa. Natal is known for its busy and complex EDs due to a large population, industries, busy lifestyles, high-impact sports, road traffic accidents and crime. Three prominent people, my father (a boy's scoutmaster, first aider and training manager/consultant), my grandfather (a male nurse, accoucheur and radiographer) and my aunt (a senior nurse lecturer), influenced me to become an RN. I often reminisce about the speed and accuracy with which my family worked in the local and regional EDs and wards, often without enough resources. Growing up, I enjoyed hearing stories of saving patients' lives. Before becoming an RN, I studied law for a year to understand human rights protection. After that, I was employed as a locum teacher in my high school before completing a comprehensive nursing programme. From a personal perspective, my primary socialisation, life experience, and close relationship with family developed an interest in saving lives and gave me insight into the realities of nurses and investing in people, especially ED nurses.

### ***My earlier role as an (ED) nurse***

Since then, I have worked as an RN for 29 years, primarily in EDs in NZ and overseas. During this time, I was again exposed to the demanding and complex work of ED medical and nursing staff and thus became deeply interested in staff retention. ED nurses utilise knowledge, training, and experience to assess young and old patients when they are most vulnerable and treat them at once. From my experience as an ED nurse in NZ and overseas, emergency nursing is not for the faint-hearted. It requires mental and physical strength; a nurse must be alert to assess and treat patients accurately. A nurse depends on their assessment skills and intuition. Emergency nursing requires relying on a team of expert nurses. A nurse is often unaware of stress due to the adrenaline cascade taking over to save someone's life, limb, or organ. There were many shifts with no downtime or debriefing; odd shift work, especially 12-hour busy night shifts, would often leave one exhausted and unable to keep healthy. Nonetheless, I often felt fulfilled and ecstatic when patients' lives were saved. These positive emotions cancelled out negative feelings and helped me cope. I saw many experienced nursing staff leave the ED. There were no exit interviews or investigations into reasons for leaving. Following my move away from ED, I strategically led

workforce development, training, and education in the disability sector before my nurse lecturer role.

### ***My current role as a nursing lecturer***

As a lecturer for acute care, simulation lead and mentor for clinical teachers, I am part of an ecosystem. I supervise students and clinical teachers in EDs and collaborate with RN preceptors who mentor students. Many senior RNs have stayed in the ED for decades and support our students, while some RNs leave after a few years. The professional relationship with ED staff lets me receive feedback on students' performance, which is helpful when designing curricula, planning simulations and pre-clinical preparation sessions, and equipping clinical teachers. Two examples would be acute assessment skills for medical and surgical patients and communication skills, particularly when faced with a deteriorating patient.

Furthermore, I am aware of the first-hand challenges in ED, such as short staffing, sicker patients, gridlocks, and stressed and exhausted staff. RN preceptors are pressured to offer quality supervision to student nurses. Many undergraduates and new graduates are passionate about ED work because of the nature of that work, the adrenaline rush of saving lives and learning new skills. Yet here lies a dichotomy: the same career goals and passion for ED nursing increase stress and burnout risk. Many new graduates are employed and face the same challenges as their RN preceptors. I am concerned that newly qualified nurses must step up while trying to learn and grow, and prove and establish themselves in new professional roles. This research is crucial to understanding what needs to be done to retain nurses, and does so by involving both junior and senior nurses. The research has given me a chance to assist and keep nurses. The following section outlines my research positionality with regard to philosophical concepts.

### ***Philosophical position***

As mentioned before, I incorporated my philosophical assumptions into the research. From an epistemological standpoint, emergency nursing is complex. It involves people interacting with each other through communication in a busy environment, and it is appropriate to understand their reality and their input into nursing retention by speaking and listening to them and seeking truth from their narratives. From an axiology stance, as a researcher, I have reflected and examined my values, assumptions and attitudes that might influence the research and respected the values or views of the interviewees, which can contribute to the research and knowledge of a researcher. I have followed all ethical principles in respecting participants and reduced risk by the application of research rigour. It is valuable to involve all nurses in the ED to gain knowledge of possible success factors. Using an ontological lens, my assumptions about ED nursing are based on my position within the research, the influence of the media, and my ongoing reading of literature around nurse retention and attrition. The rationale behind my choice of the ID methodology resonates with my values and my view that ED nurses face and deal with the realities

of the world and regularly converse with people (patients, doctors and nurses) about their reality and their day-to-day experiences. The ID methodology allows one to reflect on one's past nursing experience, examine data, and reflect on the analysis (Thorne et al., 2016).

### **Key Terminology**

This research uses some specific terminology that is evident in the literature review, discussion, and recommendations chapters.

Retention is when a person stays employed in an organisation or job (Woodward & Willgerodt, 2022). Some of the factors that influence retention are job satisfaction, attachment to work or passion, motivation, positive culture and organisational support (Efendi et al., 2019).

Job satisfaction is a state of satisfaction or contentment, and happiness coming from achievement (Alshammari & Alenezi, 2023; Liu et al., 2016). Studies suggest that job factors like the nature of one's work, positive relationships (Roth et al., 2022), the involvement of all nurses in decision-making, increased pay scales, and balancing family and work (Helbing, 2017; Staempfli & Lamarche, 2020) contribute to job satisfaction.

Job dissatisfaction is when staff are stressed, burnt-out, and unhappy with their job due to lack of support and feeling undervalued, which is evident with poor wages, unhealthy working conditions (stress, lack of resources), a lack of leadership, and a lack of career progression (McDermid et al., 2020; Senek et al., 2020). A change in the expectations of the role is linked to job dissatisfaction.

Pull factors refer to factors that draw a person into a workplace, such as better job opportunities, career advancement, monetary gains, improved standard of living, and an inspiring and positive workplace (WHO, 2021).

Push factors repel an individual from a workplace due to poor working conditions and low salaries (WHO, 2021). Those negative experiences, which nurses perceive as unfavourable and potentially harmful, causing unhappiness and stress, lead to job dissatisfaction (Alharbi et al., 2022; Roth et al., 2022; Sasso et al., 2019). Push factors are linked to the ITL when nurses feel stressed, unhappy, undervalued and unsupported (WHO, 2021).

Occupational stress is apparent when there is a mismatch between job control, skills and demands (Maslach & Leiter, 2008; Maslach & Leiter, 2022); thus, nurses are more vulnerable to physical and mental problems (Erwan et al., 2020; Li et al., 2018). When stress is constantly experienced, and beyond a nurse's capacity, burnout is a consequence (Erwan et al., 2020; Lee, 2024; Li et al., 2018).

Burnout is a state of excessive physical, emotional, and mental fatigue and frustration caused by chronic involvement in emotionally demanding situations. Burnout has poor outcomes

for nursing, causing unhappiness, job dissatisfaction and ITL (Maslach & Leiter, 2008; Maslach & Leiter, 2022).

Turnover or attrition is when a person working in an organisation leaves (Bae, 2022; Woodward & Willgerodt, 2022). Some of the factors that influence turnover are lack of organisational support, remuneration, professional development and/or career advancement, and also stress and job dissatisfaction (Marufu et al., 2021).

Compassion satisfaction describes the positive emotions that come from assisting patients experiencing trauma (O'Callaghan et al., 2020) and feeling gratified from caring for others (Hooper et al., 2010; Simon et al., 2005). Other feelings related to compassion satisfaction may be pleasure arising from wanting to enhance patients' well-being, forming relationships, peer support (Sacco & Copel, 2018) and motivating nurses to work (Yu et al., 2021).

Compassion fatigue is when one is physically and mentally drained when assisting patients suffering physically and mentally (O'Callaghan et al., 2020). If compassion fatigue is not detected early, it can lead to stress, job dissatisfaction, burnout and turnover (Francis-Wenger, 2024). Other consequences of repeated stress are post-traumatic stress disorder (PTSD) or secondary traumatic stress disorder (STSD) (Figley, 2013). PTSD has gone through several definitions but is a disorder caused by repeated trauma and stress that negatively affects mood and behaviour exhibiting clinical signs such as anger, and impulsiveness for longer than 30 days (Wolf et al., 2020). STSD is the result of post-traumatic stress due to personal or professional connections (Barleycorn, 2019; Figley, 2013; Ratrout & Hamdan - Mansour, 2020; Wolf et al., 2021) or when nurses experience stress from repeated exposure (Wolf et al., 2020).

## **Thesis Organisation**

The thesis is divided into six main chapters.

**Chapter One**, the present chapter, has introduced the topic of nursing retention, its significance, background, context, aims of the research, a brief outline of methodology, theoretical framework and research positionality including both professional and personal reasons for this research, and a thesis breakdown. The chapter has set the scene and context.

**Chapter Two** focuses on the literature review. The empirical findings from a review of relevant journal articles are arranged using Bronfenbrenner's framework, which has three levels: micro, meso, and macro. The gap in the literature on ED nurse retention is that no studies have been conducted on this issue in New Zealand.

**Chapter Three** focuses on the research design. The chapter uses the research onion to explain the ID methodology and the philosophical underpinnings of this research. Here, epistemology, ontology, axiology and qualitative ID, the specific methodological choice, are

outlined. Research methods, such as sampling, ethics, recruitment, interviews, data collection, data analysis, rigour and critical reflection, are discussed.

**Chapter Four** reports the findings and presents six main themes and subthemes. Each subtheme has corresponding participant quotes linking to the overall main themes. The chapter is presented using the organised framework of micro, meso and macro levels. Theme one, personal satisfaction from being an ED nurse, captured reasons for taking the role. Theme two, using ways of coping, captured how nurses coped in the ED. The third theme, workplace tensions, captured nurses' experiences, struggles, and challenges while working on the floor. Theme four, professional development is important, captured the significance of training and education for all ED nurses. Theme five, we all chip in, captured supportive relationships between team members in ED. Theme six, dissatisfaction with organisational structures, was centred on the effect of existing systems, processes and structures within the organisation.

**Chapter Five** provides a critical discussion of the summarised findings as compared and contrasted with the empirical literature. The chapter is presented using the organisational framework of micro, meso, and macro, which is integrated with literature on push (negative) and pull (positive) factors for ED nurse retention.

**Chapter Six** covers the conclusion and recommendations for policy, nursing education, training, and clinical practice, plus strengths and limitations. A reflection is also presented in this chapter.

## **Summary**

This chapter has presented an introduction to this thesis on the retention of emergency nurses. It covered background and rationale, research significance, NZ context, summary of media reports from November 2, 2019, to December 5, 2024, grey literature, practice and policy tensions, chosen research design, organisational framework, positionality, terminology and thesis organisation. The next chapter reviews the key literature.

## Chapter Two: Literature Review

### Introduction

This literature review chapter is divided into main sections and subsections. These are aims and objectives, summary of key national and international workforce documents, summary of key ED NZ documents, integrative literature review, search strategy, inclusion and exclusion criteria, search results, selected journal articles, micro, meso and macro level breakdown of the literature review, summary and gaps. The main findings of the micro level are that ED nurse retention is related to the positive aspects of ED nursing such as nature of work, unpredictability, challenges, and compassion satisfaction while coping strategies can assist with stress in ED. The meso level found that effective teamwork is a strong predictor of nurse retention, whilst poor teamwork leads to job dissatisfaction and ITL. The macro level found that incentives, supportive leadership, professional development and change in work culture, are significant for staff happiness and retention. The chapter ends with a summary and gaps in current knowledge around ED nurse retention.

### *Aim, objectives and questions*

The objective of the literature review was to examine both local and international literature related to the research questions, and thereby to understand factors for retention. This research into ED nurse retention aimed to examine the key factors contributing to successful retention of ED nurses employed by a DHB in New Zealand. The research questions were, firstly, “What are the perceptions of ED nurses in relation to retention?” and, secondly, “What are the success factors contributing to retention?”

An integrative review was used to review empirical research on ED nurse retention and to identify a literature gap. Three main questions were integral to the review:

- I. What are the perceptions of ED nurses working clinically?
- II. How do these perceptions influence the retention of ED nurses?
- III. What are the success factors for ED nurse retention?

Initially, there is a summation of ED challenges, identified in key workforce documents published between 2019 and 2024, and other literature and media reports from both global and New Zealand sources.

### **Summary of Key National and International Workforce Documents**

A review of national and international workforce literature was undertaken, covering the period from January 1, 2019, until December 31, 2024. The key relevant documents were from the Organisation for Economic Cooperation and Development (OECD), the ICN, the WHO, and the International Labour Organization (ILO). For New Zealand, relevant documents reviewed are

from the Ministry of Health (MOH), Care Capacity Demand Management (CCDM), Safe Staffing Healthy Workplace (SSHW) and Health Workforce Plan websites.

Furthermore, a careful examination of key workforce literature: reports, policy statements, and registers were reviewed for relevance that could help with understanding the background and current information related to the retention of ED nurses. Some of the data and statistics were made available to readers under the Official Information Act 1982 (OIA). New Zealand media sites, the *New Zealand Herald*, *Newshub* and Stats NZ Tauranga Aotearoa were closely monitored for local, national and international news or reports related to ED nurse retention and workforce development. From the media, unhealthy working conditions (understaffing, pressurised medical staff, delays in care, violence, access blocks, bed occupancy, and gridlocks) causing stress and burnout amongst medical and nursing staff were consistently reported (Hickman, 2023; Spence, 2023).

In 1961 the OECD was established to create improved policies for better lives, share knowledge about global healthcare, societal, economic and environmental problems, for example, climate change, and learn strategies from other countries to find solutions (OECD, 2024). New Zealand joined the OECD in 1973. In April 2024, the OECD released a policy brief called *Are Working Environments for Health Workers Improving?* which acknowledged similar health challenges, such as a growing, ageing population, increased costs, increased patient expectations and subsequent pressure on staff (OECD, 2024). Lowered performance, differences in perception of patient safety between organisations and front-line staff, workplace stress lowering job satisfaction and retention of staff and, investment in staffing, were some of the key messages in the *Are Working Environments for Health Workers Improving?* policy brief document (OECD, 2024). In 2023, the WHO (2023) urgently called for EDs to be safe and healthy working environments with adequate resources, such as trained staff and equipment; additionally, the WHO acknowledged that COVID-19 was still a problem for countries (WHO, 2023). Likewise, the ILO's *Centenary Declaration for the Future of Work* emphasised staff safety and treating staff with respect and dignity, including those working in the health sector, such as emergency services (ILO, 2019). In response to these statements from OECD, WHO and ILO, the ICN's 2023 report, *Recover to Rebuild*, recommended urgent and long-term government action to sustain the nursing workforce through funding, leadership training, empowering nurses to pursue advanced roles, reduction in stress and ITL and ongoing professional development (ICN, 2023).

### **Summary of Key ED NZ Documents**

In New Zealand, the National Emergency Department Advisory Group developed the Ministry of Health Quality Framework and Quality Measures Suite in 2014 (National Emergency Department Advisory Group, 2014). The framework outlines indicators stating that EDs must provide accessible care, meet patient priorities, educate ED patients, and not deny care to any

persons presenting at an ED. As part of the SSHW priorities, a governance framework known as the CCDM programme, which addresses staffing levels across acute settings, was implemented in 2010 in three DHBs. The CCDM initiative arose from a collaboration between the NZNO and DHBs following concerns around staffing levels in 2006. Since implementation, most wards within each DHB have reported that the CCDM programme (Trendcare) has been helpful (Nursing Advisory Group, 2022). However, a review called the Nursing Safe Staffing Review (Nursing Advisory Group, 2022) found that this programme was only partially implemented in EDs because of a lack of IT support and low staffing.

In response to the CCDM initiative, the CENNZ fed back that the existing short staffing and patient surges failed to meet the measurement indicators (needs of acute patients, safe standard of care in ED) outlined in the Ministry of Health Quality Framework and Quality ED Measures, and that there has been no improvement in the ED environment. The CENNZ identified that the CCDM initiative did not assist nurses in achieving the six-hour target; and that patients remained in the ED for 36 hours for assessment and treatment. Furthermore, the CENNZ called for the Minister to urgently respond to low staffing levels, increased patient volume, stressed nurses often distracted by general nursing duties rather than ED priorities, and inability to offer Māori and mental health patients the best care. The college wanted increased staff funding for nurse educators and leaders, the involvement of nurses in clinical policies, and psychological support for nurses (Nursing Advisory Group, 2022).

This situation can be compared to Australia, where the Australian Safe Staffing Levels (SSL) Taskforce rolled out a similar programme in May 2023 which led to a government boost in staffing: 2480 nurses over the next four years until June 2027 including a transition period. At the time of writing, the Australian Government has delivered on its promise for an ED with 30 treatment areas and 10 nurses on duty, and the patient: nurse ratio is now 3:1 in EDs in New South Wales (New South Wales Government, 2024).

The Health Workforce Plan 2023/2024 states that all New Zealanders must have equitable access to high-quality emergency and specialist care when they need it, wherever they live. The plan acknowledged staffing pressures leading to nurse turnover (Te Whatu Ora, 2023d). Strategic workforce development and management plans within this government plan align with the Pae Ora (Healthy Futures) Act 2022 in wanting more investment in nurse training, ways to reduce undergraduate nurse training turnover, inspire young people to take up nursing, and close pay disparity gaps. This plan is yet to be evaluated. Nevertheless, despite the current staffing situation, on April 1, 2025, the Minister of Health and Minister for Pacific Peoples, the National Party's Shane Reti, called for a national freeze on all nurses' and doctors' vacancies/jobs, restricting staffing, cutting vacant roles for efficiency and moving funds to frontline locations and bringing in more doctors (Reti, 2025). In response to the press statement, the opposition Labour Party health spokesperson, Ayesha Verrall, perceived that this move was causing New Zealand to

regress. She stated that 2,000 RNs were employed in 2023, but a brand-new theatre in North Shore is vacant due to a lack of staffing (LabourVoices, 2024).

## **Integrative Literature Review**

The same key questions noted earlier were posed for the integrative literature review:

- I. What are the perceptions of ED nurses working clinically?
- II. How do these perceptions influence retention of ED nurses?
- III. What are the success factors for retention of ED nurses?

### ***Search strategy***

The search strategy encompassed a search of the electronic databases of Cumulative Index to Nursing and Allied Health Literature (CINAHL), Scopus, Medline, PubMed, AUT Google Scholar, Google, Science Direct, Ovid and Cochrane. Bibliographies were scanned for other studies. The work of authors who published other books or articles on similar topics was reviewed and checked for relevant studies with high citation metrics for each journal article. Initially, the search terms used were: “emergency nurse” OR “trauma nurse” OR “registered nurse” OR “nursing staff;” combined with AND “outcomes;” AND “retention” OR “attrition;” AND “accident and emergency” OR “casualty department” OR “emergency care;” AND “stress” OR “burnout.”

To answer research question number one, “emergency nurse” AND “perception” OR “attitude” OR “opinion” OR “experience” OR “view” OR “reflection” OR “beliefs” was added to a search alert. Later, following the first few interviews, “nurse” OR “nursing” OR “nurses” AND “out of scope” OR “deviation” OR “expectation” OR “non-nursing” AND “role” OR “responsibilities” OR “duties” AND “emergency department” OR “emergency room” OR “accident and emergency” OR “accident & emergency” OR “A & E” was added.

The combination of these terms and examination of all descriptors proved helpful in staying close to the research questions. Although the focus was on retention, the results of the first set of five groups of search terms spoke to global issues such as nurse attrition or turnover in relation to ED nurses, so the additional search terms were added to broaden understanding of the phenomenon. The table in Appendix A shows this search strategy, alerts created and subject terms.

### ***Inclusion and exclusion criteria***

Literature was included that was dated from January 1, 2019, to December, 31, 2024 and written in English, peer-reviewed and related to emergency nurse turnover or retention. Previous studies from before 2019 were kept if they reported some correlation with ED nurse experiences, perceptions, success factors and were seminal work. Articles regarding surgical, medical, primary

healthcare, critical care, intensive care, and paediatrics were excluded, as well as those not in English.

### ***Search results***

The database results were screened for quality and relevance and included articles from the UK, NZ, the USA, Australia, and Canada. Only English-language peer-reviewed journal articles were selected. Scopus citation tracking and alerts were used to broaden the range of articles and keep the researcher up to date with any newly published articles. The search identified 200 articles, from which 20 articles were selected as they addressed the research question. As outlined in Chapter One, Bronfenbrenner's (1981) ecological theoretical framework was used to organise the literature into three levels: micro (personal and professional factors/characteristics), meso (interpersonal and interprofessional relationships), macro (organisational factors, incentives, leadership, culture, and economic factors).

### ***Selected articles***

The following sections review the 20 articles identified in the literature search described above. Bronfenbrenner's framework was applied in the literature review to assist in considering not just the nurses' individual, personal or professional traits but also how other influences, for example, teamwork, leadership, culture, and economic and social consequences, impact on the role of an ED nurse. The first level of Bronfenbrenner's framework, the micro level, is centred on the nurse's physical and psychological experiences working in ED; the second level, the meso level, is the relationship between the nurse and multidisciplinary team members. The meso level can have a relationship with the micro level, for example, poor perception of working with other nurses and experiencing moral distress and burnout. The third level, the macro level, focuses on the organisation, structures, processes and systems as well as leadership, management, organisational culture and values, which can influence the micro and meso levels (Bronfenbrenner, 1981, 1996).

The selected articles are reviewed under the headings micro level, meso level and macro level (Bronfenbrenner, 1981, 1996) and include two qualitative studies, 15 quantitative studies and three mixed methods studies. Fourteen studies included ED nurses only as participants, while six included doctors, nurses and administrators. The studies were conducted in EDs in public, private, rural, and urban hospitals. The demographic characteristics of participants that were extracted included age, qualification, role and years of nursing experience.

### ***Micro level***

The micro level, being the innermost, is where the personal factors of the role of an ED nurse, such as cognitive and emotional factors, are evident. Relevant literature is reviewed in five subsections: personal reasons for staying in ED, use of coping strategies, resilience influences

engagement, positive effect of compassion satisfaction, and negative effect of stress in the work environment. ED nurse retention is related to the positive aspects of nursing such as nature of work, unpredictability, challenges, opportunities for growth, adopting coping skills to handle stress, and a sense of accomplishment and meaning when tasks are completed.

#### *Personal reasons for staying in ED*

Reasons for staying in ED can replace reasons for leaving and encourage positivity within the work environment. Van Osch et al. (2018) used an ID methodology to interview ED nurses (n=10) and critical care nurses (n=3) in western Canada, exploring factors that encourage nurses to stay. Findings showed that most nurses enjoy the nature of the work (fast pace, variety, autonomy, use of skills, learning new concepts, teaching juniors), have strong bonds between colleagues and appreciate teamwork (trust, reliability). In addition, nurses value working closer to home and having a choice of shifts. Van Osch et al. (2018) found that many nurses felt respected, valued, and acknowledged when leaders consistently demonstrated clear communication, empathy, engagement, and accessibility, and there was mutual trust and dependability among team members. Even though the sample size was small, with a greater number of ED nurses than critical care nurses, the findings are valuable. The findings showed positive experiences (motivating factors) amongst nurses influenced retention and can cancel out any negative experiences. The authors pointed out that most studies focused more on negative aspects leading to stress, burnout, and attrition, but participants in this study did not mention any negative experiences. Therefore, attention should be given to data from nurses to understand their reasons for staying. Positivity must be reinforced to retain nurses (Van Osch et al., 2018).

#### *Use of coping strategies*

Coping strategies for junior nurses stem from senior nurse and peer support, regular debriefing and positive attitudes. Power et al. (2022) conducted a qualitative study interviewing junior nurses working in ED in London. Junior nurses with less than three years' experience (n=11) were chosen because the study sought to understand their positive or negative experiences as early career nurses and the potential coping skills that could minimise negative experiences. Junior nurses have not yet learnt the range of coping skills possessed by senior nurses, and the identification of the protective mechanisms needed to cope was another reason for this study. The participants described positive aspects of their reasons for choosing ED work, such as being drawn to unpredictability, constant learning, challenges, supportive peers, and progression. Professional development was evident as participants acknowledged a workplace that promoted learning with highly knowledgeable staff who were always available. ED provided many opportunities to learn, grow, build confidence, and improve communication skills by participating in challenging scenarios. Senior nurses regularly created an environment for learning whilst working closely

with their junior colleagues. Following learning on the floor, junior nurses recapitulated content covered in the work environment through self-study (Power et al., 2022).

The findings of this study about the negative aspects of the work were consistent with other studies (Gorman, 2019; Horvath & Carter, 2022): stress from workloads, inability to complete tasks, lack of time, lack of space (overcrowding), witnessing sudden death, “flashbacks”, trauma, and exposure to violence and aggression. In this study, participants expressed concern over the risk of violence and aggression from patients and families, and were more conscious of this risk. Their anxieties and worries were perceived as a psychological roadblock to caring for other patients (Power et al., 2022). Negative experiences such as these could lead to nurses reflecting on whether the ED nurse role was worthwhile. Senior nurses supporting junior nurses helped lessen the impact of negative experiences, together with debriefing. In addition, a number of junior nurses felt that challenges helped them learn and grow. However, some participants’ perspectives on debriefing varied; some nurses preferred not to have a debrief immediately after the event, whilst some were comfortable with a debrief with the team post event. Despite this, protective factors, such as debriefing, peer support, senior nurse support, solid social connections and acceptance of ED as an ever-changing workplace, were identified as coping mechanisms. The researchers concluded that these help with resilience. Adequate time must be given for teaching and supporting junior staff. Therefore, seniors mentoring junior staff, a learning environment, debriefing, open communication, teamwork, coping skills and resilience building are essential to retaining nurses (Power et al., 2022).

The use of positive coping strategies is important to minimise the effect of stress. Elder et al. (2019) conducted a cross-sectional survey (189 nurses and 46 doctors) looking at perceptions of staff work, stressors and use of coping strategies in two hospitals in Queensland, Australia. Mostly positive coping mechanisms such as humour, objective discussion, maintaining peace and calm were used, but some negative coping mechanisms (blaming oneself, yelling, anger) were heard. Findings were consistent with other studies in ED, indicating that occupational stresses arose from heavy workloads and inexperienced staff, sicker patients, with the most stressful events being the death of a child and abuse of a child (Elder et al., 2019). The authors suggested that more work should be done on the use of positive coping mechanisms to deal with stress rather than negative coping strategies. Limitations acknowledged by the researchers were that organisational factors were not considered, and that the study was done at a set period and not extended. Studies have found that nurses who are stressed use positive and, at times, negative or maladaptive coping mechanisms to enable them to work (Elder et al., 2019). Debriefing, conversations, humour and exercise appear to some of the main positive coping mechanisms. However, a small number of nurses have been reported to use negative coping skills such as blaming oneself and pushing the problem away or acting as if the problem is non-existent. These

negative coping skills leads to further stress (Elder et al., 2019). The next section expands on resilience.

#### *Resilience influences engagement*

Nurses' job satisfaction, resilience, and moral distress affect workplace engagement. Clark et al. (2022) conducted semi-structured interviews with ED nurses (n=14) in two mid-western and south-western states in the USA to investigate how job satisfaction, resilience and moral distress impacted engagement. The results showed that resilient and engaged nurses could handle pressures and challenges due to their life experience. Nurses who were unhappy with their jobs due to moral distress had less resilience and were not engaged in taking on extra shifts and department activities. Nurses with confidence in skills and coping mechanisms and more experience showed increased resilience and workplace engagement, but those nurses who did not have autonomy or were unable to achieve a transformation in the workplace showed less resilience. These nurses worked in areas with conflict and safety issues and thus were distressed and disengaged. Other findings were that engaged nurses are more willing to help in other projects and offer to pick up extra shifts and remain in the ED. Moral distress led to nurses being disinterested in projects, refusing to pick up extra shifts to help colleagues, and not wanting to engage with colleagues and make social connections. Staff felt neglected when there were heavier workloads, sicker patients and a lack of support, causing moral distress. This study implied that managers must build activities of resilience and engagement with staff, enhance relationships between colleagues, and foster teamwork. These strategies can increase resilience and engagement, improve job satisfaction, decrease moral distress and lower ITL (Clark et al., 2022).

#### *Positive effect of compassion satisfaction*

Compassion satisfaction refers to all positive aspects of work, such as a sense of accomplishment, joy, or gratification when assisting patients (Francis-Wenger, 2024; O'Callaghan et al., 2020). The opposite is compassion fatigue, which renders ED nurses emotionally drained and exhausted, leading to stress and dissatisfaction (Francis-Wenger, 2024; O'Callaghan et al., 2020). Compassion satisfaction can offset the negative aspects of work such as stress and fatigue (Hooper et al., 2010). O'Callaghan et al. (2020) conducted a quantitative cross-sectional survey using a Professional Quality of Life: Compassion Satisfaction and Compassion Fatigue scale (ProQOL) in two large urban hospitals in Melbourne, Australia. Researchers found that nurses experienced compassion satisfaction, but some were fatigued and stressed. Lack of organisational support, job characteristics (high workloads and acuity), and the type of patients (aggressive) were perceived as negative and stressful. Younger nurses experienced higher levels of compassion fatigue than senior nurses. Compassion satisfaction arose from helping patients, working with supportive colleagues, and accomplishing clinical tasks. O'Callaghan et al. (2020) found average to high levels of compassion satisfaction and low

to high levels of compassion fatigue. The findings were significant for nurse leaders in reducing stress levels at work and helping limit staff burnout.

#### *Negative effect of stress*

Seven studies were selected to understand the negative effect of stress on ED nurses in relation to retention.

Stress in the work environment has a negative effect on nurses. Alomari et al. (2021) conducted a cross-sectional survey using a correlational design in western Sydney, Australia. The survey saw 190 nurses out of 242 nurses respond. Nurses described three situations that caused stress: dealing with violence and abuse from patients and their families; increased workloads; and uncertain patient management and treatment plans (patients waiting for doctor review). Recommendations offered by the authors were for the organisation to review policies and guidelines to address stress, review the staffing skill mix, offer education and training to reduce stress, and improve nursing competencies to deal with uncertainty. Nurses were stressed from uncertainty regarding treatment plans which may be due to ED doctors not informing them. Less experienced nurses who have recently qualified, or nurses who are otherwise inexperienced, must have better preparation to deal to stress because they can be affected physically and emotionally. Therefore, the researchers recommended specific debriefing programs to assist less experienced nurses cope with stress. Another important finding was that younger nurses would not report the incidence of stress arising from workloads, complexity, and having less experience with trauma than older nurses (Alomari et al., 2021).

Nurses who are better prepared for the role of an ED nurse through formal orientation, tailored to ED, will develop a higher sense of personal accomplishment and decreased intention to resign. Lee et al. (2021) conducted a cross-sectional exploratory survey using the Maslach Burnout Inventory (MBI) tool to examine association between stress and burnout and ITL in Virginia, USA. The MBI measures personal accomplishment, emotional exhaustion, and depersonalisation. The response rate was 77 out of 104; 27 participants were excluded – 15 did not satisfy the inclusion criteria, while 12 failed to complete the questionnaire.

The results showed nurses who underwent the formal orientation reported an improved sense of personal accomplishment which was linked with a decreased intent to leave. The study also found that the likelihood of ITL were approximately 9 times more for nurses with 5 or more years of nursing experience, about 13 times higher for nurses with above-median emotional exhaustion, and greater than 6 times for participants with above-median sense of personal accomplishment (Lee et al., 2021). The strength of the study was the inclusion of all junior and senior staff but also use of a tested tool. The limitation was that not all factors, such as workplace culture, organisational support and caseload, were investigated. The tools focused on a single outcome and did not cover the extent of nurse experience for a comprehensive understanding.

The recommendation was for managers to ensure all nurses attend a formal orientation programme with ongoing mentorship, education and training, and a stress-free and balanced work environment (Lee et al., 2021). Well-supported nurses are more likely to remain in ED than resign (Lee et al., 2021).

The retention of ED nurses is related to the understanding of personality traits and tenure and intention to leave ED (Winters, 2019). Years of experience and personality traits can differ between inexperienced and senior nurses and influence ITL. Winters (2019) conducted a descriptive correlational design to understand the relationship between nurse personality traits, length of service and ITL. Participants were from USA, France, Canada and Australia. Variables such as honesty/humility (sincerity, fairness), emotionality (anxiety, fearfulness) and extraversion (boldness, self-esteem) were used to assess 406 ED nurses with 1–10 years' nursing experience. Results showed differences between nurses with less than 11 months' experience and those with 10 or more years' experience. Nurses who had worked for longer than 10 years had higher scores for humility than those nurses with five years or less of experience. Nurses with up to 11 months of work experience had the lowest levels of humility and those nurses with more than 10 years experience had the highest levels of humility. Those nurses with less than two years' work experience had lower levels of humility and high levels of emotionality compared to the nurses who had greater than 10 years work experience; for emotionality, the nurses who had up to 11 months' experience had higher levels of emotionality than those nurses who had more than 10 years' experience. When examining ITL, nurses with less than two years' work experience and intended to leave within one year were found to have high levels of emotionality compared with those who were more experienced. Senior nurses may not show signs of distress and may not be keen to discuss concerns. The study also showed that nurses with less experience had higher levels of emotionality than the experienced nurses, and this difference may have influenced the junior nurses wanting to leave. There was an acknowledgement that emotionally stable nurses are more likely to stay and managers should understand the dynamic between senior staff and junior staff and bridge the gap. Junior nurses who are stressed face challenges because they are not accepted by the group. Senior nurses do not stress and may not want to discuss issues with other nurses. The implication is that managers should explore ways to connect lesser experienced nurses with more experienced nurses to help new nurses emotionally. This strategy will help retain new nurses.

Stress can lead to STS which, as noted earlier, is the result of post-traumatic stress due to personal or professional connections (Barleycorn, 2019; Figley, 2013; Ratrout & Hamdan-Mansour, 2020; Wolf et al., 2020). Wolf et al. (2020) conducted a mixed-method study with ED nurses, using surveys (n=125) and focus groups (n=53) to understand the proportion of nurses experiencing STS and its effect on practice and workplace in the United States. The results showed high levels of STS amongst nurses with reports of anxiety, insomnia, oversleeping, perseveration, violence, suicidal ideation, and negative coping mechanisms such as numbing and

avoidance. Concerns included nurses' use of negative coping skills, excessive consumption of alcohol or drugs, and the fact that when the stress was unbearable, some would leave ED or the nursing profession entirely. The authors listed positive coping skills such as meditation, physical exercise, and therapy. Recommendations were for debriefing, effective leadership, teaching coping skills, education, simulation, and staff assessment for signs of stress. Further interventional studies can examine this to gauge the effectiveness of these strategies.

There can be mixture of positive and negative emotions within the role of an ED nurse. Amaral et al. (2019) used a descriptive exploratory design to interview nurses (n=10) in Brazil to uncover the working conditions in ED. At one end of the spectrum, nurses expressed pleasure in work and finding work meaningful, similar to the positive experiences mentioned earlier, but at the other end of the spectrum, nurses reported stressors. High stress levels were caused by exhaustion due to the inadequate layout of the hospital, high patient: nurse ratios, time pressures, low numbers of nurses, scant equipment and broken equipment, and poor relationships with patients. Again, the call was made to the organisation to address these issues.

Stress can lead to dissatisfied nurses, resulting in ITL. Wubetie et al. (2020) conducted a cross-sectional study with ED nurses (n=102) in three hospitals in Addis Ababa, Ethiopia, to understand the scale of ITL in ED and to extract factors that will help attract and retain nurses. The findings showed that 79 nurses intended to leave due to dissatisfaction with the work environment, heavy workloads, lack of autonomy, low morale, and poor perception of the organisation. Recommendations were to improve job satisfaction by increasing salaries, offering professional autonomy and professional development, and allowing managers to listen to concerns and intervene early. In the same vein, Moukarzel et al. (2019) conducted a cross-sectional survey in three EDs using a questionnaire incorporating the MBI, the Karasek questionnaire (job strain) and the Medical Outcome Study Form (quality of life). The findings showed that 379 out of 529 participants reported emotional exhaustion and depersonalisation, and approximately one doctor out of two had experienced burnout. The results showed that this group is very susceptible, and interventions are needed to reduce stress and burnout.

A critical point to consider is that nurses may not be aware of the risk of stress and burnout whilst busy in ED. de Wijn et al. (2022) conducted a survey-type study with data collected from 701 nurses out of a total of 949 nurses from 19 hospitals in the Netherlands, to investigate stress, job satisfaction, work engagement and ITL. A large group of nurses were happy, committed, and engaged in their work, but many were stressed due to the demands, conflict, and violent situations, yet they remained. The explanation was that sometimes, in high-demand jobs, nurses overcommit and are unwilling to leave. Nurses can overextend themselves, leading to stress and burnout. Recommendations were for professional development and reducing stress in the work environment (de Wijn et al., 2022).

In this section on the micro level, the key findings from the articles reviewed were around personal reasons for staying in ED, for example, nature of work, compassion satisfaction, and the effect and complexity of stress, the adoption of coping strategies in response to stress, and the relationship of resilience to the engagement of nurses.

The next section discusses the meso level.

### *Meso level*

This section focuses on the relationship between ED nurses, team members and patients. Two main subtopics, teamwork and workplace violence (WPV), are presented. Effective teamwork is a strong predictor of nurse retention, whilst poor teamwork leads to job dissatisfaction and ITL.

#### *Teamwork*

There are numerous studies (Ghezeljeh et al., 2020; Lapierre et al., 2019; Milton et al., 2022; Mohammadi et al., 2024; Rezaei et al., 2021; Zaheer et al., 2021) that researched factors that promote teamwork, but here the focus will be on just two (Lapierre et al., 2019; Zaheer et al., 2021).

Lapierre et al. (2019) conducted a qualitative descriptive exploratory study investigating the factors enabling and preventing interprofessional teamwork. Seven healthcare professionals (head nurse, nurse, nurse assistant, respiratory therapist, orderly, doctor and paramedic) participated in a three-phase study in a polytrauma centre in Montreal, Canada. The interprofessional conceptual framework for teamwork designed by Reeves et al. (2011) was used. The framework consists of four categories: relational, processual, organisational and contextual that are important for teamwork. Through the triangulation of data from focus groups and interviews, the authors found five main categories that impact teamwork (individual, relational, processual, organisational, and contextual), including a novel finding, individual factors. The person's ability to work competently within a team, drawing on knowledge, skills and values, can be improved through training. Also, as mentioned earlier, exposure to massive amounts of stress can lead to fatigue and lowered performance. The study also discussed respect amongst individuals in the team and organisational support, and good communication between team members. Team members who get along with each other, and demonstrate trust and respect, were found to promote interprofessional teamwork, whereas rushing, high workloads, lack of staff and lack of communication resulted in fragmented teamwork. The recommendation was to inform nurses about positive factors that facilitate teamwork in preparation for work (Lapierre et al., 2019).

Likewise, good teamwork leads to nurse retention. Zaheer et al. (2021) conducted a mixed methods study with surveys (n=185) followed by nurse interviews (n=15) in southern Ontario,

Canada; participants were from ED, medical wards, intensive care units, and mental health. A total of 88 surveys were sent to ED with a return of 60 surveys for analysis. The results found perception of leadership and ITL were associated with patient safety. Also, that senior leaders must be visible at the operational level to support staff to offer quality care. The researchers recommended organisational development of nurse retention strategies to reduce ITL, which was linked to poor teamwork and poor safety of patients; there was also a call for more support for leadership and nurses working directly with patients to improve teamwork (Zaheer et al., 2021).

### *Workplace violence*

WPV experienced by nurses in the work environment causes stress, unhappiness, ultimately job dissatisfaction and ITL. ITL is a concern because this leads to staff turnover. There is a plethora of studies on the effect of WPV on ED nurses (Carver & Beard, 2021; Davey et al., 2020; Gillespie & Berry, 2023; Hsu et al., 2022), but here one study will be discussed (Li et al., 2019).

WPV leads to job dissatisfaction. Li et al. (2019) conducted a cross-sectional study involving nurses (n=401) in 13 hospitals in Beijing assessing job satisfaction and turnover. Instruments used to measure job satisfaction were the McCloskey Muller Satisfaction Scale (MMSS) developed by Mueller and McCloskey (1990) and turnover using the Turnover Intention Tool created by Michaels and Spector (1982). There was a response rate of 92.8% with 385 questionnaires coded. Results showed that job satisfaction was lower and ITL was high amongst ED nurses. Recommendations were for managers to implement measures to reduce incidents of WPV, and to lower nurse ITL by offering compensation to increase job satisfaction. The strength of the study was a large sample size across 13 hospitals and limitations were that some participants may not have been able to remember experiences of WPV, and the tool used had only assessed three areas, WPV, ITL and job satisfaction. Other areas like organisational and interpersonal factors were not assessed. Despite this, there were important recommendations, such as managers encouraging open dialogue and the reporting of WPV, coping strategies to lower ITL through help from colleagues, promoting job satisfaction through better remuneration packages, increased salary and suitable shifts, and valuing existing staff who are skilled and competent in ED nursing (Li et al., 2019).

In this section concerning the meso level, nurse retention is related to good teamwork in managing ED challenges such as unpredictable workloads, limited staffing and stress from patient and family violence. To retain nurses, managers must explore ways to communicate with nurses and promote teamwork and job satisfaction (financial compensation and suitable shifts). The next section focuses on the macro level.

## *Macro level*

The macro level, a higher level above the meso and micro levels, is where the organisational, social, cultural and socio-economic factors are important. Here, three topics, incentives, supportive leadership and positive work culture, are significant because they are linked to staff happiness and retention. Only five studies offered ways to retain staff and were limited to NQNs. Incentives, professional development opportunities, and transition-to-practice pathways retain nurses, especially NQNs (Dawood & Gamston, 2019; Lee, 2024). A cultural tool kit (Adams et al., 2019) and effective leadership (Basu et al., 2020; Van Osch et al., 2018) were shown to lower stress levels and ITL.

### *Incentives*

Staff incentives can lead to retention, inspiring nurses to take up dual roles such as Emergency Nurse Practitioner (ENP) and ED RN which can keep expert knowledge and skills within ED. Dawood and Gamston (2019) developed a dual-role programme in two small London EDs. Twelve ENPs participated in two surveys. They allowed nurses to switch from full-time to part-time roles. The result was that nurses who would have otherwise considered leaving the ED stayed. ITL among senior nurses in their current role was attributed to stress from working full time. Other main stress contributors were the pressure on senior nurses to deliver care with limited time, resources, and staff in an overcrowded department. The findings of this study were similar to previous studies where limited time frustrated nurses in the provision of optimal care despite them enjoying the thrill of ED (Enns & Sawatzky, 2016; Sawatzky & Enns, 2012). Suggestions on ways to retain nurses were suitable rosters, managers who listened, were visible and affirmed nurses' concerns, and increase in staffing and experienced nurses (Enns & Sawatzky, 2016; Sawatzky & Enns, 2012). Dawood and Gamston's (2019) study, recommended management to consider the option of dual roles for RNs. Management must listen to senior nurses; it was argued and explore ways for junior nurses to choose ED as a long-term career rather than a short-term job. The limitation was a small sample, and participants who were involved in the education programme; however, the authors recognised the bias.

Similarly, another incentive designed by nurse managers that targets the recruitment and retention of NQNs and senior nurses may be effective. Evans et al. (2017) conducted a study that introduced an educational project built around the training and upskilling of senior staff and junior staff. Fourteen months after implementation, the vacancy rate had dropped from 65% to 14%. The strategy was that senior nurses were also offered programmes leading up to a master's degree and the implementation of new advanced nursing roles as associate practitioners and trauma practitioners. More time was spent with junior staff and NQNs. During this period, junior staff underwent a comprehensive orientation to the expectations and scope of practice within the professional role of an ED nurse. Junior nurses spent time with the team and completed a structured competency pathway for 18 months (Evans et al., 2017).

Developing and implementing a tailored education pathway for NQNs increases the chance of retention. For example, a Transition to Practice pathway for NQNs can help with retention. Lee (2024) developed a pathway that led to a reduction in turnover rate from 46% to 5.1% in one hospital. This progressed to 11 other hospitals, with an increase in retention rate of up to 82% pre-COVID. The pathway involved nurse leaders, educators, RN preceptors, and managers scaffolding the learning of ED competencies until NQNs were competent. Critical reasoning and technical skills, resilience, and confidence improved throughout the programme (Lee, 2024).

### *Supportive leadership*

The ED retention literature suggests organisations invest in professional development, involve nurses in decision-making, improve communication, and value and appreciate nurses through incentives like salary and holidays. Supportive leadership was a central theme across the three studies reviewed here (Basu et al., 2020; Sawatzky & Enns, 2012; Van Osch et al., 2018) and is pivotal in reducing stress among ED nurses.

Some studies looked at engagement, visibility and communication by leaders (Enns & Sawatzky, 2016; Sawatzky & Enns, 2012). Sawatzky and Enns (2012) conducted a cross-sectional survey on ED nurses (n= 261) in 12 hospitals (rural, metropolitan, and teaching) in Canada and found engagement dependent on effective leadership, adequate resources and suitable shift work was an influencing factor for retention. On the other hand, low engagement, taking up other roles, burnout, and poor salaries were influencing factors for ITL (Sawatzky & Enns, 2012).

Another study (Van Osch et al., 2018) found staff feel valued and appreciated when their leader is visible, accessible, approachable, and communicative. As discussed earlier, (Van Osch et al., 2018) used an ID design in interviewing ED nurses (n=10) and critical care nurses (n=3) in western Canada, exploring factors that encourage nurses to stay. Findings showed that many nurses felt respected, valued, and acknowledged when leaders consistently demonstrated clear communication, empathy, engagement, and accessibility, and there was mutual trust and dependability amongst team members. Effective leadership is vital for nurse happiness and must be reinforced to retain nurses (Van Osch et al., 2018). Similarly, a further study showed leadership is related to a decreased perception of stress by ED nurses. Basu et al. (2020) conducted a prospective mixed-method study in northern England involving ED nurses (n=63) to assess the perception of stress and the effectiveness of interventions to reduce stress. Surveys and the Swedish Demand Control Support tool were used in 2014, 2015, and 2017, allowing nurses to offer suggestions. Results in 2014 showed that staff were unhappy and stressed due to workloads, low staffing, the lack of breaks, poor rewards, lack of management support and lack of opportunities for professional development. Results of the surveys in 2015 and 2017 showed better staff support, improved communication, regular meetings, funding for professional development, support from senior staff to junior staff, and an open-door policy for staff to offer

suggestions and to debrief. The effectiveness of supportive leadership was evident when staff reported lower perception of occupational stress and increased job satisfaction during the second and third stages of the study (Basu et al., 2020).

### *Positive work culture*

Developing a cultural change toolkit helps reduce turnover and burnout effects. Adams et al. (2019) measured burnout causes before and after the toolkit was implemented. This study was done in response to a perceived hostile work environment, an inability to retain staff and staff burnout (Adams et al., 2019). ED nurses (n=38) completed two types of surveys: the anticipated turnover scale and the Oldenburg burnout inventory. A suggestion box was created for nurses to put forward any suggestions or requests for shifts, but kudos boxes were also used to recognise and thank each other. In some cases, nurses also commented favourably about supportive leaders. This strategy lifted staff morale. Findings showed that scores for burnout were lower after implementing the toolkit, and there were no staff resignations. Some positive results were the introduction of immunisation schedules for health education of patients and accurate prescription and staff training, but also better safety protocols for triage patients. The previous culture did not allow nurses to provide feedback or suggestions, and staff were afraid to provide feedback to management. The programme continued for over 18 months, although the leadership presence seemed to lessen, and staff had limited time to continue writing thank-you notes (Adams et al., 2019).

In this section discussing the macro level, nurse retention is related to four main factors. These are incentives (dual roles for nurses), structured training programme for NQNs, and ongoing support for senior and junior nurses, supportive leadership (visible, communicative and trustworthy managers) and a positive work culture. These points are significant because they are linked to enjoyment, job satisfaction and retention. The next section summarises the literature review and addresses the gaps in current knowledge that have been identified.

## **Summary and Gaps in Current Knowledge**

The literature review findings are discussed in this section in the context of the three questions posed earlier. The first question refers to the perception of ED nurses, the second concerns how ED nurses' perceptions affect retention, and the third focuses on the success factors for retention.

The first question is "What are the perceptions of ED nurses working clinically?" Some nurses see ED as a place of learning, enjoying the uncertainty and performing duties, but some can see the work environment as unhealthy. A few studies show that nurses early in their careers are drawn or attracted to the fast-paced and unpredictable nature of ED nursing. However, a dichotomy exists here because the same unpredictable nature of the work can be stressful for nurses. This ambiguity is reflected in several studies (Caulfield et al., 2023; Dawood & Gamston,

2019; Gorman, 2019). There is no quick solution except to consider the literature supporting mentoring, debriefing, and coping skills, which are needed to build a resilient workforce, and for managers to be vigilant for signs of stress and burnout.

First, stress was a common factor leading to burnout, STS, job dissatisfaction and ITL. Second, positive coping strategies were effective in reducing stress with strong social and collegial support and debriefing. Third, in studies where incentives were offered to nurses (Dawood & Gamston, 2019) and in studies where supportive leadership and positive cultures were present (Adams et al., 2019), staff well being improved and retention rates were increased. However, only five studies that were selected implemented staff retention programs that were successful, but these were mostly for NQNs (Lee, 2024). If more senior nurses had been included in these studies, it would have helped measure intervention effectiveness. Feeling valued and appreciated is essential for ED nurses to perform professional duties. Additionally, resilience backed with senior nurse support helps to retain nurses. Ongoing peer support and teamwork results in stronger relationships which can lead to job satisfaction and retention (Lapierre et al., 2019).

The second question was “How do these perceptions influence retention of ED nurses?”

Several key factors that influence job dissatisfaction, leading to ITL, are negative experiences, unhappiness resulting from stress within the workplace (de Wijn et al., 2022), poor teamwork (Zaheer et al., 2021), poor perception of the organisation, workplace violence (Li et al., 2019) and feeling that patient safety is compromised (Wubetie et al., 2020). Where there is disharmony between a nurse’s expectations and the experience in the work environment, it leads to stress, job dissatisfaction (McDermid et al., 2020) and ITL. ITL is when a nurse is unhappy with working or organisational conditions, experiences stress and mentally has decided to leave in search of better working conditions or somewhere he or she feels appreciated and valued (McDermid et al., 2020). In addition, when there are stressors with relationships, conflicts, and lack of support from the organisation, then nurses intend to leave. Studies covering occupational stress, moral distress, dissatisfaction, dissonance between expectation and reality, lack of control over the environment, and personal values conflicting with values and attitudes within the work environment were included to understand job dissatisfaction so that interventions can be explored to mitigate stress and dissatisfaction, which would increase job satisfaction and retention.

Positive experiences (motivating factors) amongst nurses, for example, compassion satisfaction from completing tasks (O’Callaghan et al., 2020), influence retention and can cancel out any negative experiences (Van Osch et al., 2018). Two significant areas underpinning these positive experiences are job satisfaction and harmony between nurse expectations and reality, though few studies have discussed remuneration and work–life balance as retaining nurses. Job satisfaction from feeling valued and appreciated through effective leadership and support (Van

Osch et al., 2018) together with the ability to execute duties to a high standard, and compassion satisfaction (Francis-Wenger, 2024; O'Callaghan et al., 2020) leads to intention to stay. To improve job satisfaction, studies offered recommendations such as relationship building, teamwork, resilience, and engagement (Clark et al., 2022).

However, nurses can be engaged and satisfied but stressed with their role, making it difficult for managers to assess for signs of stress and burnout. Another issue is coping mechanisms; some use positive coping, while others resort to negative coping when stressed. Only one study considered nurses' rumination and blaming themselves instead of using positive coping mechanisms (Elder et al., 2019). A lot has been said about nurse coping skills and resilience but, post-COVID-19, many nurses have died, left or are considering leaving and are exhausted (WHO, 2023). While studies discuss strategies to build resilience and the organisation's role in helping with resilience, at the same time, nurses are stressed, exhausted and burnt-out and, therefore, cannot be resilient; further investigation into these phenomena is needed to understand nurses, and support and care for them in recovering (WHO, 2023).

The third question asks, "What are the success factors for retention of ED nurses?" Most studies have focused on turnover, and few on retention. Many studies have indicated why nurses leave ED (McDermid et al., 2020; O'Connell, 2016), but few have shown why nurses stay in ED (Van Osch et al., 2018). Therefore, more qualitative research with ED nurses is needed to better understand the phenomenon. The articles on the preparation of NQNs show that ED-specific orientation programmes are necessary, such as meeting with ED staff and posing a question for understanding before NQNs commence work. The focus is on NQNs, but more research is needed that includes senior nurses' experiences in order to understand how they can provide support for NQNs.

This integrative review examined peer-reviewed articles, key workforce development literature, and significant reports. Two major themes were identified in the literature review, job satisfaction and job dissatisfaction resonating with other studies outside this integrative review. Job satisfaction increases the chance of a nurse remaining, whilst job dissatisfaction increases ITL and turnover, as reflected in other studies on ED nursing retention (Gorman, 2019; Horvath & Carter, 2022; McDermid et al., 2020; Staempfli & Lamarche, 2020).

Several gaps were found. Firstly, whilst there are some factors discussed in quantitative studies (stress, burnout, and emotional exhaustion) and qualitative studies (coping strategies, camaraderie, effective leadership), the extent of experiences and impact on the personal, emotional, cognitive, interprofessional relationship and social aspects, have not been taken into consideration. An example would be personal factors, work-life job fit, and external support at home. Some quantitative studies used tools, instruments with scales that focused on one single outcome, for example, MBI. Therefore, any further explanation or deeper meaning could not be

drawn from the quantitative studies. Secondly, the role of the organisation in relation to retention was at times unclear. Only five studies that were selected implemented staff retention programs that were successful, but these were limited to mostly NQNs (Lee, 2024). If more senior nurses had been included in these studies, it would have helped measure intervention effectiveness. Furthermore, limiting studies to a specific demographic cohort of ED nurses such as NQNs does not allow for deeper understanding such as interprofessional relationship between junior and senior nurses, identification of causes for attrition and success factors for retention, and impact on the rest of the ED team. To close this gap, all ED nurses, junior and senior, must be involved in shedding light on nurse retention. This review of the literature confirms a search for a deeper understanding of factors that retain nurses. Thirdly, no studies have been found that have used qualitative methods to investigate the factors contributing to ED nurse retention in NZ's public health system. Lastly, many studies focused on nurse attrition than retention. Therefore, understanding what factors could help ED nurses stay is important.

Despite these gaps, the review of the literature revealed local, national, and global concerns about emergency nurse retention. There is growing concern about the challenges for nurses, especially ED nurses, who face the stress, burnout and PTSD that lead to job dissatisfaction and then turnover. When there is a disparity between nurses' expectations and reality, job dissatisfaction will likely occur, and when there is harmony between expectation and role, job satisfaction is likely to occur. There is complexity about the role of emergency nurses and inconsistencies in what helps retain them.

This review has found several gaps in the literature around ED nurse retention. Therefore, the research reported in this thesis aimed to examine the key factors contributing to successful retention of ED nurses employed by a DHB in NZ. The research questions arising from the literature review are, firstly, "What are the perceptions of ED nurses in relation to retention?" and, secondly, "What are the success factors contributing to retention?"

## Chapter Three: Research Design

### Introduction

This chapter outlines the philosophical and theoretical framework and methods that informed the research design for this study exploring emergency nurse retention. The previous chapter examined the literature and highlighted gaps. This research aimed to examine the key factors contributing to the successful retention of ED nurses employed by a DHB in NZ. The research questions were, firstly, “What are the perceptions of ED nurses in relation to retention?” and, secondly, “What are the success factors contributing to retention?” Epistemologically, my worldview is based on previous experience as an ED nurse and my current role as a nursing lecturer. The ID methodology (Thorne, 2014, 2016; Thorne et al., 2002) was employed to examine the deeper meaning of the phenomenon of nurse retention. ID enabled me as a doctoral candidate, to position myself in the research and draw on my previous ED clinical experience and the literature on ED nursing.

The first section of this chapter presents the ‘research onion’ (Saunders & Tosey, 2012), which helps doctoral candidates build a research paradigm, and an overview of research concepts. This is followed by the methodology of ID, and the methods: research objectives, sampling, ethical considerations, recruitment, data collection, data management, data analysis and rigour.

### Research Onion

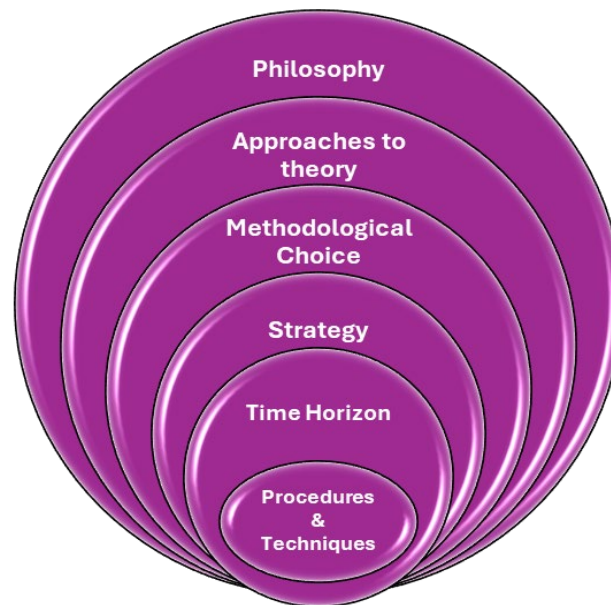
This section explains the concept of the ‘research onion’ with its different layers, followed by an exposition of philosophical concepts. The research onion is an integrated approach to research design, philosophy, epistemology, ontology, axiology, and methodology (Saunders & Tosey, 2012). After watching several videos on the research onion (Saunders, 2024), I sought permission from Professor Mark Saunders to use the research onion approach, and this was granted (Appendix B). Since the first publication of the research onion in 2003, Professor Saunders has revised the approach to now consist of six steps or layers (Saunders, 2024). The advantage is that a researcher can examine each layer of onion, from outside to inside, with questions to consider before the research begins. In this way, a doctoral candidate can determine whether the chosen methodology or method addresses the research question and objectives (Saunders & Tosey, 2012). Figure 1, below, depicts the onion.

The first layer focuses on philosophical aspects of research (positivism, pragmatism, post-modernism, critical realism, and interpretivism). The second layer includes the approaches or paradigms (inductive, abductive, and deductive). The third layer highlights the methodological choices (mixed and mono methods), followed by the fourth layer which covers strategies (grounded theory, ethnography, and action theory). The fifth layer covers timelines or horizons (cross-sectional or longitudinal) and, finally, the sixth and innermost layer covers procedures (ethical approval, data collection and analysis) and techniques (gaining data, ethics). The research

onion approach provides a framework for the development of a robust, internally consistent research design. Saunders et al. (2023) suggested that researchers should take time to reflect on and explain their world view and rationale. In this way, the researcher can establish internal rigour and reach the central core of the research onion. In doing so, a researcher can see the importance of a study. As mentioned, rather than just going through layers, a doctoral candidate must methodically show insight or meaning by explaining each layer and how it strengthens the research design (Saunders et al., 2019).

**Figure 1**

*The research onion*



*Note.* Figure from Saunders et al. (2019). Adapted with permission.

### ***The philosophical layer***

The philosophical layer, commonly known as the “worldview” or paradigm (Borbasi & Jackson, 2016) usually includes assumptions, reality beliefs (ontology), multiple realities (epistemology), and the researcher’s own values (axiology) (Polit & Beck, 2021). Likewise, Creswell (2009) described a paradigm as a general orientation of the world, the type of research, beliefs and previous experience of a novice researcher. Whatever beliefs the researcher possesses will determine whether the research takes on a qualitative, quantitative or mixed methods design (Creswell, 2009). In other words, a paradigm can encompass the philosophical intent of a study. My beliefs, positionality and potential biases that might affect the research were discussed in collaboration with my supervisors. This step was important because a researcher’s values can influence the research by generating, for example, biases and false assumptions (Polit & Beck, 2021; Thorne et al., 1997). The paradigm is important because it can be a way of fulfilling the aims, benefits, and values around reality and philosophy (Houghton et al., 2012). But also, understanding the philosophical notions can solidify the research design and enhance the “quality of the research outcomes” (Halcomb, 2018, p. 6). Therefore, the first layer of the onion can bond

the layers within the design, but also, when viewing the research onion from different angles, a doctoral candidate can assess whether the layers are internally cohesive or not, and if the latter, further research, discussion, and amendments can be made to strengthen the design (Saunders et al., 2023; Saunders & Tosey, 2012).

The next section explains how four main philosophical notions were understood; these are then framed later in the ID methodology section.

### ***Epistemology***

Epistemology is defined as a connection between the person enquiring for knowledge and what is already known and what makes up knowledge (Grant & Giddings, 2002); and as the study of knowledge and the connection between the researcher and participants (Houghton et al., 2012). In my position as an ED nurse and lecturer, I already have knowledge of being a nurse in an ED but, in this study, I am interested in the knowledge obtained from conversations between the research participants and myself (Polit & Beck, 2021).

### ***Ontology***

Ontology is defined as the fundamental beliefs about human beings and their realities, and it is a foundation for epistemology (Grant & Giddings, 2002). An understanding of a reality is created by the individual perceiving reality, but it is subject to different interpretations (Crotty, 1998). Under the naturalistic or constructivist paradigm, reality is constructed in multiple and subjective ways (Polit & Beck, 2021). As a doctoral candidate, I am mindful of knowledge that is different to my own clinical experience. An example would be differences in what a practising ED nurse would consider helpful to retain nurses and what the priorities are for a positive workplace. Recognising these differences can help in understanding ED nurses' reality and acknowledge other priorities voiced by participants in regard to retaining nurses.

### ***Axiology***

Axiology is defined as the influence of the researcher's values on the research (Omodan, 2024). According to Merriam Webster dictionary, axiology originates from the Greek word "axia" meaning "worth or value" and is part of ethics; the character, kinds and criteria of values and judgement are the main points of axiology (Merriam-Webster, n.d.). Axiology is important for a researcher because values and perspectives can shape the research design and the meaning of findings. Therefore, ways to limit any researcher's influence must be carefully reviewed (Pretorius, 2024). I have declared my previous experience and current role in ED and have acknowledged any possible coercive influence and power imbalances in the ethics application, form EA1. In addition, I reflected on potential biases and assumptions with both supervisors, to reduce the risk of any transference of values that could affect the research (Bianchi, 2021).

## ***Methodology***

Methodology is defined as strategic plans or steps of a research process to achieve results in alignment with epistemology and ontology (Crotty, 1998). Methodology concerns how the researcher acquires information or knowledge in the research question's context (Houghton et al., 2012) and can help shape the steps and tools or instruments employed (Grant & Giddings, 2002). As stated earlier, I chose ID, which refers to the inductive nature of qualitative research. Here, an understanding of complex phenomena and development of ideas, patterns and theory is possible. For qualitative research, the approach is inductive (Saunders et al., 2023). In this case, a semi-structured interview strategy was employed to gather information from ED nurses to understand their perspective and assess this information for any success factors in regard to retaining nurses (Merriam & Tisdell, 2015). ID methodology was suitable for this research, and this point is discussed later in this chapter.

The final layer is the time horizon. Ethical approval was granted on October 6, 2020. For more detail, see the subsection "Ethical considerations prior to recruitment" in the "Methods" section, below. Participants were interviewed from this date until December 2021. The next section covers qualitative ID briefly, followed by a discussion of the principles of ID, theoretical scaffolding which covers the literature review on ED nurse retention and positioning within the research. Also, the evaluation criteria for ID research quality: epistemological integrity, representative credibility, analytic logic, and interpretive authority are explained (Thorne, 2016).

### **Methodology: Interpretive Description**

This section covers the background to and description of ID, theoretical scaffolding (literature review and positioning), a review of philosophical notions, forestructure and evaluation criteria. This is followed by the methods section, covering the data collection process and analysis, and providing context to the methodology.

### ***Background***

The ID methodology, which Sally Thorne developed and was initially called non-categorical ID (Thorne, 2016), is suitable for this study. Sally Thorne and her graduate students in the applied and practice disciplines, for example, medicine, education, and nursing, employed qualitative methods. During that era, many popular techniques and methodologies (such as ethnography, phenomenology, and grounded theory) were used in the social sciences disciplines and formulated for research projects by accomplished researchers, and academics (Thorne, 2016, 2020, 2021). These methodologies had complex knowledge and intellectual themes. The emphasis was more on theorising (Thorne, 2020, 2021). Despite these research techniques and methodologies being popular, they were too rigid, stringent, and complex, and it that seemed some useful methods delivered poor findings systematically (Thorne, 2016, 2021). For example,

some methodologies like ethnography, grounded theory, and phenomenology did not speak to the professional practice discipline of nursing. Sally Thorne referred to this as methodological rigidity, and Thorne has said that other researchers have strengthened her thinking and desire to explore a different approach (Thorne, 2016, 2021) so that the aim and objectives of one's research can be achieved (Sandelowski, 1986, 1993). This was due to a need for a more clinically based research approach which had implications for clinical practice, for example, in nursing science, which would mean nurses could use their prior intellect logically (Thorne et al., 1997).

Thorne (1991) challenged the research community by stating that standard qualitative methodologies did not necessarily meet the research objectives or produce the data needed to answer important research questions or develop a research design. Her vision was to have a different methodology tailored for the health discipline requirements. In the 1980s, there was much resistance and negativity. In 1997 she introduced ID as a non-formal way for qualitative researchers in applied disciplines to address "So what?" questions. Here she used the words "non-categorical qualitative alternative" to mean "not phenomenology, not ethnography" (Thorne et al., 1997). This alternative to qualitative research uses some trusted techniques but not all the theoretical frameworks. Thorne also referred to this as applied disciplinary epistemology (Thorne, 2021).

ID is relevant to a professional discipline like nursing, as it aims to probe and understand human experiences. As mentioned, qualitative ID stems from a naturalistic belief that values people's experiences, adding meaning and insight into their experiences (Loughery & Woodgate, 2019; Thorne, 2016). The qualitative ID approach is pragmatic and "intellectually logical" rather than conceptual or theoretical, as seen in the social sciences (Thorne, 2016). ID is based on clinical issues, such as the question this study seeks to answer about ED nursing workforce retention and is characterised by its strength in using communication to understand and explore reality and phenomena. Essentially, qualitative research utilises spoken words as valuable data, which is then gathered and interpreted through a range of techniques. Thorne (2016) noted that nursing has always been in the evidence-based world because nurses' knowledge is constantly evolving with new ways of doing things and new studies or evidence. Nurses draw on their own values and theoretical knowledge and bring these into research (Thorne, 2016, 2021). This prior knowledge can be applied to, for instance, understanding ED nurses' perspectives and identifying possible success factors in the workplace.

### ***Scaffolding of the research***

Two critical elements were considered prior to the research. Firstly, the literature review, and secondly, the positioning in it. This is called theoretical scaffolding and is essential to build a foundation before the research (Thorne, 2016).

In Thorne's earlier work, the term "analytic framework" was used to refer to the prior knowledge and disciplinary orientation one brings into a study (Thorne & Sandelowski, 2008). Later, the term changed to "theoretical scaffolding" since the previous terminology was misleading researchers into believing that the structure and concepts led to the analysis of research data. The terms were properly used to separate the researcher's positionality before the research.

As a doctoral candidate, my own clinical experience can be used: as a base to build a theoretical scaffolding but also to examine literature gaps, interview questionnaires or initial findings for modification in questions (Hunt, 2009). I developed my research question from the gap in the literature identified in the literature review in Chapter Two.

Furthermore, this research position is privileged since a researcher can have prior knowledge of the phenomena, which can help in understanding, for example, findings, whether similarities, differences, or tensions within a dataset (Thorne, 2014, 2016; Thorne et al., 2002). However, the researcher's preconceived ideas or attitudes may influence how the research is conducted and completed. This is called "theoretical baggage" (Thorne et al., 2016, p. 60), which can be taken from my role as an ED nurse and lecturer. Any disciplinary biases, preconceived ideas, and prejudices can lead to important statements from participants being dismissed. Biases can lead to misinterpretation of the meaning of interview results and therefore constant reflection and supervision is required (Hunt, 2009).

### *Theoretical forestructure*

Theoretical forestructure has three parts: theoretical allegiances, location within a discipline and relationship within the ideas (Thorne, 2016). A consideration of the theoretical forestructure is a step that must be taken by the researcher adopting an ID design to examine their position in the field and the theoretical world encompassing this field (Thorne, 2016). Here, a researcher must carefully plan the research and consider what meaningful role they will play before data collection. Therefore, I documented all carefully thought-out steps in the research proposal before the data collection (Thorne, 2016) so that the goal of the research, which is understanding perspectives of ED nurses and contributing success factors for nurse retention, is achieved.

### Theoretical allegiances

The relevant peer-reviewed articles and key workforce development documents (Thorne, 2016) led me to understand that the issue of nursing retention is global. NZ is not alone in facing challenges with retention of nurses. As outlined Chapter Two, there is a gap in the literature, as many studies did not allow for the understanding of participant-related retention factors. I opted for the most relevant articles that examined retention factors or pull factors, such as supportive leadership, positive organisation culture, support for NQNs and nurse feeling valued, respected and appreciated through good communication, incentives and career pathways. Parallel to this, I

reviewed the push factors which affect retention, such as stress from poor working conditions and lack of organisational support. Other articles beyond the scope and timeframe were not included.

#### Location within a discipline

My epistemological positioning in the research guided the research design. My previous role as an ED nurse and current role as nursing lecturer made me aware of the realities of working as an RN in ED. The professional discipline of nursing involves caring for patients and applying all the skills and knowledge I am aware of, and I carried this information into the research.

#### Relationship within the ideas

I thought about my biases or prejudices before the research commenced as seen in the section on “Research Positionality” in Chapter One, and kept a reflective journal documenting my thoughts and feelings throughout. This practice is essential to minimise any transference of values to the research (Dyar, 2022; Lincoln & Guba, 1985; Polit & Beck, 2021). This was done so my questions during the interview were not leading the data; I was aware of my biases and tried to be neutral (Polit & Beck, 2021). At the same time, I drew on the literature on ED nursing to develop semi-structured interview questions. For example, questions such as “What makes you happy about being an ED nurse?”, “How do you manage stress?” and “What was your experience with COVID-19?”, were posed to participants.

Drawing on interpretivism, from an epistemological perspective, professional nursing knowledge comes from working clinically and as a nursing lecturer. My relationships with students, and stakeholders like clinical charge nurses (CCNs), clinical nurse educators (CNEs), RN preceptors and ED doctors, provide knowledge about positive and negative experiences. From an ontological viewpoint, nurses wanted to be heard and communicated constantly to express their experiences. Furthermore, nurses could communicate if they did not want to contribute to the research.

From axiological perspective, ethical principles must be respected. This means all participants must be treated with respect, dignity and appreciation. Therefore, ethical principles, such as informed consent, confidentiality and privacy (Polit & Beck, 2021), are evident in documents like the consent form (CF) and the participant information sheet (PIS). No one is forced to participate in the research.

#### ***Evaluation criteria/principles***

There are four evaluation criteria or principles for ID research quality: epistemological integrity, representative credibility, analytic logic, and interpretive authority (Thorne, 2016). These are discussed below. The criteria were met throughout the research which in turn satisfied rigour and credibility (Thorne, 2016).

### *Epistemological integrity*

This research followed a rational approach, from the research question, aims, and objectives to the strategies and techniques used in the data (Thorne, 2016). A thorough literature review was conducted using peer-reviewed journal articles and key workforce literature from local and international sources. Furthermore, my epistemological positioning in the research, based on my personal ED experience, was used to design the interview guide (Appendix C). The interview guide was piloted following an approved interview protocol (Appendix I) and checklist (Appendix J), before being used for the remaining 11 participants. Peer refining through an iterative process of reviewing the semi-structured interview questions was tracked to show changes (Appendix D). The findings are compared and contrasted with national and international literature on ED nurses (see Chapter One, Introduction, and Chapter Two, Literature Review). Additionally, the provisional findings were presented at the CENNZ conference on 19<sup>th</sup> October 2023, where feedback was received that acknowledged the findings were consistent with the challenges faced by ED nurses in other parts of NZ.

### *Representative credibility*

This research has contributions from a rich, diverse group of ED nurses, for example, junior and senior nurses, and nurse leaders with many qualifications. An integrative review of peer-reviewed journal articles, key documents related to workforce development, WHO reports, media and research data was done. As mentioned in the Chapter Two, a summary of the literature showed little on retention. Some studies pointed to positive experiences, but there were few studies focused on strategies to keep nurses in EDs.

### *Analytic logic*

An audit trail was kept showing processes, steps, changes, reflections, and decisions in the field (Dyar, 2022; Lincoln & Guba, 1985; Polit & Beck, 2021). Interviews were transcribed, examined and reviewed by supervisors for accuracy. The methods sections, below, outline all the steps and changes. The interview guide was continuously reviewed and modified so participants could recount personal experiences. When no new information was discovered (data saturation), a decision was made to stop interviewing and begin the analysis process.

### *Interpretive authority*

ID uses rich data from participants, letting them express their experiences in detail (Thorne, 2016) which, in this study, provides an elaborate understanding of ED conditions. To illustrate an example, many participants used metaphors to describe a problem and how they felt about it. All transcripts were coded and verified before the final thematic analysis, alongside self-reflection and peer-review. Critical reflection involved journal entries to remove any biases or attitudes. Themes were constantly reviewed so that the data reflected the reality of the workplace. The interview guide was used to facilitate open dialogue, not lead questions. Concurrently,

member checking by the supervision team was conducted before transcripts were emailed to participants. The six phases of thematic analysis recommended by (Braun & Clarke, 2022) were adhered to, such as the formalisation of codes and the initial and final thematic map, with member checking to ensure accuracy and organisation. The next section covers the full range of research from start to finish.

## **Methods**

In this section, a description of methods is provided followed by research objectives, sampling, ethical considerations, recruitment, ethics, data collection, management and analysis and rigour. Before deciding to adopt ID, I examined the strengths and weaknesses of standard qualitative methodologies such as grounded theory, action research, ethnography case study and mixed methods.

The decision to adopt ID as a methodology for the research was taken after careful study of several other types of qualitative research methods such as phenomenology, interpretive phenomenology [hermeneutic], grounded theory, ethnography and mixed methods (Borbasi et al., 2016; Sandelowski, 2000; Smythe, 2012; Welford et al., 2012). Firstly, I examined phenomenology which looks at the lived experience of persons and drawing on in-depth understanding of philosophers, for example, Edmund Husserl and Martin Heidegger. Parallel to phenomenology, I reviewed interpretive phenomenology which explores meaning of experiences as accurately as possible built on philosophers such as Hans George Gadamer, Patricia Benner and Van Manen. Secondly, I studied grounded theory which builds theory from observation using the philosophy of Barney Glaser and Anselm Strauss to reach a hypothesis. These two required in depth understanding of philosophy and restricted researcher preconceptions. Thirdly, ethnography, which required time to immerse in the field examining culture and practices was examined. But also, the researcher's presence can influence the behaviour of participants (Sandelowski, 2000; Smythe, 2012; Welford et al., 2012). COVID-19 restrictions during the study prevented any research from being undertaken at the hospital. Therefore, ethnography was not used. Lastly, mixed methods such sequential exploratory [interviews then surveys] and explanatory [surveys then interviews] mixed methods was examined. Mixed methods design has many positives such as testing, answering of complex problems and comparison of interviews and surveys (Dolan et al., 2023) but it is time consuming, labour intensive and if one is not careful with the two different philosophical notions, positivist and naturalistic, confusion and overload of data and going offtrack, is a possible consequence (Creswell, 2009). Interpretive description offered a time-efficient, practical and nursing based qualitative method where I could acknowledge my preconceptions and prior knowledge (Dolan et al., 2023; Thorne, 2011, 2014; Thorne et al., 2016).

As discussed earlier, the methods chosen to fit with the overall research onion layers can be mono or multiple methods (Saunders et al, 2023). Methods are called techniques or procedures

and are used to extract data (Bradshaw et al., 2017; Houghton et al., 2012). Methods have carefully planned processes and systems designed by the research team and are executed to ensure the research questions are answered and aims are met (Bradshaw et al., 2017; Houghton et al., 2012). In qualitative research, the methods see the researchers deeply involved in gaining data using iteration, and analysis (Bradshaw et al., 2017; Houghton et al., 2012). Before the data collection and throughout the research process, the procedures and processes employed in the present study were checked and were found to be internally coherent (Howard-Grenville et al., 2021) to reduce the risk of misfit, which can arise in qualitative research (Howard-Grenville et al., 2021; Thorne, 2021).

### ***Research objectives***

This research aimed to examine the key factors contributing to successful retention of ED nurses employed by a NZ district health board (DHB). The research questions were, firstly, “What are the perceptions of ED nurses in relation to retention?” and, secondly, “What are the success factors contributing to retention?” The empirical evidence gathered could be used to inform recommendations for workforce recruitment and development.

### ***Sampling***

Purposive sampling was employed (Fisher & Bloomfield, 2019). This technique involves sampling individuals with specific experiences, characteristics, or interests. In ID, sampling stems from research questions, aims and objectives, and what is already known about ED nursing. The benefits of purposive sampling are that the researcher can develop clear criteria (Thorne, 2014), choose which participants are accessible for data collection, and have specific characteristics which, in this study, were age, ED experience, qualification, ethnicity (Bradshaw et al., 2017; Fisher & Bloomfield, 2019) and diversities (Hunt, 2009). In total, 13 ED nurses were interviewed. Even though qualitative studies are small when purposively selected, participants can vividly describe experiences or interests and “provide a powerful picture” (Borbasi & Jackson, 2008, p. 157).

As the largest metropolitan city in New Zealand, Auckland has three public hospitals with EDs. All three EDs, provide twenty-four hour, seven days a week, emergency care to people of all ages (Te Whatu Ora, 2024). ED nurses employed at two of these hospitals were invited to participate. The inclusion and exclusion criteria applied to the recruitment of ED nurses from October 6, 2020, until the completion of all Zoom interviews on December 12, 2021. All potential participants were emailed only once; no further communication was expected.

The inclusion criteria covered:

1. All RNs employed in ED for a minimum of six months at either DHB site.
2. All ED RNs employed in ED at either DHB site.

The exclusion criteria applied to:

1. All pre-registration nurses employed in ED at either DHB site.
2. Any external agency staff employed in ED at either DHB site.

In total, 13 ED nurses were interviewed, with ages of 25 to 60 years and an average age of 35; nursing experience was from 18 months to 40 years, with an average of 10 years. New graduates (n=2), senior nurses (n= 9) and charge nurses (n=2) participated. There were 12 female nurses and one male nurse. A limitation is acknowledged in the participant composition that, there was one male nurse and, eleven senior nurses and managers.

The ethnicities were as follows: one Asian, one Māori, and 11 NZ European. Four participants had worked extensively overseas and returned to NZ.

### ***Ethical considerations prior to recruitment***

The steps of the locality approval process are described here. Two nurse managers at two public hospitals in NZ were emailed on June 11, 2020, seeking approval (Appendix E). On June 12, 2020, both (=2) managers signed the locality approval form (Appendix F). On September 5, 2020, an application was made to the Auckland University of Technology Ethics Committee (AUTEC) using the EA1 application form. On October 7, 2020, the DHB Research and Knowledge Centre manager approved the proposal, which is reflected in the Locality Approval form (Appendix G). The Application for Approval of the Research form stated the aims and objectives of the research with four managers' signatures. On October 6, 2020, AUTEC granted ethical approval (Appendix H).

### ***COVID-19***

In the application to AUTEC, form EA1, a document called the interview protocol (Appendix I) stated that the COVID-19 pandemic together with winter workloads, and existing staff shortages had put considerable pressures on ED nursing staff. Considering future lockdown uncertainties, and staff pressures, the plan was to use a videoconferencing platform (Zoom) as opposed to face-to-face interviews was planned. The Zoom interview protocol outlined the process, instructions on how to use Zoom, testing on pilots, a contingency plan for any technical glitches, and the advantages and disadvantages of Zoom, with risk mitigation comprehensively explained (Archibald et al., 2019; Irani, 2019). AUTEC granted the use of ZOOM to collect data (Appendix H).

### ***Recruitment of participants***

A poster displaying my contact details, e-mail and phone number (Appendix K) was placed in the ED staff tea lounge in both locations. The poster's duration was from 6th October 2020 until the completion of all Zoom interviews, 12th December 2021. Those nurses who were interested contacted me via email. Once they contacted me, I emailed a PIS and CF (Appendix L)

for them to review and then suggest a suitable time for a Zoom interview appointment. The PIS and the CF outlined the research details and consent process so that detailed information was available to interested nurses. My contact details were displayed, so that anyone interested could contact me for participation and/or clarification.

Interested nurses would e-mail me their contact details and phone numbers. All participants had a month to respond and could e-mail any questions before the interview was arranged. Eighteen nurses indicated their interest in the study, but only 13 were interviewed. Five potential participants were interested in the study but did not consent due to shift work, and personal commitments to their families during COVID-19 restrictions. Recruitment was stopped on December 12, 2021, when data saturation was reached.

### *Ethics*

Ethical principles such as informed consent, confidentiality and autonomy were satisfied in this research.

#### Informed consent

All participants gave verbal consent after discussion around their rights which satisfied the rights within the Health and Disability Services Consumers Code of Rights (1996). To ensure that participants had complete knowledge of the study, two documents (CF and PIS) (Appendix I) clarified that participation is voluntary, and that participants have a choice to withdraw from the “research without disadvantage” (Borbasi & Jackson, 2016, p. 86). This accorded rights such as self-determination and autonomy, which is linked to the principle of respect. As ED nurses work rostered day and night shifts, it was inconvenient to scan and email consent forms to me. Therefore, only verbal consent was required from all participants at the beginning of the interview; this was recorded on a Dictaphone as proof before the interview began and was not included in the interview data. Verbal consent was recorded with the participant’s location and stored separately from the interview transcripts so that participants understood what was needed. Verbal consent was obtained by reading each bullet point on the consent form (CF) (Appendix L). The purpose of obtaining verbal consent over Zoom was to confirm that they had read and understood the PIS, and the expectations, and had been given sufficient time to consider the research. This was in adherence to the comments from AUTECH (Appendix H). Participants were reassured that they were free to withdraw their consent at any time during the interview process, again satisfying rights such as self-determination and autonomy which are linked to the principle of respect and dignity.

#### Confidentiality and anonymity

All data collected was protected by storing it in a password-protected computer (Salmons, 2012). Zoom interviews were only audio recorded, and the recording was removed from Zoom

cloud after it was downloaded onto an external hard drive. Privacy was maintained by conducting interviews in two rooms, mine as the researcher and the participant's home or in a space chosen by the participant, as stipulated in EA1. All virtual interviews were conducted away from the ED so that other members of the ED could not identify the participants. No personally identifiable information is present in any reporting, thus ensuring anonymity. I maintained participants' confidentiality by ensuring that the responses by the participants were not discussed with any other participants or members of EDs. In terms of anonymity and confidentiality, numbers were assigned to each transcript to anonymise participants.

### Data protection

All transcripts were handled by me and will be destroyed after six years. Participants received copies of their transcripts, which were stored in a secure file on a password-protected computer. No one but me had access to the data. Only provisional findings were briefly mentioned at the CENNZ Conference October 19<sup>th</sup>, 2023.

### ***Approach to data collection***

#### *Development of semi- structured interview guide*

In developing the semi structured-interview questions, I drew on information from the journal articles on nurse retention and used the two research questions posed in this research.

1. "What are the perceptions of ED nurses in relation to retention?"
2. "What are the success factors contributing to retention?"

Thereafter I posed questions drawn from the literature about what information could be important for the study, for example, "What do nurses find meaningful or rewarding?" and by considering what clinical information addresses my research question. A semi-structured interview guide was developed and reviewed by my supervisors on May 7, 2020. Changes were made to the initial interview guide before the pilot to contextualise it to Zoom interviews (Appendix C). I was advised to reduce the number of prompts if I was going to use them and relax the structure and deal more with the nuances of the study. For prompts, I added personal, professional and organisational headings for consistency. The interview guide was later changed further to include questions related to COVID –19 and exploration of positive experiences.

#### *Pilot interviews*

Two senior RNs who met the eligibility criteria and were outside or separate from the main study population agreed to be interviewed for the pilot interviews. The pilot aimed to assess the clarity of research questions in gathering data, timing of interview and ambiguity in the interview questions.

The first pilot interview ran seamlessly, but there were some technical glitches with Zoom, so a phone call was made to the second pilot interviewee. The second pilot was audio recorded using a Dictaphone, whilst the other participant responded to the Zoom invite and was recorded both on Zoom audio and Dictaphone. It was encouraging to see that the verbal consent could be separately recorded without any problems and that the Zoom audio file converted and could be copied and stored on a password-protected local computer.

During the interview, I asked the interviewees to clarify when they were prompted, and I rephrased the questions. Each interview lasted for approximately 45 minutes. Transcripts were emailed to them for review within two weeks, with no corrections being received. Both nurses did provide positive feedback about the interview, reiterated the need for ongoing support for ED nurses, and wished the supervisory team well. On reflection about my involvement, I recognised that I was too fast and needed to slow down with questions and be confident when posing questions to the senior nurses.

It must also be noted that after the two pilot interviews, and after an initial good response from six nurses, for several months thereafter, response to my poster was poor. Therefore, a decision was made at the beginning of April 2021 to collapse the pilot interviews into the primary data or main cohort. The two senior nurses met the inclusion criteria, but they were also included because of the richness of the data from their nursing experience (a combined 70 years of ED nursing experience). The pilot interview data was also used to fine-tune the interview guide for the subsequent interviews.

#### *Zoom semi-structured interviews*

For each participant, verbal consent was obtained prior to the Zoom interview and evidenced by them stating that they had read and understood the information sheet and consented to participate in this research. This consent form was immediately recorded and saved onto a password-protected memory stick. Initially, I thanked the participant for consenting to be part of this study on retention of ED nurses and confirmed they had read the PIS. I repeated the topic of ED nurse retention and reassured them that whatever was said in this Zoom interview is strictly confidential and that they would have the opportunity to review their transcript. I attempted to make them comfortable by asking them if they would like to do anything before the interview, for example, fetch a glass of water. Before the interview, I inquired if they had any questions and reminded them that a summary of results would be sent to them if they desired. Interviewer bias was minimised through values clarification, reflective journal entries, keeping an audit trail, feedback from interviewees (Lincoln & Guba, 1985; Polit & Beck, 2021) and ongoing discussion with supervisors. Having a warm-up chat offline before the interview to establish trust and to build rapport alleviated any anxiety, fear, or anger (Braun & Clarke, 2022). To minimise any power imbalance, I chatted with the participant before the interview about our backgrounds and social topics, for example, weather and hobbies, which lightened any feelings of hierarchy.

The interview guide was used for all questions. Open-ended questions were used to understand the “entirety” (Borbasi & Jackson, 2016, p.147) of nurses’ experience. There was no set way or wording, questions were posed so that certain information was extracted to meet the research aims and address the research questions (Merriam & Tisdell, 2015). This technique encouraged conversation and dialogue in a relaxed manner, allowing the sharing of the nurse’s perspective and providing an opportunity to probe for information. Examples of questions are: “What are your thoughts about being an ED nurse?” or “What makes you happy about working in ED?” or “How do you cope in ED?” The conversation was recorded on an audio Zoom file and a Dictaphone as back-up. Interviews were conducted in two rooms for a Zoom conversation to minimise any disruption. During the interviews I made familiarisation notes and, as mentioned, I also probed participants for further understanding about their responses. I also paid attention to their words, sentences, voice and tone. See Appendix N.

The interviews were discontinued once data saturation was iteratively reached; this means similar responses patterns were being encountered during interviewing and there were “no new insights” (Merriam & Tisdell, 2015, p. 101). All participants checked their transcripts before the analysis and interpretation thereby satisfying credibility. Checking of their transcript was done to minimise any misinformation or miscommunication during the interviews.

To ensure credibility, there were checks on whether the discussion or understanding of the interviews corresponded to the recording, which occurred at the data analysis phase. There were back-up plans or actions as part of a contingency plan for loss of data, as there can be obstacles in integrating the findings (O’Cathain et al., 2007). There were no problems with the interviews that required the back-up plans to be used.

### ***Data management***

I transcribed the initial seven interviews to engage with the data and better understand the participants’ experiences. Immersion in the data is important for a doctoral candidate because this also meets any concerns about credibility (Polit & Beck, 2021). I listened to the audio file three times before making notes. Lincoln and Guba (1985) referred to this period as incubation where a doctoral candidate is immersed, reliving the experiences and looking for patterns in the dataset. Each interview audio file, which lasted from 35 to 55 minutes, took approximately two days to transcribe word for word. I sent the transcript within a week to the participant to check for accuracy. The next six interviews were transcribed by a professional transcriptionist suggested by my university. The nominated transcriptionist completed the confidentiality agreement form, agreeing that no third parties would have access to the information, and acknowledging that all material would remain confidential and discussion about each transcript would only be done with me (Appendix M). Once it was returned, each transcript was rechecked by me and emailed to the participant. There were no revisions needed with any transcripts. From there the research process

moved into the analysis, and the next section describes the six phases of thematic analysis devised by (Braun & Clarke, 2022).

### ***Data analysis: Braun and Clarke's six phases of thematic analysis***

Braun and Clarke's (2022) six phases of thematic analysis were used to analyse the 13 interview transcripts. Merriam and Tisdell (2015) explained that data analysis can be overwhelmingly labour- and resource-intensive. These comments were reflected in the fact that I spent two to three days listening, replaying and re-examining my notes before transcribing.

Before using the six phases, I reviewed the data analysis used in ID, namely open, axial, selective and theme selection coding (Thorne, 2016, 2021). After reading literature by Braun and Clarke (Braun & Clarke, 2019, 2022) and by Byrne (2022), I watched a webinar called *Thematic Analysis – An Introduction*, recorded at the University of the West of England in 2018 (Clarke, 2018). I decided to follow the six phases as the authors cautioned that a researcher should not think of these phases as rules but as suggestions, and the process of analysing data is not linear but recursive (Braun & Clarke, 2022; Clarke, 2018). In her own words, Dr Virginia Clarke explained that the analysis of transcripts and reaching the construction of themes, the process was messy and not entirely procedural (Clarke, 2018).

#### *Phase one: Familiarisation with the dataset*

In the initial phase of analysis, a researcher becomes familiar with the data and must listen to, read, and repeat this for the entire data set (Braun & Clarke, 2022). A researcher can choose whatever method to make notes, such as on the transcript, using a highlighter, or jotting points on paper. In this way, one can read the data through an analytical and critical lens rather than merely glancing at the transcripts (Braun & Clarke, 2022). During this phase, simple questions about how participants feel about their experiences, values and the reality of their workplace can be posed. This would add meaning to reading and establish a close connection to the data (Braun & Clarke, 2012).

I listened and relistened to the Zoom interviews without taking notes, which was helpful as I did not have the stress of transcribing (Byrne, 2022). Then, I took two days to transcribe the interview verbatim. I read and reread the transcript and paused at times, making brief notes and using colour to highlight some key phrases. I attempted to make sense of the data as I transcribed it and posed questions to myself about how I felt regarding the data. I transcribed the first seven interviews myself to understand the content and jotted down points that appeared significant to me. I kept both the research question in front of me and notes made at the time of interview. During each interview, I made some familiarisation notes. My first set of familiarisation notes is provided in Appendix N as an example of these notes. After the first five interviews, I noticed some similarities between some of the responses but also differences. At the end of 13 interviews,

I had reviewed familiarisation notes for the entire dataset to assist with coding and construction of themes. The entire dataset notes can also be found in Appendix N.

*Phase two: Generating initial codes*

In the second phase, codes were generated. These codes are either descriptive or interpretive labels that can be assigned to each excerpt and although the code is short and succinct, plenty of detail should exist in the code to identify the association to the quotes (Braun & Clarke, 2019, 2022; Byrne, 2022; Clarke, 2018). An error to be avoided is to move too hastily to themes; codes require reflection, time, and flexibility before themes can be constructed. The codes are assigned to clusters, to allow the construction of themes later, and this requires several rounds of coding and evolution (Braun & Clarke, 2022).

The second phase was where I assigned codes to each group of words and/or sentences by marking the code in the margin. For deeper immersion, I printed a few transcripts and assigned various colours and created simple diagrams and mind maps (Appendix O).

Again, I referred to the research question and familiarisation notes made at the time of each interview and reflected on these words before adding a code. After making initial codes, I returned to each transcript and then re-worded the codes to promote the clustering of many codes and long codes that were almost equivalent to the data extracts. Following three iterations, and regular meetings with my supervisors, I was able to refine these codes and compiled a large table with codes and data extracts. I found some overlap of codes and reduced them from 100 codes to 20 codes. I then clustered these codes by referring to the data extract (transcript). An example of my initial codes is shown in Table 1.

**Table 1**  
*Extract of initial codes*

Illustrative Comments/Quotes	Codes
MDT (multidisciplinary team) really supportive, no concerns	(teamwork to help with nursing care)
Medical staff – is very generous with their time	(benefit of medical staff teaching others)
Down to earth medical and nursing staff	(supportive medical staff)
We are all learning together	(education by medical staff)
No job too small or big for anybody	
Even when a doctor has to change a patient’s underwear	
We just work together	
When it’s all over we get the lollies out, we have some sugar	(humour after work)
Find the multidisciplinary team really supportive, and I have no concerns there even from academics well you know from ED support. If ever I needed to go and speak to the charge nurse, they’re always available, they’ve always got time and I don’t have	(supportive medical staff/team)

any problem with any of them. I think they great throughout the hospital, it's great	
Not knowing what's coming in keeps you on your toes Inconstant learning challenging. Love going to work No two patients are the same Very pleased Variety – paed	(enjoy variety and challenge) (enjoy ongoing learning and practice development)    (happiness)
The uncertainty, the change, unpredictability with those ... I loved the challenge of working in different areas and the challenge of not knowing "what next". Every shift was different. Some EDs enable shift flexibility to help staff work around "home situations". The type of work encourages staff to extend current skills and to evolve their practice as new evidence supports changes in treatment management.	(love the unpredictability and challenge of ED) (benefit of rosters/shifts – job fit) (learn skills and progress practice in nursing care)

### *Phase three: Generating initial themes*

Initially this phase was called searching for themes, but Braun and Clarke (2022) felt that this was misleading because researchers' understanding and prior knowledge about data helps generate themes (Braun & Clarke, 2022). In the third phase, one examines common patterns across the entire dataset and then carefully develops a group of codes that appear to have a commonality. Braun and Clarke (2022) suggested that codes have a "specific or a particular meaning, themes describe broader, shared meaning" (p. 35). In phase three I was able to place initial themes with each cluster of codes, and again through team discussion and critique, complete a framework with developed themes, and then final themes. See Appendix P for the initial/early thematic map of five participant themes.

### *Phase four: Developing and reviewing themes*

In phase four, the goal is to review the codes and initial themes and to return to the complete data set. It is important to acknowledge the central organising concept, which means that certain ideas or themes must be dissolved, and to look at the connection between themes, current knowledge and broader context of the phenomenon studied (Braun & Clarke, 2022). This also includes checking the themes are unambiguous and attempt to address the research questions.

In the present study, both supervisors reviewed the initial themes and codes several times. Themes were revised to reflect the significant patterns across the data; decisions were made to collapse several subthemes into one subtheme, move some subthemes, and to discard other subthemes. For example, a decision was made to collapse subthemes into one, named 'workplace tensions' (see Appendix Q for development and collapsing of subthemes).

*Phase five: Refining, defining and naming themes*

In this phase, relevant questions can be posed, such as what the theme tells the reader about the story and how it slots into the wider story about the data. Here, one can write a short and ‘gutsy’ name for each theme (Braun & Clarke, 2022). It is important that, at this phase, there are clear names for the themes that capture the central meaning of each dataset.

For this research, I reviewed the initial themes and went back to check the transcript and codes, and familiarisation notes for accuracy. Initially there were five themes, but after the checking with the supervisors and analysis of transcripts by both supervisors, the sixth theme was built to reflect processes and systems, socio-economic implications for participants, and dissatisfaction with the organisational structures. Similarly, theme three ‘workplace tensions’, had 9 subthemes which were further refined to five subthemes, with some subthemes, such as “life is expensive”, being placed under theme six. This is shown in Table 2, below.

**Table 2**  
*Refining of themes and subthemes*

Major Theme	Subthemes
<b>Theme Three: Workplace tensions</b>	It feels like a third world department. Finding more solutions for Mental Health patients. Feeling horrible from patient verbal and physical abuse. Covid-19 is game changer for nursing. Treating each other in a different way.
<b>Theme Six: Dissatisfaction with organisational structures, processes, and systems.</b>	Feels like old school. Rosters that put me off. Life is expensive- you cannot save here! Health target is a conveyor belt like a Toyota factory. Are we getting more staff? Feeling as though management does not hear us.

*Phase six: Writing up*

In this last phase, one edits and checks themes to inform the reader of the story, bringing in the literature together with the theme and subtheme to critically analyse themes (Braun & Clarke, 2022). In the present study a table with six main themes and subthemes was finally

organised from the micro level to the macro level and discussed in the context local and international literature. This final thematic table is shown in Chapter Four, Findings and the discussion is found in Chapter Five. The next section discusses how rigour was satisfied in this research, and the criteria underpinning rigour, namely confirmability, credibility, member checking, dependability and transferability, are explained.

### ***Rigour***

Rigour or the principle of truth in the research was satisfied by meeting the four criteria developed by (Lincoln & Guba, 1985) – credibility, transferability, dependability and confirmability (Johnson et al., 2020; Merriam & Tisdell, 2015; Sandelowski, 1986). In this section, member checking is also discussed, immediately after credibility, as it too addresses the principle of rigour.

### ***Credibility***

Credibility is met through immersion in data, prolonged engagement (Dyar, 2022; Lincoln & Guba, 1985), member checking (of, for example, methods, and findings), debriefing, asking participants to check for accuracy of transcripts, and data saturation (Dyar, 2022; Lincoln & Guba, 1985; Trainor & Bundon, 2021). Credibility assesses the correlation between data collected and its interpretation. In this research, member checking and audit trails were completed. The credibility of the researcher, that is, the ethics of the researcher is seen in, for example, how interviews are conducted, and whether exchange of information may negatively affect participants affects rigour (Merriam & Tisdell, 2015; Sandelowski, 1986, 1993). Even though I may refer to ethical guidelines and protocols in this thesis, it was my sole responsibility to conduct the entire qualitative study in an ethical manner and always be conscious of my values and “philosophical orientation” (Merriam & Tisdell, 2015, p. 265). Strategies to ensure rigour were shown from the time AUTEK approval was granted; I reflected on my assumptions all the time, and I documented my feelings and thoughts in a reflective journal to share during regular supervisory meetings (Dyar, 2022; Lincoln & Guba, 1985). Only the participants’ voices are made visible in the findings (Borbasi & Jackson, 2008).

Also, I examined my biases and documented them. After each interview, I remained available by Zoom or phone for any questions or issues that might be raised by the participants. For prolonged engagement (Dyar, 2022; Lincoln & Guba, 1985), I dedicated time to each participant interview and immersed myself in transcribing and analysing the first few interview scripts. Enough time was allocated for data collection in a private space that was shared only with the interviewee. The supervisors reviewed audio transcripts and initial transcript findings to ensure accuracy and to satisfy credibility (Borbasi et al., 2016). Rigour involves member checking, audio transcription and reflexivity (Dyar, 2022; Trainor & Bundon, 2021), and thick descriptions of events that contextualise the data so that readers can relate to and member

checking (Borbasi & Jackson, 2008). Only deidentified raw quotes, excerpts from interviews were utilised and aligned in the findings. The six steps of data analysis devised by Braun and Clarke (Braun & Clarke, 2022) were used and added to credibility. No further interviews were conducted when data saturation was achieved; data saturation, the point at which no new data is evident from interviews, also adds to rigour (Borbasi & Jackson, 2008).

### *Member checking*

Member checking was one of the approaches used to confirm the results (Polit & Beck, 2021). Besides participants checking the accuracy of transcripts, both supervisors regularly checked each stage of data collection (Lincoln & Guba, 1985). The interview guide, formulated from the literature, was checked and piloted on two participants. The pilot transcripts were also checked by the participants and the supervisors; the same checking was done for the remaining 11 transcripts with coding and analysis. After the first few interviews, the questions were modified to widen the area of investigation and a record of the changes was made for reference. For accuracy, supervisors checked the familiarisation notes, initial codes, and initial themes. Feedback suggested paying a little more attention to themes, and that more rich description was needed. Furthermore, supervisors discussed the novelty of the findings, and to keep the essence of subthemes; themes needed directionality such as “lack of or poor teamwork.”

During supervisory meetings two important pieces of advice was emphasised. Firstly, both supervisors cautioned about the use of professional workforce type themes, and categorising themes too early; rather, it was better to stay close to the original data, to let the “data shine through.” The rationale for this was that the participants’ voices are the basis of the study aim, as in, for example, “Running around like little factories” and “Being a fairy god mother.” The advice offered was to see if participants’ statements were positive or negative, what stood out, and what will help differentiate, and to drill down to nuance. A nuanced quote gives a point of reference. Secondly, I was cautioned around using the meso, macro and micro framing too early, and, at all stages, to immerse myself in the data. Furthermore, due to the over-recruitment of females, and more senior nurse participants, it was decided to widen the sampling to include the recruitment of male nurses, new graduates, and junior staff once staff returned to work after the Christmas/summer break in January 2021. We went through a process of reviewing data transcripts, considered using a table and, when coding, used colours and wrote subthemes. When initial coding was shown, feedback from supervisors was “not to force the data” but to leave coding open, look for richness, and ambiguous data. Transcripts were emailed to both supervisors to which helped in the iterative development of the next set of interview questions, which were modified versions of the previous set. The interview guide was changed on January 12, 2021, and feedback received for further amendments.

### *Transferability*

For the results to be applied to similar settings in the future, the entire methodology and methods sections have shown all steps, and processes in sufficient detail. Comprehensive information has been provided about the study's location, sampling, setting, the researcher, the supervisory team members, and demographic data, and themes have been supported with illustrative quotes (Dyar, 2022; Lincoln & Guba, 1985).

### *Dependability*

After AUTEK approval on October 6, 2020 (Appendix H), strict protocols (such as for contingency plans and Zoom process – Appendix I) were used for recruiting, sampling, interviewing, transcribing recordings, and analysing data. An audit trail was set up in October 2020 to record the decisions of meetings with the supervisors. Initially, regular meetings were held, at first face-to-face but this changed to meeting on Zoom because of COVID-19. All regular meetings were recorded, and discussion notes were maintained for robustness. Together with accessible minutes of all meetings, which were safely stored on Teams app for clarification around decision points, records of revised work plans and deadlines were stored (Dyar, 2022; Lincoln & Guba, 1985). Regular meetings involved reflection with both supervisors, and the review of sample interview guides, samples with reflection, preliminary analysis, code refinement, and findings (Dyar, 2022; Lincoln & Guba, 1985). Reflection on these meetings with supervisors led to further reflection. For example, a drive for change in sampling was needed based on the data, that is, a need for more males, more new graduates, etc., before any more interviews took place. I recorded any challenges, for example, the lack of participants due to COVID-19, and tensions such as the differences in participants' responses to stress (Lincoln & Guba, 1985; Trainor & Bundon, 2021).

### *Confirmability*

To meet the criterion of confirmability, I reflected on all my prior biases before data collection; constant checking with my supervisors helped to minimise any biases. I adopted a reflexive position at all levels of the research process through regular journal entries (Trainor & Bundon, 2021) and regular discussion with my supervisors for guidance (Dyar, 2022; Lincoln & Guba, 1985).

Before leaving this section on rigour, I would like to mention that I was able to share preliminary findings at a conference in NZ where I received feedback about the study.

### *Professional feedback*

I presented a provisional analysis at a regional conference at the CENNZ Kia Mataara Conference in Christchurch on 19<sup>th</sup> October 2023. On reflection, I found it difficult to cover all aspects of the research due to time constraints. As this was preliminary data, I shared an outline of themes. At the conclusion of my session, five attendees inquired about the research: an ED

doctor/consultant and researcher, a nurse lecturer, a nurse educator from the local DHB, a nurse manager, and several senior nurses. All were deeply concerned about stress, limited staffing, education and training of nurses, interruptions to professional development in ED, and lack of debriefing. Interestingly, there was also a brief discussion with an educator in the audience around preparation for early career nurses prior to ED nursing.

## **Summary**

This study employed an ID methodology in investigating ED nurse retention. The epistemology, ontology, and axiology underpinning ID guided the research's internal rigour. Theoretical scaffolding, forestructure and evaluation criteria drawn from ID were integrated. Purposive sampling was used and, during data collection, ethical principles, such as confidentiality and anonymity, were observed before and during recruitment. The next chapter is the findings chapter, and it is followed by the discussion chapter.

## Chapter Four: Findings

In the previous chapters, the literature review, methodology and methods were covered. In this chapter the findings are presented. As explained in the previous chapter, the ID methodology was selected as best suited for this research because it values existing knowledge around clinical experience and brings out the needs of nurses (Thorne, 2016). Furthermore, in this study, ID describes any phenomenon within ED but stretches beyond knowledge of this phenomenon to what this would mean for ED nurses and patients. The implementation of this methodology allows a researcher to look for any similarities and differences in the data to answer the research question, and achieve the aims and objectives (Thorne, 2021). This brings out rich data by capturing the voices of the participants and any unique experiences, so that meaning can be extracted, and data analysed for discussion later. In this study, the personal perspectives of ED nurses were used to construct six main themes and subthemes. Table 3, below, outlines the six themes and associated subthemes.

**Table 3**  
*Themes and subthemes*

Major Theme	Subthemes
<b>Theme One: Personal satisfaction</b>	Taking the scariness out. Seeing results quickly and making a difference. ED nursing is never boring.
<b>Theme Two: Ways of coping</b>	Looking after myself. Keeping your empathy tank full. Someone to talk to and vent.
<b>Theme Three: Workplace tensions</b>	It feels like a third world department. Finding more solutions for mental health patients. Feeling horrible from patient verbal and physical abuse. Covid-19 is game changer for nursing. Treating each other in a different way.
<b>Theme Four: Professional development is important</b>	Study days need to be protected. Knowledge is power. Being a fairy godmother for junior staff.
<b>Theme Five. “We all chip in”</b>	A sense of humour. Relying on each other. Everybody just mucks in.

<p><b>Theme Six: Dissatisfaction with organisational structures, processes, and systems</b></p>	<p>Feels like old school.  Rosters that put me off.  Life is expensive – you cannot save here!  Health target is a conveyor belt like a Toyota factory.  Are we getting more staff?  Feeling as though management does not hear us.</p>
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### **Personal Satisfaction**

This theme reflects personal satisfaction. Most participants described reasons for wanting to be an ED nurse as stemming from the three subthemes (“taking the scariness out”, “seeing results quickly and making a difference”, and “ED nursing is never boring”) examined below. The main reasons for choosing to work in ED were the fast-paced and intense nature of work, which relied on their knowledge and technical clinical skills. Equally, participants shared their satisfaction from making a difference to patients’ lives, the autonomy, and seeing immediate results following prompt treatment but also from offering ongoing physical and psychological support to an ethnically diverse population group across a wide range of ages.

#### ***“Taking the scariness out”***

Many participants said they were in a unique position to calm and reassure patients by being transparent, available and promptly explaining procedures. Participants recognised this as important because patients can feel scared about sudden hospitalisation, impending treatment and/or procedures in EDs. Nurse 9 commented on how she offered support to patients:

*“I’ve learned over the years that to establish a very quick relationship with the patient, it is important for their confidence in me and the whole trust relationship. They’re anxious, they’ve been chucked into an ED, and they thought that they were going shopping, but they’ve turned up in ED. So, for them and their whānau it’s important to establish that relationship quickly, make sure that I’ve got a very honest trusting relationship. I give them information; that doesn’t take much to give people information, look in the eye and say, it’s going to be a wait.” (Nurse 9)*

Similarly, Nurse 5, a team leader, and Nurse 6, a senior nurse, saw the importance of keeping patients informed at every stage of their journey whilst in ED:

*“We are very open with our patients, we tell them exactly how it is, always give them time to question, we always tell them what’s going on. I think communication is key, so if you just keep patients in the loop and keep telling them, look it’s going to be a little bit longer, this is the reason why, but I haven’t forgotten about you, they really appreciate that. They don’t just like to be left in this great abyss of no information. And if you communicate effectively then there is not a problem.” (Nurse 5)*

*“You tend to meet people when they’re generally at their most frightened, sort of flight fright response, they don’t quite know what the plan is and often we’re maybe the only face they see when they come first, big thing is the way nurses set the scene. And if you can get there at the start of the experience, you can keep them a lot safer. What I enjoy about working in ED, what’s a bit more fulfilling is you get to be that first person,*

*although they can be very sick, they might not absorb what you need but what I love is you can set a much calmer, more informative scene.” (Nurse 6)*

### **“Seeing results quickly and making a difference”**

Participants in senior nursing roles felt satisfied that ED nursing produced rapid and tangible results because of early intervention, critical thinking, and advanced nursing skills. Participants spoke to numerous acute clinical scenarios that were perceived to be challenging but satisfying with rapid results. Two participants, Nurses 1 and 9, shared their reasons for taking up ED nurse roles by stating this in similar ways:

*“I am one of those people, I just love the fact that everything happens very quickly, and we can do a lot in a short space of time and trying to provide care in a very short time space for our patients.” (Nurse 9)*

*“So, it’s always challenging; quickly making people better and seeing results quickly, not knowing what’s coming in and having such a variety.” (Nurse 1)*

In addition, Nurse 1 spoke about being able to help patients experiencing physical pains which was also emphasised by Nurse 2 and Nurse 7. The ability to ease pain and discomfort was consistently heard amongst most senior nurses interviewed:

*“Somebody with a fractured humerus who you know is going to have a lot of pain or fractured hip to help getting their blocks and their plasters done so that their pain is alleviated because sometimes IV pain relief isn't going to fix it until we put the bones back where they are supposed to be, or your give them an arm block.” (Nurse 1)*

*“Being able to make a difference for people who are in physical or emotional pain or scared really quite rapidly.” (Nurse 2)*

Nurse 7 another senior nurse with extensive ED experience enjoyed her unique ability to ease discomfort, adding that she noticed appreciation by families:

*“I felt like I could make a difference, I enjoyed the interactions, contact with patients and was able to offer relief of discomfort/pain and see immediate or quick resolution and change in their condition. Families were grateful for your efforts; it was a privilege to be able to ease their concerns or comfort them when needed.” (Nurse 7)*

### **“ED nursing is never boring”**

The third subtheme describes the personal satisfaction of working in different areas of ED, filled with the unique acute clinical presentations of patients. Participants enjoyed the challenge of no two days being the same and constantly learning in the unpredictable and challenging ED environment. One participant felt that this unpredictability makes one alert stating that “it can keep you on your toes” (Nurse 5):

*“I think you never quite know what's going to come in. So, it really does keep you on your toes! I enjoy the challenge of, I might not know everything about every disease, but it's about that constant learning and that constant improving one's practice and what has previously been done might not be the best research approach now. I also enjoy the fact that no two patients are the same even though they present with similar sort of presentations, that they are different.” (Nurse 5)*

Likewise, Nurse 4, and worked for several years in other clinical areas, commented that ED is “my life now” (Nurse 4):

*“So, it's interesting, you never get bored, it's fun, especially, with a good team to support you, toward a good learning opportunity because every day is different, and because healthcare is changing day by day, there's something new you learn every day.” (Nurse 4)*

Two other participants, Nurse 8 and Nurse 12, shared similar comments regarding the variety and challenges each shift brings:

*“The uncertainty, the change, unpredictability with those patients; loved the challenge of working in different areas and the challenge of not knowing what's next. Every shift was different. The type of work encourages staff to extend current skills and to evolve their practice as new evidence supports changes in treatment management.” (Nurse 8)*

*“Just doing variety of things really, a variety of presentations. So, it's not boring – you've got to know variety of different things, it's never the same each day you go to work.” (Nurse 12)*

Moreover, participants expressed the need for ED nurses to possess a comprehensive knowledge base and a variety of technical skills. As one participant stated, “you are like a jack-of-all-trades” (Nurse 4). Likewise, Nurse 2, who had not practised a particular clinical task for a while, could draw on her previous ED experience and knowledge, and accurately assess a patient independently before any further deterioration. She felt excited and pleased that her prompt action led to a favourable outcome for the patient:

*“That was exciting because you don't always get to do things; you're not always in [that space], you not always looking at ECGs. So, having not looked at one for a while and being able to pick up a heart block, was quite rewarding for me: it meant that the patient was kept safe, not waiting to collapse like she did at the restaurant. That's rewarding!” (Nurse 2)*

Staying with working independently, Nurse 7 found ED work appealing and rewarding when she completed a primary assessment and initiated baseline diagnostic testing before the arrival of an ED doctor:

*“A fast-paced environment, exciting because of the variety, you did not know what was coming through the door, so you know something different all the time, I think that was what appealed initially, and to add, a variety of clinical presentations, autonomy of initial assessment – being able to fully examine patients, commence investigations, i.e., bloodwork, urine analysis, x-ray orders, etc.” (Nurse 7)*

The nature of the ED work environment, the variety and unpredictable nature of patient presentations, facilitated senior nurses in this cohort to support other nurses clinically. Nurse 1 and Nurse 10 felt satisfied from frequently supporting other staff so they can upskill and work independently:

*“I am extending another person's knowledge so that is rewarding in itself, so I am upskilling other people, helping them to become autonomous.” (Nurse 1)*

This upskilling was confirmed, by Nurse 10 who appreciated this level of support from senior ED nurses, CNEs and clinical nurse specialists (CNSs) when she first started because she had no prior acute medical and surgical nursing experience:

*“So, we have the clinical educators who are always there that we can go to. They do deal mainly with the new grads, but they are there for us as well to upskill and with things regarding our portfolios and then obviously as we advance through. I think the CNSs do a lot of that as well we’re just lucky that we’ve got good CNSs that are willing to jump in and give us a hand too.” (Nurse 10)*

At the end of this section of three subthemes, it is also worth noting that a small group of three participants provided other personal reasons for working in ED, citing convenience, comfort, and being closer to home.

*“That working closer to home and working in tandem with my husband, it's convenient for me because I home school my kids as well, so I can't do a 9 to 5 Monday to Friday job. I have to do shifts to [fit in with] my husband ... so we tandem, so he works and then you know, I work. Yeah, I would say we've got a really good thing going.” (Nurse 4)*

*“Why have I stayed? Because I love the work within; it's what I know, and it's close to home. I know how the department runs. I feel comfortable.” (Nurse 1)*

*“If you do not want shifting with all your family and friends because life is good here, you’ve accustomed to heaps of family friends, schools are nice, colleges are nice, that stops us leaving and the laziness, you have to uproot everything, and then establish from scratch – that’s the main issue of staying here.” (Nurse 5)*

This first theme highlighted the personal satisfaction in choosing to take the role of an ED nurse. Participants gave their reasons for working in ED, such as being in a unique position to offer physical and psychological support, enjoying the fast-paced nature of work, intervening quickly and drawing on their knowledge and experience, and autonomy, but also seeing the immediate effect of their interventions. Some participants referred to the work as “never boring” which, at times, provided challenges and opportunities for constant learning. It was clear that participants felt satisfied when they learned something new, and when they accurately assessed patients and provided care to patients.

## **Ways of Coping**

This second theme describes how participants coped. A common thread through most of the interviews was that nurses’ experience of working in ED enabled them to cope and work even though there were ongoing challenges within ED. Within this cohort of ED nurses, one participant (Nurse 8), who has extensive ED nursing experience, highlighted early on that ED nurses may not be aware of the stress they carry. Therefore, coping with stress was crucial for ED nursing. Some nurses had similar strategies for coping with stress while others had their own way of coping.

*“I think that the stress from working in an ED, especially a really busy one, quite often you are not aware how much stress you are actually carrying with, I think that there is a lot of unmanaged stress on nurses.” (Nurse 8)*

Coping strategies helped to refuel nurses in this study, to allow them to continue working despite stress. Several participants shared that there is no chance to debrief and that staff take their frustration out on each other. As one participant summed up, most participants alluded to that there not being a debrief after a complex situation. This differed from the work in other international EDs. The following four excerpts below provide context from Nurse 2, Nurse 10, Nurse 12 and Nurse 13. The three subthemes following these excerpts illustrate various ways in which some participants were coping.

*“Debriefing has never been something that we’ve kind of routinely, done in this department; in other places I have worked overseas it was routinely done after a stressful event. You’d gather everybody together and you would all discuss it, but here it just seems to be probably the nurses will discuss amongst themselves or, if it was really bad, you’d probably discuss it with the doctor.” (Nurse 12)*

Parallel to what senior nurses were commenting on the lack of debriefing, Nurse 10 reiterated the absence of any debriefing during her time in ED:

*“In the time that I’ve been there I, I’ve not had, we’ve not done any of it. If I’m honest, No! Doesn’t happen. I mean maybe it happens at a management level, I’m not sure, or a charge nurse level. But it doesn’t happen at our level.” (Nurse 10)*

Similarly, Nurse 13 admitted to not receiving any debriefing in ED, providing a recent clinical example:

*“I have not been given any opportunity; even yesterday we had a particularly challenging patient we were required to treat from a mental health perspective but ended up a physical altercation. I didn’t get hurt but I did ask the [nurse in charge] if we could debrief with the security team and psych liaison team, and we could have a chat. I noticed in my previous role there was never the opportunity and on the odd occasion that I did get to – it was so beneficial to understanding everything, what went well and reflect on what we could have done better. But I have not been given an opportunity once in my current role to debrief after a complex situation.” (Nurse 13)*

The lack of downtime or space to debrief during long 12-hour shifts, particularly during night shifts, and times of high acuity, short staffing and high workloads, left many participants tired and exhausted. This made it impossible to debrief or vent.

*“It was a hard few shifts, and I got to the end, and I just said to my manager, I just can’t do it, I can’t keep going with that much emotional load on, I need a break. So, I just left, and no help was offered which is interesting, ‘cos she said, ‘We don’t have time for that and you’ve just gotta keep going,’ and I understood that department was constantly hammered, we were lucky to get a break let alone have time to sit down and learn anything.” (Nurse 2)*

Participants resorted to other ways to support each other and adopted one or more of the following ways. Besides talking to each other, some participants like Nurse 12 shared the use of

social media platforms: Facebook Messenger and WhatsApp, though unofficial, as a current way of debriefing. Participants considered these platforms an agreed way to support each other that was safe:

*“So it’s just kind of venting to people and, we have got a few kind of Facebook kind of WhatsApp groups with people, I’m in a [with] few different people from work, so you can feel it’s a safe environment to vent any kind of issues and things like that as well so that’s another thing but, yeah, it’s mainly talking to each other really.” (Nurse 12)*

It seems some level of debriefing occurs through personal one-on-one conversations within the department. Carpooling between colleagues was an ideal opportunity to converse privately in the car on the way home (Nurse 8). It was clear that conversations with their immediate family members were extremely helpful after a stressful day because of the considerable time pressures and lack of opportunities for debriefing. As one participant stated, “It is important that staff have time out of work” (Nurse 8).

### ***“Looking after myself”***

Some participants affirmed that it was important to take care of themselves to be healthy and to continue working safely and competently. Besides regular conversations amongst colleagues, a small proportion of participants were able to cope by regularly exercising after work such as bike riding, going to the gym or walking with their family members or simply cleaning.

*“My sort of coping strategies are more outside of work. So, if something does happen at work, there have been a few times where I’ve just had to sort of walk away and sort of compose myself but definitely, I have to stay on top of exercising. I need to exercise in the morning; that’s one thing I’ve noticed that if I don’t do, I start to get really frustrated, really scratchy, and I can’t concentrate. So, I’m looking after myself at home.” (Nurse 13)*

Nurse 3 placed significance on exercise and stress reduction, which resonated with a couple of other participants (Nurse 8 and Nurse 9). It was clear that exercise helped with stress reduction:

*“I am quite active, do a lot of exercises, helps with stress. You have to do your best at the time.” (Nurse 3)*

*“I used to play a lot of sport and get rid of my stresses in the early days. Also think that the lack of recognition to debrief as a team after some shifts contributed to increasing stress levels.” (Nurse 8)*

*“I will go for a walk on the beach, and we do other things outside of work, which is very important, cycle to keep fit, and we tramped.” (Nurse 9)*

Participants who were on rostered shifts spoke about the significance of adequate rest, good nutrition, and adequate hydration (plenty of fluids), plus doing something relaxing and unstructured outside of work. Nurse 7 explained:

*“So, I over time when you are not sleeping it kind of tends to exacerbate stress; it makes you short with your family, you can often get short tempered. I tended not to go out as much socially because I was tired. And I think there were times you have to really look after myself and just take a step back and go out and enjoy yourself and do things for you and making sure you are eating well and getting adequate exercise and spending quality with your family to take your mind off the pressures of your workload.” (Nurse 7)*

In the same manner, Nurse 4 spoke about how he copes, and the importance of rest. However, some participants acknowledged the inherent difficulties with ensuring adequate rest after a roster:

*“In response to these challenges, we just go for an 8-hour, 12-hour shift, so we know this day will pass by so we just do what we can. At the end of the day your shift is done we come home and rest, so whatever happens we work as a team. We try to support each other, we do what we do, it's really exhausting but then you are coming home and taking rest.” (Nurse 4)*

In the same vein, Nurse 10, who was working long shifts, shared similar comments around lack of rest:

*“And I mean the way that we're rostered I mean at the moment, for example, I've just done three, 10-hour shifts and then I had Saturday and Sunday off and now I've got three more. So, there's not a lot of time between your, your rostered shifts to kind of recuperate yeah.” (Nurse 10)*

In addition, participants described how essential it is to take regular tea breaks and even prompt toilet breaks whilst on the floor and ensure nurses relieve each other. Participants gave importance to stopping and regularly engaging with each team member around breaks. This “checking in” with each nurse meant assessing current workloads, capacity, and the type of shift each nurse is assigned; whether an eight-hour or 12-hour shift, so that breaks could be allocated. What was clear from their responses was the need for an ED nurse to pause, recharge, and recuperate during their breaktimes while working long shifts as part of ensuring their wellbeing. Nurse 6 and Nurse 10 shared their views on coping in ED:

*“You have to sacrifice your own time, or time with another patient who's not as acute, because there are not enough resources. And that's a huge stress is lack of eating, lack of hydration. So, on a 13-and-a-half-hour shift, massive amount of stress; missing breaks and hydration, I gave a student an opportunity to practise a bladder scan on me. I only had 45mls in my bladder after a 13-hour shift – I hadn't peed all day – that was common to not have breaks. My only issue with it was missing out on breaks and often my shifts were far longer than the 12 hours or eight hours.” (Nurse 6)*

*“I've got a military background so, we are naturally put in stressful situations but for me prioritising that work, stays at work, and that the breaks that I do get, I'm outside in the fresh air away from the hospital environment.” (Nurse 10)*

In contrast, Nurse 11, a senior nurse, sounded dissatisfied with not being asked about a break, which was important for her to continue working long shifts:

*“One of the things I was annoyed about was I was on an eight-hour; two members of the team were on a 12. I was busy working up a patient; when I came back, they'd chosen all*

*their breaks and left me with bugger all and it's like, well you've left me with a 2 o'clock lunch break and I go home at 3!" (Nurse 11)*

### ***"Keeping your empathy tank full"***

The constant needs of patients in ED meant participants often had to put aside their own needs. Many participants had to manage their emotions to offer empathy and show compassion. As mentioned earlier, with little time to catch one's breath, participants recognised the importance of being empathetic and remaining mentally and emotionally strong. A participant said she would often walk away from the work area and look inwardly to compose herself to continue working. Spending time alone seemed to provide relief to return to the unit and continue work. Despite not sharing an opportunity to vent or debrief at work after a stressful experience, such as losing a child, a senior nurse commented that:

*"You got to give yourself time to process everything, you gotta to have sympathy and have your empathy tank full to what comes through the door" (Nurse 2).*

This participant went on to say that that she would portray an outward appearance of being "fairly calm" by holding stress internally and help herself feel emotionally and physically able to face the next challenge due to time pressure.

Nurse 9 spoke about how she dealt with stress, which she felt was essential when leading other nurses:

*"As an ED nurse you have to learn to compartmentalise your life because if you don't, you will just fall apart. So, having been a ED nurse for many years you have to learn how to put your stress aside because you can't go home and take that to your family, you get quite good doing that, having strategies to deal with the stress; as a manager the work is never done, you have to yet again get very good at doing that. So, you have to kind of sift through your own professional life and decide how things are going. I think in terms of my stress I have always been very calm. When you're leading a team, you have to be very calm, give an air of confidence." (Nurse 9)*

It was another significant aspect of empathy and linked to earlier findings that allowed time to engage socially, such as with family or work colleagues. Nurses in this cohort found this equally helpful because it "gets one's mind off pressures and doing things for you"; however, it may not be possible to socialise due to, for example, shift work, sheer exhaustion and the recent COVID 19 restrictions (Nurse 7). Whenever the possibility of socialising occurred, almost all nurses would take this opportunity.

### ***"Someone to talk to and vent"***

Not all participants engaged in exercise, reflection or distraction to keep stress at bay, instead, some would choose to chat with family members after work whilst others would look to a colleague to chat to during a shift. One participant acknowledged her mother-in-law, who shared similar faith or spiritual values, as someone she could trust and talk to when stressed. This

participant described how devastating it was to lose an infant or child in ED despite several attempts to save their life, but speaking to her mother-in-law helped her to deal with this situation.

*“The emotional ones, I mean I've got a strong faith so I my faith helps me and that's probably the foundation of where I go with tragedy. I talk to my mother-in-law believe it or not because she's an ex-nurse, and she's also a lovely strong Christian woman. So, I can discuss that with her.” (Nurse 2)*

Another participant (Nurse 9) in a senior leadership position mentioned her husband's role in coping with stress.

*“I tend to manage that – I've got a really good husband, and I'll go home and just talk about the day not about patients and he'll say ‘Let's have a cup of tea on the deck.’ ... And that's kind of how we manage that situation.” (Nurse 9)*

Most participants said that when faced with an issue or problem during a shift, having another person who could listen was helpful. Speaking to other doctors and nurses was one of the ways to vent before something drastic could happen.

*“I guess one of the things you have to do is give the staff the ability to offload how they're feeling about it and try to stop it becoming something that causes them anxiety or your or affects how they can perform their work. But sometimes, most people just need to have a little bit of a vent, don't they?” (Nurse 1)*

Similarly, Nurse 7 echoed the chance to vent:

*“I found not being able to ‘fix an issue’ stressful; patients waiting times to be seen, waiting to ‘see’ a Dr, waiting for results. This becomes tiresome for nurses which in turn can make them cynical and sarcastic. I manage stress by talking to colleagues ‘having a whinge’, spending time with family.” (Nurse 7)*

Another finding under this subtheme of “someone to talk to and vent” was how participants engaged with several members of the ED team such as colleagues, senior nurses, line managers, doctors and administration staff. On most shifts, discussion of the problem with team members would facilitate the exchange of ideas and options for clinical decisions or the best course of action. Communication in the form of an upgrade by participants to their shift managers, especially when participants felt unsafe during a shift. Their comments suggested they also felt anxious, concerned and stressed when unable to control a busy ED and escalated this to superiors. One participant, Nurse 12, felt her timely escalation had a favourable outcome because she could be honest with her shift manager, who listened and organised help during a hectic shift. Nurse 12 acknowledged her vulnerability in that situation since she could not take responsibility for her patients. Her actions resulted in a significant increase in the number of nursing staff who triage patients.

*“So, I contacted the [shift manager] to ask for some help and the initial response was we don't have anybody, and I said surely there has to be someone in the whole hospital that has to help because I take my responsibility for this waiting room has gone now. I don't have any responsibility for this, it's just too unsafe. They eventually sent someone from the bureau that helped in the wards. And so, we kind of addressed that and then she said*

*she was going to bring it up in the meeting the next day and since then I've worked out the front, we have had one to two extra staff each shift; so, it has been addressed and it has been actioned on, which was good.” (Nurse 12)*

In the same way, two other senior nurses (Nurse 11 and Nurse 2) valued chatting with another senior nurse, who could help with pressure on the floor.

*“I find it easier to bring it up with the charge nurse because then it's their responsibility to take it up with the person, but sometimes they're very stressed as well so, it's, it's very difficult working situations at the moment.” (Nurse 11)*

*“I do deal a lot with stress by talking to others. So, if we're in a stressful situation and I'm able to discuss things with the team, get ideas, delegate and work out better ways of doing things - faster ways of doing things. It's usually time pressure and it's usually acuity pressure. So, you might only have five or six patients, but the acuity might be high with them, and they might need a lot of your time, and that can be quite stressful. So, discussing with a team and taking it to someone like your charge nurse as well or the team leader. That was always quite good; they were not as rushed and hurried as you guys are.” (Nurse 2)*

This second main theme with three subthemes highlighted the ways in which participants faced the challenges ED presented. Some of these pressures were around time, acuity and wanting to offer the best care. Coping strategies helped participants deal with stress and continue working in ED. Participants also shared how important it was to look after themselves and have someone to talk to during and after a stressful day and offered examples of a healthy lifestyle such as exercising, rest, family time, balanced diet and recuperation.

## **Workplace Tensions**

The third theme reveals the perceptions of participants working at the frontline and the tensions between the role of an ED nurse and their ability to provide patient care. There were concerns, such as lack of resources (workforce, time, equipment) and impact on the entire team in some trying times. This theme involved conversations about ongoing challenges such as stressful environment, staff clashes and risk of abuse from patients faced by all participants.

While many nurses shared their reasons for wanting to work in ED, such as excitement about the fast pace, supportive colleagues, being able to apply skills/knowledge, autonomy, humor, convenience, and comfort, equally significant was the unhappiness that arose from negative experiences within the current work environment. When asked, “What makes you happy about being an ED nurse?” two senior nurses, Nurse 11 and Nurse 12, sounded unhappy about the inability to perform quality care:

*“It is you know it was for the satisfaction and being able to help people you know ... just a variety, but these days recently it's not possible. So, because it's just so busy that, we're finding that we're unable to do that at the moment.” (Nurse 12)*

*“When I can give good care. When you work with a good group of people, you feel valued, and when you actually have time instead of, like it is a lot of the time it's just basically tasking.” (Nurse 11)*

As mentioned, experiences related to stressful working conditions and/or unwarranted behaviour by team members and, at times, patients and families. To illustrate some examples, Nurses 1 and Nurse 5 were concerned about distressed and agitated mental health patients presenting and commented on better ways of handling them. Likewise, violence from patients and family towards staff was also experienced, leaving staff afraid and anxious. Many participants were stressed from working during COVID-19 in a challenging environment. A group of senior nurses also perceived unwarranted or unprofessional behaviour from other team members, making them upset and concerned. These workplace tensions resulted in many nurses feeling distressed, afraid, fatigued and, to some extent vulnerable, signaling their intention to leave ED unless urgent action was taken by management.

Despite sharing negative experiences in the workplace, several participants described being totally committed and trying to provide the best level of care that they can by prioritising tasks, being vigilant, looking after each other, regularly using coping skills (exercises, family time), and working as a team to ensure patients are always protected and safe. Comments by Nurses 3 and 4 underscored the value of best patient care, ED nursing's heartbeat:

*“The ability to help patients and that’s the whole point of nurses, and even 10 years down the line making I am very passionate about making the patient the most important person, giving them the best care that they have had, has not changed, so I guess that is rewarding.” (Nurse 3)*

*“For us our patient is the main priority so caring for them or looking after themselves, that is our main priority for us. They should not be on any negative side; they should not be harmed. So, we try to give quality care as possible.” (Nurse 4)*

### ***“It feels like a third world department”***

Some participants who returned to New Zealand after working overseas were shocked at the state of ED, describing other departments as more efficient and equipped to deal with emergencies. There were vivid examples of the lack of hygiene, uncleanliness, fewer cleaning staff, and a lack of basic equipment. Participants were concerned about the spread of infection. In addition to a staff shortage, anecdotes of working with a short supply of core equipment were voiced in the interviews. This created added stress when performing essential, urgent clinical procedures like 12-lead electrocardiograms with faulty equipment and measuring baseline vital parameters with faulty blood pressure machines, saturation probes, and beds. The flow-on effect was time being wasted in searching for working equipment. Participants were instructed to work under these conditions and make the most of it. Moreover, Nurse 7 stated that many ED spaces and beds were unclean and found it challenging to find cleaning staff as they were often short-staffed. To meet patient demands, nursing staff would often have switch roles to do the cleaning, which was time consuming, stressful and placed already stretched staff at risk of infection. Participants also reported having to do other tasks even though they were extremely busy:

*“higher (stress) even if there's no orderly to take the patient we have been asked, oh, can you push the patient? So we are doing the orderly job we are doing their job, so it's a high pressure to move the patient.” (Nurse 4)*

Nurse 7, who returned from overseas spoke, about the state of ED:

*“I had worked overseas the working conditions were good. There were countries where they had the money to buy basic equipment, and staff their departments with skilled people. So, coming back it just felt like even though we are a first world country, we're working in a third world department; there was a lack of hygiene, stretchers with old blood, I would end up cleaning myself, because I thought if this was my own family in this bed I would be quite disgusted! So then just little things which over time wears thin, makes you feel deflated because again it comes down to lack of funding, getting adequate people to keep, especially a hospital extremely clean.” (Nurse 7)*

Nurse 7 expressed her feelings when she went on to elaborate about the state of ED:

*“There is often a lack of adequate equipment, I was working often basic equipment, portable pressure cuffs, things that you would use all the time, so you just have to basically make do and that can be time consuming looking for equipment that is working especially, in ED where you need things, at your fingertips basically, you need them when you need them. Stressful whilst you worked on the floor for obvious reasons, and lack of adequate working equipment – often basic equipment such as blood pressure cuffs, O<sub>2</sub> saturation monitors, IV poles, blankets, etc.” (Nurse 7)*

Participants also shared experiences of the negative impact of ongoing limited funding with existing scant resources such as workforce and working with faulty medical equipment. These affected the nurse's ability to deliver safe and effective emergency nursing care. Nurse 3 expressed her thoughts and feelings about resources by comparing countries:

*“I've worked at two major trauma hospitals in the [country] which has double the amount of people who come through the doors over the years and a lot more resources and services provided.” (Nurse 3)*

Most participants reported short staffing as a major issue and obstacle on almost every shift, which affected the ability to provide nursing care. Early in the interview process, Nurse 1 sounded angry and frustrated when she commented that many nurses were hastily moved from an area that was equally busy, leaving other areas with staff unable to fulfil their professional obligation to perform duty of care.

Similarly, Nurse 4, explained that the nurses must constantly rethink, plan and shuffle workloads when help from other ED nurses was not readily available. He found it unfair that ED nurses must adjust their workloads to meet this shortfall when others do not. At times, management would send nurses to ED, but he said ED patients have specific and holistic needs. Therefore, they need an able ED-trained nurse, one with knowledge, experience and specialised technical skills, and help from others cannot meet this need. He felt frustrated from checking work and completing outstanding tasks in a busy ED.

*“We are in a great load – its meaningless, wards keep staff according to their numbers. If there is a sick call, it is taken for granted you can adjust, you can shuffle staff. We are*

*asked to adjust to do two, three staff jobs. You will not get staff straight away, never constant, ever changing. We are helped by management, but staff come to task but not of great help.” (Nurse 4)*

Staying with shuffling, Nurse 10 commented about how she felt with constant reshuffling staff to meet shortfalls:

*“I’d be lying if I said I hadn’t considered leaving, and but that’s just I think that’s just the increased workload and I think, that because of the environment we’re in, if you’re particularly good in an area, then you’re put in that area a lot in that, that gets exhausting, and I think we’re not very good at addressing if people are not performing in certain areas. We kind of reshuffle the staff which I mean makes sense but actually it burns out those that are always constantly reshuffled. I can totally see the more experienced ones that are leaving, why they are leaving, and it simply is that, that they’re burned out, it’s that constant pressure, if you’re performing well, you know, to pick up the slack I guess.” (Nurse 10)*

Nurse 12 echoed the challenge of lack of senior staff supporting junior staff within a busy ED:

*“At the moment we’ve got the nurse practitioners, and clinical nurse specialists not working as their clinical role; they’re gone back to a nursing role to help cover the staffing because we don’t have the staffing required now. So out the front predominantly we’ve got very kind of senior staff so it kind of works alright but I think the rest of ED probably is struggling with enough senior staff, the main area predominantly because resus [resuscitation] is generally well [staffed] and the COVID-19 area has got all the senior staff. You’re ending up with junior staff in the main area, which is not ideal.” (Nurse 12)*

The effect of a busy ED and short staffing on nurse specialists was again mentioned by Nurse 10, who had limited ED experience:

*“I think, well, stress is pretty high at the moment! With COVID-19 and it does it comes back to that the staffing levels just being so low the patient load has increased, and, for whatever reason they’ve reshuffled our staffing so that our clinical nurse specialists are no longer working as clinical nurse specialists they’re working as RNs on the floor because we’re so short staffed. So, therefore, that workload, has also increased where we have these complex kind of patients that the CNSs normally deal with that we’re dealing with at a nursing level on the floor which, you know, doubles the workload.” (Nurse 10)*

A senior nurse consistently signalled issues with short staffing on many shifts. Moreover, she also had to adjust but was clearly unhappy when working with very junior staff. Despite asserting herself, she felt her issues were not answered. Limited funding was marked as the reason for gaps in staffing putting more pressure on the team:

*“At staff meetings we would be told we are two staff down or shift changes and then we would regular team meetings staff would bring up the issues of are we having the staff replaced. ‘Are we getting more staff?’ was one of the mostly asked question and management would say we do not have funding to reemploy or add another FTE to the teams.” (Nurse 7)*

Nurse 7 sounded angry when she described the stress working with lesser staff imposed on her and the rest of the team during busy shifts. Nurse 7 repeatedly brought up the issue of limited and untrained staff during the interview:

*“So basically, it was funding, they just could not afford the staff that was needed-, management, but it basically came down to lack of funding for the staffing were the answers that we used to get. To me it was not ever prioritised that adequate staffing would actually benefit the department.” (Nurse 7)*

Nurse 7 went on to say that:

*“I think that there were a lot of times that there was not enough of staff, so staff shortages, which was stressful for – while you worked on the floor – for obvious reasons and at times, it felt unsafe to give good safe care to everyone you were in charge of, basically. There was often a poor skill mix, many new staff, a lot of staff were inexperienced or new grads, did not have the experience to prioritise as a more experienced staff member, which was stressful whilst you worked on the floor for obvious reasons.” (Nurse 7)*

Almost all participants commented on how unsafe it was working with limited staff and when sick patients are placed in the waiting room; when the department was busy, participants did not know what the patients’ reasons for presenting were. Being in the waiting room meant that they could not be attentive to them but were expected to keep an eye out for any problems. Also, at times, participants could not account for a patient’s whereabouts due to the nature of work in ED. Nurse 11, who often led other nurses, commented on patient safety:

*“We were down two staff out the front and where normally you’d have maybe 8, 10 in the waiting room. At this stage we had 27 patients in the waiting room, so there was no allocated nurse for the front of the house to organise them and you had one consults nurse working with the doctor. So, at one stage, you just had a triage nurse and you had 28 patients, there were no beds, so we had the waiting room as well and it got to the stage where none of us knew exactly what was going in ED, we didn’t know every patient, very unsafe. We had a lady approach the desk who had been sitting there for four hours and none of us realised (because there were two triage nurses) that she hadn’t been triaged.” (Nurse 11)*

### **“Finding more solutions for mental health patients”**

Several participants interviewed stated they were concerned about the care of mental health patients in ED and wanted more solutions. Five participants commented about the increased number of mental health patients presenting; they wanted to offer a high standard of care but faced challenges. Their recent accounts show how mental health patients are handled in ED and nurses felt their concerns were not acknowledged. A few senior nurses, who used strategies such as therapeutic communication (calming and listening, being visible and always accessible) and, at times, administered prescribed medications to help these patients, felt that these strategies did not help in the long term. Senior nurses expressed a sense of hopelessness and moral distress from having mental health patients wait for long periods, which took away valuable patient time with other ED patients. Nurse 1 tried to keep patients calm by being transparent and honest with these patients and their families:

*“There needs to be more solutions for mental health patients. Help the nurses with a mental health patient and try and keep the patients deescalated. Apologise for the wait and do what I can to keep them happy and get them to have a decent sleep.” (Nurse 1)*

Similarly, Nurse 5 spoke about the pressure she was under while in charge.

*“I am a leader, and I've got to keep my third eye on what's happening around the corner, it puts a big strain on the team, and that's what is a huge problem, not the number of cardiac patients you have in but it's the mental health patients. (Nurse 5)”*

The other common concerns from participants were that there was no reliable plan, processes, and systems for patients at risk of deteriorating psychologically. Often, ED nurses would put more time and energy into the patients and wait for the speciality team to review them.

*“I think the most thing I find stressful in ED, is looking for after mental health patients. I find it frustrating that often with mental health patients the teams have not charted a plan. We have bundles, easiest way to look after mental health patients, I've used the matrix in the past. I find my colleagues are bit slack at starting it. They wait for the eruption to happen before like forward pre-thinking about stuff, so I think that gets me distressed, because I find a lot of stuff not done in ED is common sense, really and its nothing to do whether you are senior or junior. So that got me stressed out.” (Nurse 3)*

Nurse 5 felt that the mental health system was under resourced. Coordinating a shift caring for patient with mental health problems was stressful, resonating with the previous interviews; and the current set-up of the bundle, which is a tick box or algorithm, is not helpful:

*“I think there is a there is a challenge with mental health, I mean the whole mental health system is just dire anyway, and it's dying a very slow death, literally and figuratively, but I find that when mental health patients come in, we don't respond as appropriately, as we should, because of the lack of resources that we have in the department for mental health patients.” (Nurse 5)*

*“We've just got best bundles for agitated and mental health patients that has been maybe four/five months roundabout there, maybe a little bit longer so we do have a bit of a pathway, but the pathway is literally what medication can we give them. It's not so much about the management. It's what medication can we give them quickly to knock them out. So, there's not a problem. And that's literally what it is, how much diazepam can I shoot up your bum?” (Nurse 5)*

At the same time, having a therapeutic observer where a person talks to the mental health patient, was perceived as inadequate. She acknowledged that mental health patients were focused on but needed more input for prompt treatment by the mental health team.

*“Now, we've got these therapeutic observers, and they will talk to the patient. They will calm the patient, they will liaise, they will let the nurse know if the patient needs anything so it's much more open much more therapeutic, but it's again, it's just like a holding pattern at an airport. You just waiting for something to happen waiting for something to kick off and it doesn't bring the mental health team any quicker. So, it's a bit fluffy if you ask me” (Nurse 5)*

Again, Nurse 4 continued that it was unfair performing all essential tasks for mental health patients without an incentive to nurse them.

*“that should be beneficial because I think mental nurses get 30% extra for the risk allowance, so risk allowance, these are the same patients who come to ED in their extreme behaviour when they are in psychosis, agitation, stuff like that, they come to ED then we give the medication and then settle them and send them to mental health unit and incentives are given to mental health unit when they are medicated and well settled than to ED nurses when they are in the extreme of their behaviours.”(Nurse 4)*

Participants who had been shift coordinators expressed frustration with the lack of beds; that there are never any beds for distressed mental health patients, and that they are “sitting in the middle of a busy ED waiting for hours and hours for somebody from mental health to help to come and assist them even or find a bed for them” (Nurse 9).

However, Nurse 1, was frustrated when she described the danger of patients waiting for an assessment and treatment in a busy ED with lack of beds:

*“The other patients that get stuck are mental health patients because there is way more people needing mental health intervention than there are mental health beds. I think that most I could have in a shift is eight mental health patients, so whilst they are safe and we are looking after them, they are not getting mental health care. They just basically babysat in the department and the longer you wait when you are under distress as a mental health patient, the longer you wait for care. So that brings in behavioural challenges and more at-risk behaviours and ‘code oranges’, unfortunately, because they're stuck in a plate, in a waiting pattern in an ED where they are not supposed to be. So, I think I would not say bad behaviour, more frustrated behaviour and mental health anxiety from the wait.” (Nurse 1)*

Her comment was on par with that from Nurse 5, who appeared angry and fed-up with the mental health team’s approach and commented on limitations within the current process when patients are eventually seen.

*“So, for example, when we have somebody coming in who has been medically cleared and they have to wait hours before the mental health team assess them and their behaviour can be very challenging while they're in ED and take up a lot of resources – the mental health come and see them for five minutes and they're fine to go home, but all hell's broken loose for the last six hours because they haven't wanted to be kept in and we've sectioned them and eight, nine hours later will see them for five minutes and say it's okay for them to go. We don't feel that they [are] safe to go home. But obviously mental health has assessed them, and the patient has told them some story about how they're going to keep themselves safe and off they go. I find that very disruptive, I don't find it an appropriate service for our mental health patients.” (Nurse 5)*

Nurse 5 also spoke about bringing in a trained mental health nurse to deal with ED patients.

*“I know that there are changes happening for mental health, but we were told this two years ago, and nothing has changed. Even if we did have a mental health nurse there, they can't make those executive decisions, and those are the decisions we want. I find mental health extremely distressing because I don't feel that the patients are treated in an appropriate environment for them, and they should not be coming to ED when they are medically unwell.” (Nurse 5)*

### ***“Feeling pretty horrible from patient verbal and physical abuse”***

Four participants gave vivid accounts of abuse by agitated patients and its impact on them and the department, outlining that working in ED carries a risk of verbal and physical abuse. They described harrowing experiences during busy shifts. These included stories of families abusing nurses:

*“One of her family members threw me up against the wall and was shouting at me ‘Save her, save her, save her!’ and I had to tell him that she was going to die. So, that was a pretty horrible.” (Nurse 2)*

In the same vein Nurse 8 was concerned about increased exposure to harm compared to the past:

*“The numbers are a lot bigger than what they used to be, people are presenting a lot more acutely, they are a lot more unwell, people with a lot more medical history in this day and age, more harmful drugs people consume recreationally, a lot of staff that can say that is enough a lot [of] violence from the patients but also from family members. I have seen a lot of nurses being intimidated by family members that are high on drugs or extremely worried, aggressive and I think that has to have a huge impact to get confronted with that sort of behaviour every day.” (Nurse 8)*

Nurse 4 expressed the risk of harm when working in ED:

*“Then again, same risk of people like physical risk mental health people, physical or verbal abuse. It's high in ED situation. So, you're in a higher risk of getting physically assaulted by people, mental health people or alcohol or drugs abuse people; verbally abused so that comes with the ED scenario.” (Nurse 4)*

Nurse 6 was vocal about the harm to staff and commented on difficulties in managing the abuse because she had been the subject of abuse:

*“We do get a lot of high percentage of unsatisfied, scared, agitated, aggravated and fully aggressive patients whether that's related to delirium, psychosis, or a personality. We're the first one in, so everything's heightened and intense. I had more a physical assaults in a post-operative setting than I have in ED, but I'd say that the, intensity of the physical assaults were worse in ED; I have a cigarette burn, I got cut by a pair of dressing scissors that got left by someone else, and sort of more from a disinhibited personality perspective rather than a psychosis or a delirium which is what I've experienced more post-operatively, but I'd definitely say that verbal abuse has been massive in ED compared to any other department I've worked in.” (Nurse 6)*

Nurse 6 also stated that there are not enough staff and experienced staff to call a ‘code orange’ to alert security when confronted with aggression which was perceived as unsafe. She continued to explain how she tried to raise awareness about her experience working with mental health patients:

*“I went on the strike, and I wore a pair of light blue generic scrubs, wrote the word for every injury sustained on the job. Now the uniform is covered in scars, burn marks, arm twists, inappropriate genital touching, kicks, punches, bite marks – I've got good scars from teeth that won't go away. I got people to write comments about their experiences,*

*and every time they would come up to me and say, can I ask, is that true, are those all injuries you got just at work? And I said, yeah, absolutely these are, these are only the ones I can remember because of the sheer volume of violence that we experience. (Nurse 6)*

### **“COVID-19 is a game changer for nursing”**

Participants shared their experiences about COVID-19 in relation to working on the floor, but what was consistent was that COVID-19 was perceived as another layer of stress added to an already stretched ED. Participants referred to a specific area in the department in response to COVID-19 as the ‘COVID corridor’ or ‘blue zone’ or ‘COVID zone/area’ where all COVID-19 or suspected COVID-19 patients would be assessed and treated. This was an attempt to mitigate any potential infection. Participants working during the pandemic showed how COVID-19 affected resources like time, space, staff and patient impact. Nurse 3 shared her experience about the readiness of ED for COVID-19:

*“With Covid, I felt I would be better prepared for COVID in the military than I did with Covid in the hospital. I think that the second wave has been dealt with a lot better.” (Nurse 3)*

Participants in leadership positions said nurses were first given mixed messages and had to deal with changes daily but, eventually, through teamwork, responded quickly.

*“I think the first time it hit, we had a lot of work to do in terms of getting a tent outside and looking at how we could screen patients, what I found really frustrating was the lack of timely communication in that project. You get communication from all angles and it was probably because COVID is COVID, and people don't quite know what that meant and what do we need to do. So, there were changes on a daily basis, but I, what I did like was that we were very quick to make those changes in the ED.” (Nurse 9)*

Participants also acknowledged the impact that COVID-19 had on staff’s personal lives with regard to their family:

*“I think what was really important that we looked after our team, people were very nervous; there was a lot of anxiety from team on the floor. People had obviously suddenly issues at home. They were turfed out of their flats, their family really nervous about their mum or dad coming to work and then maybe passing onto COVID. So, it was really looking after the team, which is something I love to do, and being aware all those aspects. So, there was a lot of work, but I think we did extremely well in the short space of time.” (Nurse 9)*

Nurse 12 offered empathy for nurses and their family affected by COVID-19:

*“And I think we as well have a lot of international nurses ... a lot of [a particular country] nurses that have lost family members or are trying to support family members that are unwell in their country and with COVID and so that’s extra stress on top of already work stress.” (Nurse 12)*

Patient dishonesty about COVID-19 symptoms was voiced by a couple of senior nurses, and was perceived as unpleasant and adding to stress. Not knowing if someone had COVID-19 or any other disease was a concern for nurses working during the pandemic because they could

unknowingly contract this infection when patient volumes were unpredictable. Nurse 4 and 11 relayed the risk during COVID-19:

*“When patients with this newly Corona virus or infection, well, being an ED nurse you're in the forefront, we never know what's coming, so you have to be prepared with all the PPE [personal protective equipment] and protect yourselves, especially with infections like this because patients are coming directly to you; they don't have any stickers on their forehead that they are ESBL[extended spectrum beta lactamase] or KP[klebsiella pneumoniae] or TB[tuberculosis]positive. So being ED you are exposed to those infections, risks and everything, so that exposure of the infection and other risks are always there in ED. And then you are taking it to your family to your home. So that's an extra risk being an ED nurse.” (Nurse 4)*

Nurse 11 was concerned about patient response during COVID-19:

*“Well, it can be very stressful depending on how well or unwell the person is. We don't treat the sick patients in resus we treat them in an isolation room away from everybody. It takes a lot of staff to look after one person which takes other staff off the floor. We've also got patients that aren't honest. So, they will lie about their symptoms to get treatment and then put everybody else at risk. It's not a pleasant environment to work in that's for sure; some days it's a huge issue depending on how many patients walk through the door.” (Nurse 11)*

One of the participants, Nurse 10, believed that COVID-19 had “worsened” the work or practice environment. She was one of many ED nurses who felt COVID-19 added extra stress in an already stressful environment:

*“That's probably the biggest one and I guess that just puts a strain on personally your practice not being able to provide the care that you would like to provide for every patient. It's particularly worse now obviously with COVID. So, we work in that blue zone that COVID zone. And I think it's probably put overall strain on us. As far as we were already quite short staffed, have a high turnover of staff and that's worsened with COVID. I think it just brings in that extra stress in an already what can be stressful environment. I think well stress is high at the moment with COVID-19.” (Nurse 10)*

At times, the pace of work within the designated COVID-19 area was slow, and frustrating for inexperienced staff. Participants commented that work in this area took a considerable amount of time because nurses had to follow a strict protocol of wearing PPE correctly. Staff allocated to this area followed process but were more conscious of the spread of infection to themselves and colleagues, so the process was perceived as labour intensive and stressful.

*“And I think it's just increased more this burnout kind of thing from COVID. As well the workload is, more intense – you're donning and doffing constantly, you're constantly in a N95 and full PP. That in itself for 12 hours is hard work.” (Nurse 10)*

Nurse 12 emphasised both the physical and emotional impact of COVID-19:

*“COVID-19 is a game changer really for nursing in that it slows you down and you feel like you are a little bit on edge when you are nursing these patients because you're constantly kind of thinking. So, PPE on fine and just every kind of step is, seems to be kind of slowed down because you're just ensuring that you are kept safe, and your*

*colleagues are safe. You are also conscious that you're trying to make it the best for that patient because that patient also feels you feel horrible and I'm sure they don't like having it and they probably feel you know like they're putting us at risk, and they quite often would mention that. So, you're trying to make them feel at ease.” (Nurse 12)*

A number of participants witnessed improper practice in the use of PPE. Sometimes, some staff did not follow the protocol, as evidenced by the lack of mandatory masks and gowns, even though compliance was monitored. Likewise, another senior nurse (Nurse 8) felt wearing PPE should be compulsory when patients are first seen at triage. Nurse 8 gave an example of the staff response following exposure to a positive COVID-19 patient because of consistent improper PPE practice at triage. As a result of this practice, staff were faced with the real challenge of attempting to retrace this patient.

*“I think COVID has changed the way we nurse permanently but interestingly, anecdotally, a lot of people and I am talking from personal observation watching staff work in ED, a lot of staff are not prepared to or they are not in PPE, they are not wearing masks and that all the time, especially at the frontline and I think that if you are doing triage, it should be mandatory that you should be wearing a mask and that's not happening and all of a sudden you get a positive COVID patient, then they are tracing, 'he was there, and what and how!' (Nurse 8)*

Comments from Nurse 13 about poor compliance with PPE policies were similar to those from Nurse 8:

*“In terms of PPE etiquette, it's not very well maintained, like, we've got our donning and doffing procedures, and we have an auditor but it's not consistent, is what I've noticed.” (Nurse 13)*

In reference to staffing mentioned earlier, many ED nurses interviewed pointed out that less space and fewer staff left the triage area with scant staff. Senior staff being deployed to the COVID-19 area led to junior staff working alone in other areas of ED.

Nurse 1 echoed the frustration expressed by another nurse in a leadership position after promises about adequate staffing were not fulfilled during the COVID-19 pandemic, leading to desperate measures to combat COVID-19:

*“We are supposed to have extra nurses for COVID. So, I could do a shift where I was three nurses short, not a nurse to cover the COVID corridor. So, if I had a patient who was COVID-positive, I would have to steal from another area which was already short.” (Nurse 1)*

Participants were anxious and afraid about people presenting with COVID-19. Nurse 12 commented that patients were aware that they are putting their staff at risk. The staff and patient anxiety were noticeable. The 'no visitor policy' which ED used to have now meant that all communication was over the phone rather than face-to-face communication, leading to frustrated and anxious relatives and staff. A couple of nurses in this study felt challenged, helpless and stressed because they could no longer engage in therapeutic communication with the patient's

family and include them in their nursing care. Nurse 10 revealed that families were more hostile because they were concerned but could not visit:

*“As far as families go, I mean with COVID-19 that’s become particularly difficult because we have a no visitor policy, only on compassionate grounds, so the relationships that we used to have with families which we could sit and could talk with them and we could see them, we don’t have that ability to do that anymore. So, I find the family side is far more hostile than it used to be, just simply for that reason is that they are concerned but they can’t come in. So, we’re doing a lot of, communication over phone, rather than that face to face, which is what, what they want.” (Nurse 10)*

Nurse 13 shared similar opinions about the no visitor policy.

*“During COVID especially, our COVID lockdown alert levels and with that we have a no visitor policy which includes family members and so that’s been particularly challenging when I’m looking after a vulnerable patient, whose family members can’t come in or it’s not quite I mean we do have an exception on compassionate grounds but, most of the time we don’t allow visitors in and it is a high stress environment I mean nobody goes to ED to relax right?! So, I deal with exclusively scared, frightened patients who are in pain and, and I have to tell them that their family members or support person can’t be there and it’s frustrating.” (Nurse 13)*

Nurses 12 found disproportionate staff allocation to the area set aside for COVID patients stressful. The loss of staff, and fewer patients, meant junior staff were prone to making errors from the lack of senior staff to precept and oversee their practice. Furthermore, more junior staff were deployed to non-COVID-19 designated areas, which meant there were less experienced staff in already-stretched areas in ED.

*“There’s senior staff all in the COVID area so you’re left predominantly junior staff everywhere else. So that makes that more difficult, and you’ve got less space to see those patients. So, you’ve got the normal patients coming into the white area; anxious about getting COVID. It’s kind of trying to relieve their anxiety and reassure them but you can’t reassure them completely because you know we’ve had issues where there have been COVID patients in a white area and that’s unavoidable really, because you can only screen and do the best you can. People are asymptomatic or people are not answering questions correctly and appropriately, so you’ve got all that anxiety that comes with it. We’re still getting the volumes in, but we’ve got a small area to put the volumes in.” (Nurse 12)*

### **“Treating each other differently”**

Participants shared negative experiences with team members and hoped they would treat each other with respect and collegiality. A small number of participants described unwanted or unprofessional behaviours, tensions and feelings between staff. A couple of senior nurses raised concerns about their experiences with undesirable behaviour from staff not wanting junior staff to progress. One participant who was upset indicated that she felt angry showing there was a problematic relationship among staff:

*“Educators that were not approachable to new staff. Education was lacking. Turnover is huge, it does impact on your job especially when experienced staff leave because they are harder to replace.” (Nurse 3)*

Nurse 2 experienced behaviours that did not make sense to her and gave examples:

*“As nurses, we don't, we eat our young and I mean quote unquote, I actually got told by my senior when I went to help a staff member pass her medication test, she'd struggled and failed the first time and I'd sat with her for a few hours trying to help her and learn and go through the book and teach her the book and I was told when she was going to sit it again that, 'If she passed it was my fault!' And what kind of statement is that? 'If she passes it's my fault!' I want her to pass and why do you say that it's my fault! It makes that her passing is a bad thing. What kind of statement is that to give a.) the person who is underneath you, kudos for making her pass and we did not actually wanted to and what a horrific thing to say and that kind of thing is nasty, it is just nasty, it's just unnecessary! We should have been putting our all into teaching this person, making them passionate about being an ED nurse and wanting to be there and not being like that.” (Nurse 2)*

Nurse 2 shared her feelings around the impact of uncalled-for behaviours within ED:

*“When we're not running around like headless chooks, you feel like people are looking at you like you're lazy, it's a different type of pressure and it's uncomfortable almost political-type pressure, which is uncomfortable, and I'd almost prefer the tragedies to tell you the truth over politics. Yeah, because sure that tragedies can't be helped but politics certainly can be helped and that is an ugly scene people get into and it's being forms mistrust and it makes your work environment a bit of an uglier place to be in.” (Nurse 2)*

In concluding her interview, this participant expressed her opinion that nurses should be kinder to each other:

*“Being demoralised on the floor. So, people who disagree about people's treatment or how you've looked after a patient and, I don't know, the rumour mill is rife. So, that can be saddening when you hear bad news about someone that has tried hard and you think we shouldn't be sitting here moaning about them, we should be teaching them. This is, you know, we need to be more like the medical staff where a mistake is a teaching opportunity not a bitching opportunity.” (Nurse 2)*

*“Yeah, I was talking to one of the charges nurses the other day and I think that nursing almost needs to take a break from itself and take a leaf out of medicine's book and start treating each other in a different way. We need to maybe take a more softly approach with each other and or be kinder to ourselves, in each other.” (Nurse 2)*

Participants in leadership roles who experienced undesirable behaviours referred to them as subtle. They felt they could prove nothing. Being excluded from meetings or hearing staff gossip about them left them feeling always uncomfortable, suspicious, questioning their abilities or as to why opportunities for growth were not offered to them.

Nurse 9 was upset and vocal about her experience:

*“It's very underhand and its pretty much in the vein of, they make you give you a certain persona with their mates in the management structure so then you come across even when people don't even know you, they might have said she's a hopeless manager or she's very stubborn or whatever, and that gets carried across as their picture of you, which I think's really dishonest. After a while you stop and I can talk to myself, you start distrusting people because here's somebody that you never talk to say something that you said to, you thought was your mates, or your colleague the month before; you think, hang on, how did that person know that? Or they'll talk about your department, and there's no way they*

*could have known some of the stuff about people in your department. And they know, so there's a lot of gossip. And I think it's very negative and people constantly seem to be trying to bring you down. I mean, that's just my feeling and so what happens is that you stop talking to people and you stop trusting people and so you have to have very good coping mechanisms to cope with yourself in the job.” (Nurse 9)*

She said it was difficult to prove she had experienced this behaviour:

*“They are so sly, it's very underhand, and even when we have very good examples to get rid of them, it's so very difficult; and why those people do it is beyond me but it's horrible and it affects the whole team, and that's why it's not great.” (Nurse 9)*

One participant (Nurse 8) stated that staff were “picked on by both middle and senior management and management was not supportive”. Senior nurses interviewed asserted that staff who experienced undesirable behaviour were afraid of what would happen if they were to complain:

*“I do think that a lot of senior staff basically suck it (for want of a better word) rather than confront issues of concern because of personality, conflict and that with people in senior management but also too they have seen what happens to colleagues that have fallen by the wayside.” (Nurse 8)*

*“I think that people will not speak up because they're scared of the repercussions. So, for instance if I say something about that senior nurse then my roster's going to get worse or I'm going to get less opportunities or I'm going to be overlooked for promotions. That is a lot of that fear that if you're going to say something it is going to be disadvantaged you. It's an awful thing about nursing, particularly senior nurses, people who have been there for a while are more likely to do that to younger nurses. I really detest that, really think it sad. So, we had a nurse who had been around for little while come to a senior nurses' group and discuss how the staff felt on the staff's behalf – it was incredibly brave of her. But now her work is now microscoped. So, she's a person that may leave because of it because everything she does, they will criticise her because she had the courage to come to a meeting and say this is what the staff are saying, this is what staff feel, and it didn't, it didn't help her career. She is mature enough to know but that's bad, too, because we should be able to listen to the constructive feedback and get better. I think if your leaders are insecure in their own practice then they're not going to take that.” (Nurse 1)*

Nurse 1 added that she is trying to convince the colleague affected by negative behaviour to remain:

*“They didn't hear the message. We talked about it because I don't want her to leave because of it and it was maybe eight months ago now. She still thinks of leaving a lot.” (Nurse 1)*

Another participant labelled the environment as toxic – earlier she gave a vivid scenario of not being asked about being relieved for a break. She felt that staff are not cared for; her perception was that there was an underlying element of people playing off against each other and unfairness within the unit (Nurse 11). Having worked there for several years, she chose to reduce her hours to avoid this unpleasant experience again:

*“Well, I love the nature of the work, but I was there full time and I left because it's quite a toxic environment like, there's an underlying element of sort of playing people off*

*against each other and not giving some people stuff and giving other people stuff. There's ineffective management.” (Nurse 11)*

Nurse 11 went on to add:

*“The people above don't necessarily know what's happening on the floor and certain people get away with things that they shouldn't get away with, but they're not stopped but then somebody else does something and they're jumped on. So, there's no consistency. It's easy for me because I come, I do my job and I go. But, yeah, there, there's definitely this underlying sort of toxic environment, which every so often bubbles to the surface. And I think I can't see myself ever going back there; I mean once it gets into your blood if you've done it long enough, you're always going to want to do it in some shape or form. But the staff aren't valued and they're a number – you can be replaced.” (Nurse 11)*

Another participant's roster was affected when she tried to escalate ED problems:

*“And then you try to report or incident report it, I've even casually spoken about it to the head of [department]. They tried to not roster me on those days. They tried to, when [a certain person] was on the floor that was probably the only day I we had so much staff that we could take breaks properly. And in my opinion, it was so that I wouldn't be on the floor when [that person] asked me about how we thought we were dealing. And so, you know going up against something that seems so hugely against you keeping just simply your patients safe, is too much so too hard basket – I'm out. At least, that's, you know, what it can feel like at times.” (Nurse 6)*

Participants also felt they were left out of communication and not properly informed when there were important events, information and or changes affecting ED nurses This caused them to feel disconnected and undervalued:

*“What I find is a bit of a stressor is the communication lapses. So something will change the people that were with you on shift will know about that and then that's it, nobody else knows, and then you'll go and do it the way it used to be done for instance; say there's a change to triaging which has happened just recently – they changed the paperwork – and we've never had any communication about that, no emails, so few people know about it, some people don't, so those sort of things.. We're going to continue the old way and other people say no you must have new way. So, that causes friction in the team. I think if people were better at communicating the changes, send an email to all staff saying or put a sign up where it [equipment] was staying, where it is now, it's simple stuff like that that wastes a lot of time. There's often no one taking responsibility for that change, and we had a lot of changes from the COVID, whole rooms were moving without people knowing.” (Nurse 1)*

Nurse 13 referred to being left out of communication as a cloak and dagger setup and felt this was reason for staff leaving:

*“So, we've had about, I think, we've had 12 senior staff members just resign, and it has been for various reasons but a majority of it was, that a common trend I had noticed was the progression and the dissatisfaction with the upper management, those were two common themes. And various reasons of, financial sort of incentive a lot of people are going to Australia. And I have noticed, ah, about four new staff members start and they have been brought over countries but through managed isolation and they've started on the floor, so I don't know, like there's, there's a, it's under cloak and dagger, and upper management don't talk to us about where they're sort of recruiting people from.” (Nurse 13)*

This third theme with the five subthemes captured participants' feelings about tensions within the work environment. Their experiences impacted them. The tone within this theme suggested nurses were fatigued, stressed, discouraged and hopeless, yet continued to work in EDs. Many participants felt unappreciated and used words such as feeling not valued and deflated and "just a number", and shared negative experiences.

### **Professional Development is Important**

The fourth major theme highlights the importance of professional development, education, and training. Participants used words such as "study days," "upskilling," "conferences," and "courses" to refer to the theme of professional development. They spoke to three key areas which formed three subthemes: whenever PD is offered, all staff have opportunities to attend, but also PD sessions are not postponed or cancelled. Also, most participants commented that education sessions should be regular, and content carefully planned around specific training needs of nurses. Furthermore, all inexperienced staff must be supervised by senior staff to continue to work confidently, efficiently and safely. The main message is that any junior staff be left alone but are constantly mentored and supervised.

The following accounts from two senior nurses support and set the tone for this theme. These participants voiced concerns with trained ED staff leaving the department and trying to keep up with retraining new staff. Nurses have limited time and staff to offer training during a shift, and the quality of education can be very diluted when there is constant staff attrition.

*"Well, it does have an impact on my job, because I got to keep training up new people."*  
(Nurse 5)

*"So, they train a lot of people up and then they leave and then they have to start again, and you know so people fall through the cracks and do miss out but it's just this constant, cycle of retraining people basically."* (Nurse 11)

### ***"Study days need to be protected"***

It was discovered that priority is always given to escalating patient loads rather than professional development, not only for junior staff but also for senior nurses. During the interviews, it was often heard that long-awaited professional development days were abruptly cancelled due to staff shortages and workload demands. Because of this, participants were left feeling disrespected and frustrated.

Participants spoke about their rostered professional development days being impacted, and that they had been asked to abandon study days and work clinically due to staff shortages. Also, training in core technical skills is missed when study days are cancelled to meet staff shortfall:

*"I think that the struggle to complete learning/in-services to further education due to lack of staffing/time. There would always be delays or you know cancelled because we did not have adequate staffing to cover you while you did the in-services, so, you know education."*

*So, I think education was lacking. That was a kind of priority in some of the international EDs I worked in.” (Nurse 7)*

Nurse 13 felt she missed an important opportunity to become competent.

*“I’ve had study days that have been cancelled, we have a list of standing order medications that we can administer but we’re required to do a, a med test which is fine and perfect you know absolutely that needs to be governed in a way like that but that’s something that normally gets done for new staff within the first two weeks and, as I said, I’ve been there a year and I have not done that or had an opportunity.” (Nurse 13)*

### **“Knowledge is power!”**

Many participants commented on how staff can benefit from education sessions that are planned and implemented and consider ED nurses’ learning needs and how this can improve patient outcomes. Nurses 7 and 8, with extensive ED experience, felt that offering carefully thought out, structured and regular education and training would build confidence in the nurses’ knowledge, clinical abilities or competence. Most participants agreed that sessions should be continuous and plentiful so that all staff can gain technical proficiency and confidence in nursing patients.

*“I’d like to see EDs have the adequate education, have in-services so they feel confident. I think if you feel confident in your position you more than likely to stay, and you can handle situations and stress a lot better, I think if they had that opportunity to be able to do courses, and multiple scenarios, enough staff, I think that the retention would be higher, I think staff would feel more valued, when you are doing the same old thing and told, you know, ‘No, you cannot work in that area because you not qualified, you have not had enough experience, you have not done the in-service to work in that particular area.’ I think it can be a little bit demoralising.” (Nurse 7)*

Nurse 8 spoke about how she felt with the current training offered and challenges:

*“So, we have official study days and but, on the floor, supportive training was not there because logistically they couldn’t manage it, we barely had enough nurses to patients. There’ll be better supports or better infrastructure or better training or more recurrent training rather than just being trained once and just being assessed a year later” (Nurse 8)*

Nurse 5, who had worked abroad, felt that rotating junior staff between hospitals allowed them to be exposed to a variety of settings and learn expert knowledge and skills. She pointed to the current system commenting that “staff get itchy feet” once they are skilled in all areas, which can lead to boredom and cause them to seek opportunities elsewhere:

*“So, I think if we just had a little bit of access and learning at other places and a proper learning package to go with you it follows you around, then you broaden your experience, you bring that experience back to the unit and that makes you feel like you’re contributing and you’re learning at the same time. So, it’s a win-win – you win with extra education and the areas win because you bringing back your knowledge and I don’t understand why they don’t do it. It’s crazy, we used to do it in [another country] and I went for neurosurgery. So, I was there for like four or five years and then we went to cardiothoracic and then you did six months there and then you went back down to general*

*cardiology, it was great, and you could choose to go on, you didn't have to do; but if you did, it just gives you a variety.” (Nurse 5)*

Senior nurses with over 30 years of ED experience and training felt that, at times, they had to seek training themselves due to other staff PD needs, and gave specific examples of what kind of professional development, education and training would help them working in ED:

*“I have to seek that myself and sometimes and a very good example I used to go to an ED meeting that was really important to us with all the CNMs [Clinical Nurse Managers] of New Zealand and all the EM [Emergency Medicine] clinical directors and it was really important in terms of what was happening you know with your mates and what were other people doing in their departments and it was a lot of learning and education. We just don't get asked to go there anymore. So you have to look for your own opportunities and you owe it to yourself to keep learning because it's so important. Otherwise, you just stand still and that's not healthy and I'm constantly looking for opportunities to learn.” (Nurse 9)*

*“They brought new graduates directly into ED and they started to increase the numbers; that meant that there was a lot more responsibility from senior staff but it also meant that all the education priority went to the new staff and more senior staff are left by the wayside and if they wanted to seek education, they had to find their own means to do it because their department was not providing that stimulus. I used to find it frustrating that all the support went into junior staff and experienced staff were ‘neglected’ in terms of study days.” (Nurse 8)*

*“I think we don't have enough coaching around things that individual nurses need to improve or upskill on. So, for instance, myself, I can put my hand up and say I'm dreadful with computers. I would love to find somebody who could just take me through and teach me that so if I had funding for that, I could go into a course, you know what I mean? There are, there are not necessarily a course on asthma or some diabetes. But and even that's fantastic if somebody could go a spend a day supernumerary, and orthopaedic ward or coronary care that are going to ECGs, those sorts of things (Nurse 1).*

Nurse 1 said that it seemed that some staff take up all training opportunities compared to other nurses. She was one of several participants who suggested a better approach to ensuring this training is fair in ED:

*“I think if we treated nurses as ... individuals not as a big lump, so for instance to get funding to study, you have to apply – some people get to go together and do lots of studying, some people get none – so [city] nurses have a system where each nurse gets x amount of dollars and they can use it towards university studies or going on courses or going to conferences which to me seems a bit more fair rather than if you're the person that knocks on the educator's door, who is it all the managers door and knows the right things to say, you're going to get all the input. Whereas some people, we've got nurses that have been in a department for over 10 years who have never done anything and nurses who have been there 18 months have done heaps. So, for those people that have been around for a while who might be a bit quieter, ... a little bit less university savvy or a little bit fearful of that, they are not going to get education really apart from study days that are offered and that's it.” (Nurse 1)*

Nurse 1 suggested a way to offer training for each nurse:

*“We've got eight less hours per year per nurse now for, since COVID-19 has happened. It's taken away eight hours and those eight hours have gone for good and the nurses need to do, I'll trying to think, 30 hours a year, something like that, PDRP [Professional*

*Development Recognition Programme] and we've taken away eight. That's a significant amount. So, I think if we had a per nurse system so that it's fair and then you as an individual nurse you have personal responsibility for utilising that those the hours that you will get for the dollars, however they work it out, to ensure that you keep upskilling. Rather than, well, she's got, she's been sent on five courses, I've been sent or none, so that gives a little bit more autonomy to them to actually, you know, organising themselves, [to] find stuff themselves in get some help with.” (Nurse 1)*

Nurse 1's comments on funding echoed with another participant, Nurse 5, who hoped to have funding enabled to fulfil her passion for postgraduate courses. She attributed staff turnover to the lack of funding for study, among other things. She compared funding for postgraduate studies with her previous role and justified reasons for the organisation to fully support staff with further study:

*“When I was at [Facility A], there was funding for further education. So, we got \$300 a year per staff member up to a maximum of \$900, \$950 is your cut-off and you can just it just keeps accumulating each year up until about \$900 a \$1000 and you could use that for conferences for books for, study days. On top of that, in [city], we if we apply to funding to do a postgrad certificate, diploma, master's or PhD, you will quite likely to get it. There is nothing like that in ED. I've just applied for funding to do a postgrad diploma because I got my postgrad cert, I've just applied, I'm still waiting but I mean it apparently, it's very scarce and what they'll only do is fund you up until postgrad diploma, and when I queried this, they said, well, there's only got a little pot of money and they've got to spread it out thinly.” (Nurse 5)*

### **“Being a fairy godmother for junior staff”**

Throughout this study, several senior nurses' narratives echoed the view that junior staff were not prepared for a busy ED and, therefore, do not stay long. Junior staff require a lot of support, care and encouragement from senior staff, and there was a consensus that junior staff lacked skills, knowledge and experience and while they knew “stuff,” they had not matured enough to fully care for patients. Junior staff were therefore unable to handle complex patients or needed a lot of checking up on or watching until the task was completed.

*“Having trust in my workmates is important and I do, I do have to admit I have trouble having trust and a lot of these new people that are coming through but have no experience like the new graduates. And I know it well, but they do well by being pulled through a hell of a learning curve and they often still miss out on some stuff, some intuition that you get from seeing things again and again and again, and a lot of the nurses that we hire now seemed to come from areas that have no real medical background or no real surgical background, and they've got big holes and their training and their learning in such an acute environment, that does erode some trust because, you know, as the senior you've got to go and check everything and you hardly got time to do your own work, let alone take everyone else's.” (Nurse 2)*

Some of the senior nurses felt that competence in ED depends on the individual nurse and what each day brings, whilst many other staff felt that ED is a very hard environment for new people, especially with no experience, and they described feeling that junior or new staff can become overwhelmed:

*“But ED is a very hard environment for new people, especially with no experience. They you know, it’s, it’s easy to burn them out because it’s so, it can be so overwhelming like I look at some of the new staff that are working on the floor now and they’re just shell shocked. Like, you know, so overwhelmed because, on any given day, you could be two or three staff short and there’s more patients coming through the door than you know what to do with. I mean you can support them to the best of your ability but, it’s, it’s not an environment for everybody.” (Nurse 11)*

*“Your attitude towards yourself, and to others, is a little bit more martyr-focussed, a little bit more self-important. And with that those attitudes can come an environment that can eat your young.” (Nurse 8)*

Therefore, a participant in a charge nurse position ensured that junior staff are cared for and supported, which she referred to as “wrapping people up.” She explained how another senior nurse is like a fairy godmother for new graduates since, from day one, she makes herself available and there is close monitoring and support for inexperienced staff with teaching on the floor:

*“We wrap people up, the new grads, to change; Mrs X one of our charge nurses, she’s like their fairy godmother so she checks on them very often and we tell them they must come and see us when they got issues and you know all that sort of stuff, and we read our people quite well so between senior team and myself we quietly realise that somebody might have an issue and then we will very quickly intercept and talk with that person or provide support or whatever.” (Nurse 9)*

*“So it’s absolutely essential that we do that to get them on the right track start with because it’s scary being a new nurse and we’ve currently got four new grads that we started preparing, so it’s very obvious that – and we know this – when they were new nurses are like a baby nurse, they need a huge amount of support. So a lot of our new grads come from pre-reg. We kinda of already assess them as a student at pre-reg time and that’s very good for us because we kinda of already get a gauge of how well they work in an ED. And then we have a coaching system where we have supernumerary coach who’s not part of the team of each area in ED but they spend a month in each area, you know that we have several areas in ED, which is a real challenge because unlike the wards that’s a huge amount of orientation we have to provide to make sure people are safe.” (Nurse 9)*

A participant who worked as a team leader in ED was able to teach junior staff and highlight the importance of prompt communication in relation to patient outcomes:

*“So, I’m having to put a lot of trust in staff that I don’t know very well and sometimes it’s great when you have experienced staff with you and it just flows, honest, touch wood again, nothing much has happened and all that, even the junior staff have done very well but I do say to them, you need to come back to me and tell me, one, if you don’t know what you’re doing and, two, if you get an abnormal result, and three, you’re having difficulty undertaking something. I don’t you know in an hour’s time. Oh, sorry, I couldn’t get any blood. I need to know these things. So as long as I can have open communication and that they’re comfortable with communicating with me. Yeah, because I think with nurse training, sometimes they do not want to tell you that they don’t know, and I always say to the students and new staff, it’s okay to say you don’t know but it’s not okay to pretend that you know, because our patients and our safety of our patients is paramount and not your ego.” (Nurse 5)*

A new graduate expressed her concern about being expected to precept other nurses or students when barely graduated themselves. This affected the workload negatively. Similarly, one

junior staff member commented that there was frustration amongst staff when they were expected to precept new a staff member or student despite the RN preceptor being unfamiliar with ED specific policy or procedure. She stated that it was an “oversight” to not offer an option to staff, which makes it difficult to excel when she must learn (Nurse 13).

*“And even the people that are team leading are predominantly reasonably junior staff so they wouldn’t be resus trained. And they’re the ones that are kind of the team leaders so it’s yeah, I think it’s a difficult environment to work in. And they don’t know what they don’t know.” (Nurse 12)*

According to a senior RN, emergency nursing comes with experience and ability to plan, prioritise and time manage patients, and junior nurses just do not have these skills.

*“And I think a lot of things in ED nursing is kind of gut nursing and learning from experience and yeah just being able to pick up that something’s not quite right and I think that comes with experience and it you know everything like that which they don’t have.” (Nurse 12)*

Nurse 12 spoke a lot about junior staff working in ED. She commented on the previous way of nurse training, in which solid medical and surgical nursing was foundational and a prerequisite before a nurse applied to ED. She added that ED nursing relied on instinct referring to this as “gut nursing,” which only comes with training and experience in ED.

*“And just basic knowledge of, you know, medical, surgical issues and things like that you learn on the ward. I think ward nursing is good to start with and I think it’s, well, it used to be when I first started emergency department, you had to have I think two or three years post grad, medical, acute nursing, like some either medical, surgical, orthopaedics you know, but it had to be acute nursing before they would consider you for an ED post. I think I’m from back in the days where they used to retain staff probably a lot better.” (Nurse 12)*

Nurse 12 was concerned about the experience she had whilst working with junior staff.

*“ED, is, is very difficult and it’s not the right place for them but, yeah. And, you know, they do get upset and I’ve seen especially in these days, everything is very big, and patients and relatives are very highly they’re everyone is stressed. So, ... in [city] at the moment so people will fly off the handle. I’ve had a few incidents lately where junior staff, this is predominantly at triage because this is where I’ve been working most of the time, patients come and yelled at us, and they’ve just burst into tears and it’s just, yeah, it’s just lots of things like that. They haven’t got the skills to deal with that really because of what’s happening [patient yelling], and I think you know it’s difficult, especially now, I think it’s very hard for them so no I don’t think it’s the right place for them.” (Nurse 12)*

There is consensus amongst many experienced staff that junior staff are thrown into a more challenging clinical situation compared to previous years. In the past there was a gradual progression from one area of ED to another, with plenty of senior nurse oversight and support. Nurse 12 summed up that ED was not the right environment for new graduates, suggesting that all junior nurses complete acute nursing (medical/surgical) before employment in ED. In addition, there are currently no experienced staff to oversee and train junior staff.

*“It’s a difficult environment for new grads and I’ve always said I don’t think it’s the right environment for new graduates. I think they could have experienced working somewhere beforehand, whatever it is it doesn’t matter, just a kind of acute nursing first before they come to ED. I feel quite strongly about that difficult environment, and we don’t actually have the staff these days to actually precept them properly and give them time that they need and quite often now, like I say, in the flight deck now it’s predominantly all junior.” (Nurse 12)*

This theme outlined the significance of professional development, education and training for all nursing staff in ED. Comments from nurses in this group revealed that the structure and content and delivery of education and training must be considered. Emphasis was placed on investment and commitment to all forms of professional development sessions. This means sticking to a prepared education session, and ensuring that sessions are not cancelled to meet the demands of ED. Furthermore, a lot of emphasis was placed on how junior staff are precepted to meet the demands of ED because they do not have the same experience, skill and knowledge as ED nurses. Experienced senior staff hoped to see junior staff (inexperienced, new graduates) supported (“wrapped up”) through constant supervision, teaching and mentoring. Furthermore, nurses will feel respected and valued when these education sessions are available. Robust education and training for any ED nurse would reduce a nurse’s stress as they would be better informed, better equipped and more confident in dealing with complex patients in a busy ED.

### **“We All Chip In”**

This fifth theme focuses on the importance of teamwork and positive experiences in working with colleagues. As one nurse pointed out, “you cannot be a lone ranger” (Nurse 9) reiterating importance of a team. Collaborating as a close-knit team, even during short shifts, seemed to create happiness and provided strength to each team member. Even though nurses faced relentless challenges daily, nurses supported each other, regrouped after a stressful event, kept an eye out for each other, were available for clarification or help, but also tried to adopt socially acceptable ways of appreciating each other whilst at the frontline.

*“It’s great when you’ve got a team of people that you know that you’ve worked for us for a while that you trust and that you can just bounce ideas off and get help from and really work together as a team.” (Nurse 2)*

### **“Sense of humour”**

During complex workplace roles with no time to debrief, the participants spoke of entertaining each other with short stories, jokes/humour which helped each other relax and allay anxiety. This resulted in team cohesiveness during long and busy periods.

*“Oh yeah, sense of humour is huge, sense of humour is big, I love to laugh at work with my workmates, and that’s what makes the team enjoyable to be around and what gets through the darker moments as well, because there are some dark moments at work, ‘cos there’s camaraderie.” (Nurse 2)*

*“It's really fun, especially with good team to support you, to guide you toward a good learning opportunity.” (Nurse 4)*

Teamwork was the chief reason for almost all nurses working in ED, as one nurse commented:

*“Well, I think that it's mostly the team that you work with, I think it's really important, the culture of the department is very important, so people, are you know happy and thrive in a place where they learn, and you know further their career.” (Nurse 9)*

Participants who were in leadership roles appreciated their teams by helping them and, where possible, reduced the workload of individual nurses, checked on and rewarded team members at the end of a busy shift. This simple gesture valued the team, which in turn strengthened team members and boosted their confidence.

*“Everybody's working flat tack; when it's all over I get the lollies out and we all have some sugar. That's great.” (Nurse 5)*

*“I think, what, a bit more about leading by example, trying to take away some of the load from the staff and trying to problem-solve with the doctors that are looking after a patient.” (Nurse 1)*

### ***Relying on each other***

Participants said they had a good mixture of experienced and inexperienced staff, who were like-minded, that is, they shared things in common:

*“I think that I have worked in places, I have worked with a team that generally is multi-skilled, highly skilled, and [in the] time I've worked there they have like minds, so we had things in common we like to see.” (Nurse 7)*

Nurse 7 went on to say working closely helped during patient surges:

*“And staff, as I said earlier, were great teams and initially a good mix of staff, both experienced and newer staff, and also, a good variety of ages – which is important in a department like that too; you had your younger staffing and you had your older, more experienced staff and they had to get along with each other, because they worked very closely especially in resuscitation areas where there is high volume of patients.” (Nurse 7)*

*“I would say generally I have a great relationship with the people I work with, so I guess that is rewarding. It is nice to go work every day, you know. We have a good rapport with your colleagues and it is great to have being able to intervene when patients are sick, and actually know where their disposition is gonna be, act on that early, and I really enjoy that part, I enjoy the part of, you know, intervening early, using my critical thinking and skills and you know 'cos a lot of the time the doctors are junior and it is nice to be able to work like more collaboratively together, you know, suggest things, 'cos you could maybe give that patient a better outcome – help patients. So, I guess the rewarding things are good teamwork.” (Nurse 3)*

### ***“Everybody just mucks in”***

One of the participants commented that *“there's nobody sitting down and picking their nails while another team is rushed off their feet”* and that their *“stress and trauma is everybody's*

*stress and trauma.*” She was one of many other nurses who enjoyed helping each other out and referred to this as *“everybody just mucks in”* (Nurse 5). Furthermore, her view was that there was, to a certain level, a flattening of hierarchy in ED; that everyone is learning irrespective of professional rank or title (Nurse 5).

There were many conversations about working with effective team members or allied health teams, such as social workers. Participants spoke about easily accessing them, collaborating and formulating plans for the patient, including ongoing care once discharged.

A senior nurse explained:

*“With allied health – they were part of our close-knit team and allied staff, you had to work closely with them and have a good relationship, good rapport with them so that you could get the job done.” (Nurse 7)*

Other nurses spoke about their experience working with health professionals in ED.

*“Multi, multidisciplinary team in ED, you end up with a good relationship with all kind of, aspects of everybody really, especially kind of, predominantly the, emergency team. You have a really good relationship with them. Sometimes it can be a little bit strained on the specialities depending on who’s on and that, but generally I think ED you have a pretty good relationship with most because you do face to face and you know most of the time they respect your knowledge And your previous skills and so they will kind of listen when you’re concerned about a patient or want something. Yeah. So, I think, yeah, you probably have a better relationship in ED then what you would do on wards and things I would think.” (Nurse 12)*

*“I do enjoy, and I love doing and we have a social worker, and we have a discharge coordinator who I have a good relationship with and sort of we know each other, we all know who we are, and I know what I can ask from them. And they’re very, they’re very supportive and very proactive in getting everything done. And they, they’re really encouraging so you know if there’s something that they can’t do that, that I would be able to achieve then, then that’s you know we, we sort of help each other out in that way which is really nice.” (Nurse 13)*

A couple of participants commented on the relationship between themselves and physiotherapists, occupational therapists and social workers, and COVID-19 affected patients accessing them.

*“Okay so in ED we have, discharge coordinators. Well, we don’t at the moment because of COVID but under normal circumstances we do. We’ve got very good physios and, social workers who are there specifically for the ED patients. So, yeah. I mean there was all of those resources there, it’s just a lot harder, for patients to access them because of COVID.” (Nurse 11)*

*“Yeah, so with the MDT I think we’re pretty lucky where we are in that we all know each other and it’s quite easy to kind of contact each other and work together you know when we’re concerned or need something extra for a patient. Because we kind of had the same staff you know, the same physios, the same OTs, that kind of stuff, the same social workers. As far as families and that go, I mean with COVID-19 that’s become particularly difficult.” (Nurse 10)*

This fifth major theme with three subthemes incorporated the significance of teamwork and some positive experiences working as a team, such as humour and helping each other, thereby offsetting stress and pressure. Participant experiences extended to other members of the multi-disciplinary team, pointing out team cohesiveness or joining together as a team and complimenting each other in delivering acute care in a busy ED.

### **Dissatisfaction with Organisational Structures, Processes and Systems**

This sixth theme describes dissatisfaction with organisational structures, processes and systems. Most participants reported difficulties with the government's health target, the six-hour rule, the ongoing lack of staffing, problems with the organisation, and lack of appropriate remuneration. Participants illustrated this with examples of feeling not heard at times and referred to the hospital system and culture as old-fashioned and hierarchical. Many participants felt they were not valued.

*“But you know I, I appreciate more like feeling valued and where, where I am and not feeling just like a number or an extremely replaceable person.” (Nurse 13)*

As mentioned, one senior nurse (Nurse 3) made a comparison among countries. In the quote below, Nurse 3 expressed her thoughts and feelings about the ED culture:

*“I definitely have had, difficult conversation with somebody and the way that I talk to doctors, you know, I respect them, I will challenge them if I don't agree with something. The challenge I had with a colleague was that they thought I was being rude to the doctor, that I should have listened to what the doctor said. You know I said I think that we are from very different cultures/backgrounds. In my country it is absolutely fine to challenge a doctor, it is encouraged, but in your country here it is [somewhat] frowned upon. We get now on really well with each other, but we needed to have that conversation and not be unpleasant. I never want people to be uncomfortable around me.” (Nurse 3)*

#### **“Feels like all very old school”**

There was a strong sense that the hospital system with its culture was very hierarchical and “old-fashioned”. Several participants shared encounters within this system which left them feeling frustrated and without hope. Two main examples were presented where nurses had to wait for a doctor to make decisions, which contrasted with one participant's previous experience nurse. Nurse 3 felt it was normal to challenge doctors and make decisions based on her assessment at that time, despite her colleagues' perception that her approach was unusual and disrespectful. She asserted that her professional integrity was questioned by this perception.

*“I think in NZ the nurses are handmaidens to doctors sometimes, I think people understand that I am not going to be subservient. I think the different qualities of healthcare professionals are separated not integrated. You feel like it's all very old school.” (Nurse 3)*

Another participant gave an example of how exit interviews were not mandatorily offered to staff. She felt it important that these be offered to staff so that management could better

understand reasons for attrition and address issues. She felt the current system does not tackle ongoing issues of attrition and needed to change if management hoped to keep staff:

*“I do not know, I think the hospital system is very hierarchical and so there is if you go without of the department, so I know that you have been exit interviews done by people who wanted you to do them, exit interviews are offered as a norm. So, the people that want to do them, usually are the people that have some, did something that they need to say. So, some of the stuff they have told HR [human resources], nothing’s been done or [little]better than nothing, I think. Why aren’t they listening? Why, why is this, you know, ability to talk to people who are leaving who don’t have to face consequences. Why isn’t that happening?” (Nurse 1)*

It is important to note what was heard from one participant who felt that, despite her extensive acute experience, she was not considered for what she termed “expected career escalation trajectory.” She felt that her skills were underutilised, was no longer confident in using her core skills, and was disappointed and dissatisfied after investing considerable amount of time studying. Her suggestion was to review the ED culture and have a manager who acknowledges and invests in staff growth.

*“The culture of working in any department is probably what would make me, stay more and obviously, a financial incentive would also help! I appreciate more like feeling valued and where, where I am and not feeling just like a number or an extremely replaceable person which I know I am. And I’ve invested you know, ... years of my life into tertiary education and I’m not really thrilled and all of that was clinical further education and I’m not really that happy with where I am and, and the opportunities there that have been presented to me. So, yeah, I think definitely just having a manager that would, sort of, at least acknowledge and, sort of, make a plan about how, that is my previous experience would be recognised, and I would be helped to progress.” (Nurse 13)*

### **“Rosters that put me off”**

Rosters, long shifts and night shifts caused exhaustion amongst many participants. Many nurses commented how exhausted they were from back-to-back long shifts and not having enough time to recuperate between shifts, and how this left staff burnt out (Nurse 10). Many participants were denied leave requests because there was not enough staff to fill gaps due to attrition or there was a need to cover staff away sick and on annual leave. This was an ongoing pattern for almost all shifts, meaning there were unfamiliar faces each time. While Nurse 1 felt turnover was much better, she acknowledged that staff attrition was due to rosters and amount of night shifts.

*“We’ve had terrible turnover, haven’t we? It’s been shocking, think it’s a lot better. I think the reasons for people leaving now are more around not getting the shifts they want, the percentage of night shifts.” (Nurse 1)*

Both junior (new graduates) and senior nurses felt rosters negatively impacted staff when they were not getting their requests granted. Participants disclosed comments such as “lack of hours”, “unsuitable rosters” and “exhausting extra shifts” during COVID-19 were heard.

*“For the last couple of months I haven’t had regular shifts, giving my shifts because it has all been pending on a job interview, you know, pilot – I know we’ve had COVID, but I feel not like it probably, like, never gonna be, like, fluid anyway. I can see why younger*

*people move. My roster for my shifts was not very good, weeks where my shifts was non-existent or did not have enough of hours. I think that put me off.” (Nurse 3)*

In the same manner, Nurse 12 and Nurse 10 felt the roster had a negative impact on nurses.

*“Well, there’s always been a big turnover of nurses in the department. Variety of reasons probably a big reason, if people are unable to get the roster that suit them and their family, that has made a lot of people leave. I think management probably is a big thing as well.” (Nurse 12)*

*“I think the roster does, I think it, as far as the care that we give that, I mean that comes back to our staff numbers. I mean at times it is unsafe because of staff numbers and people do do a lot of shifts, especially now in COVID with people being stood down you know, not being able to come to work if they’ve got a runny nose, that kind of stuff, and so, people are picking up extra shifts which obviously is exhausting them. And then, obviously it makes it hard to balance with that home life because a lot of us do have families at home that we care for, or kids.” (Nurse 10)*

### ***“Life is expensive – you cannot save here!”***

Many participants in this group felt there was a pay inequity between ED nurses and other nurses that made it difficult to meet the rising cost of living. The ED nurses interviewed felt it was unfair that while they worked much harder than in other specialities, referring to aged care and mental health, and that they saw little or no personal monetary rewards to afford living in [city]. As one participant stated: “You cannot save here!”, whilst another nurse made up her mind to move to Australia for a better pay scale. The idea of relocation to Australia because of lack of reward was heard from junior and senior nurses in this study.

*“So I am in Hospital A, staying in [city] is very expensive, the life is expensive, the house prices are expensive. So, in that the monetary terms, when we see that in New Zealand there is no pay for each and any corner of New Zealand you go, all the nurses get same pay, but then the house prices and land prices are not the same, life expenses are not the same monetary pay – is cheaper in outskirts and stuff like those outskirts. In that terms of, I want to leave, I can go somewhere else where I can buy house, buy a land or something, keeping the pay same, I do not have any benefit from working in [city], extra benefit and even if you see you think of leaving you can go to Australia, the per hour rate is high, things are less expensive than NZ. People who are comfortable leaving, that’s the main reason of leaving because anyway you have come to lead a family life, you have to provide to your family, housing and other things, you get more paid for what you do get paid in Australia or other parts of NZ apart from [city], so that’s the main reason I think people leave.” (Nurse 4)*

Several other participants echoed the issue of pay as a possible reason for nurses moving overseas.

*“So obviously we’ve got lots, I mean, you’d know we’ve got pretty high turnover. I think or I mean we’ve got several people at the moment that are leaving shortly, and I know, ah, you know just from talking to people that are leaving, obviously pay is an issue, the long hours and the workload that we do it’s quite low pay. which is a factor. [city] expensive to live in and so they’re moving outside of [city] or overseas. You know, Australia, that’s a big draw card!” (Nurse 10)*

Nurse 11 provided her reasons for staff leaving.

*“Like the rumour going at the moment is [large city] paying time and a half for all shifts staff working with COVID patients okay. This hospital is giving anybody working in a blue zone, one and, one hour at time, and a half in lieu of working at a higher risk. People working in a supermarket get 10% and they’re offering us one hour at time and a half. They don’t value you. And it’s, it’s that reason, that’s a lot a reason why I mean it’s not why all of them leave. Like some of them, we get a lot of people that come from overseas that do their time, get their citizenship, get their skills and leave, and that was always their plan. We’ve now got a lot of the younger ones who are getting the experience and going and doing contracts so that they can go and buy houses if they can’t afford to buy houses. You know I mean why would you stay working for \$30 an hour when you can go and earn \$60-100 Australian an hour doing a contract.” (Nurse 11)*

A few nurses interviewed made the comparison between nursing in an aged care facility before ED nursing and doing far less than ED nurses (who do more acute, advanced nursing) yet receiving similar pay scales, which they felt was morally and ethically wrong and unfair. Similarly, there was a feeling that ED nurses are expected to complete all tasks including lifesaving tasks for unsettled mental health patients in ED, but mental health nurses receive better payment when they do not perform these advanced lifesaving tasks. Again, nurses were angry, frustrated and feeling that they were not valued when they were not paid more for their work and experience.

*“I do think working in ED you should get paid more, critical care because you are doing so much more and I am not devaluing or depreciating the ward nurses because they do a really sterling job, but their skills are completely different and I think even a small incentive to work in ED, I think if they paid a bit more overtime, people might wanna stay. I personally have thought about going to Australia because I would get paid 20 to 30,000 more than I would get paid now, so why wouldn’t I think about that, and I know a lot of young nurses two to three years postgraduate would go to Australia. I feel that quality is a lot better in some places for nurses.” (Nurse 3)*

Parallel to that, Nurse 4 sounded upset about the perceived unfairness of nursing:

*“Then the incentives to work in a high-stress and high-paced environment, that should be beneficial because I think mental nurses get 30% extra for the risk allowance, so risk allowance, these are the same patients who come to ED in their extreme behaviour when they are in psychosis, agitation, stuff like that, they come to ED then we give the medication and then settle them and send them to mental health unit and incentives are given to mental health unit when they are medicated and well settled than to ED nurses when they are in the extreme of their behaviours.” (Nurse 4)*

A major unfulfilled promise was the government's inability to achieve its pay equity settlement because participants were eagerly looking forward to this pay rise and lump sum payment to cope with rising living costs. Nurses, who out of “good faith” had picked up extra shifts to help when short-staffed during the pandemic, felt let down and were seeking employment overseas. Many participants were committed to nursing and hopeful for promotion but felt other nurses were recognised, for example, new nurses are now classed as senior nurses after two years (Nurse 11).

### ***“Health target is a conveyor belt like a Toyota factory”***

Within New Zealand’s healthcare system there are several health targets set out by the Ministry of Health for public hospitals to meet, one of them being Shorter Stay in Emergency Departments (SSED), where 95% of all ED patients must be processed and discharged within six hours of admission to ED (Government Targets, 2024). The SSED has advantages such as progressing ED patients, and minimising the risk of overcrowding, gridlocks, and bottlenecks. This is still being used by EDs as a performance indicator even though the target was removed.

Participants spoke of the considerable limitations of the target approach. As one nurse responded:

*“In some respects, it makes them more of a conveyor belt like a Toyota factory, where they are basically this is the neck down and then they moved on and it's not necessarily the best for the patient.” (Nurse 1)*

Later in the interviews, a senior nurse acknowledged SSED’s usefulness but also expressed her frustration:

*“I think you know, ED gotten very busy as just got way out of control and I think the six-hour target was a very good tool to try and manage that; however, there’s so many frustrations the fact that there's never any beds.” (Nurse 9)*

Some participants felt pressured to meet the target on top of other responsibilities whilst others felt that this quick movement interrupted nursing care leading to suboptimal care.

*“Sometimes it’s a bit challenging situation when you are short-staffed and, moreover, because of this [many] years of experience, we are always mostly your [leader], so that adds up to the responsibility when you are pod coordinator you have to take care of everything in your pod, your patients, your staffs, yourselves, and then there is a pressure for this breach timing which is six hour” (Nurse 4)*

Nurse 8 and Nurse 4 were frustrated when she shared similar concerns about time pressures:

*“Some of the challenges, lack of space for patients in the department, the fact that when they brought in the six hours rule and that there was in the area I worked, a very, overzealous manager, who would whisk patients away before they been properly worked up and that caused a lot of frustration and resentment from staff.” (Nurse 8)*

*“So, then the main pressure is on the nurses of about this breach or it's so since we are not reason of this breach, but the main pressure is on us for the patient is breaching. Can you move? when you move, can you move? To move the patient before the six-hour target, so that it's just the namesake of saving the breach, so if the patient breaches it's the nurse responsibility to do the breach report.” (Nurse 4)*

Parallel to the above excerpts, other participants commented about this abrupt or diminished care offered to patients when trying to meet SSED.

*“Time limits for patient stay within the department means patients are often moved to other areas before a comprehensive workup is completed.” (Nurse 8)*

In the same way, Nurse 1 wanted more quality time with patients.

*“Let's just think of a recently diagnosed cancer patient, very upset and you've built up a rapport, they divulged stuff to you and then you say you got to go, you got to five hours 30 minutes. It's not therapeutic necessarily. I don't know that we're thinking, I don't know. I don't know, all our decisions are made with the patient at the forefront, which they should be. It's like if somebody comes in with chest pain, you could know about their ECG and your heart rate and blood pressure. Who is this person? What's their job? Has having a heart attack affected their future, I mean, even a loss of a finger in any of those things, we're basically fixing the issue or do what we can for the issue, but we're not, I don't know if we necessarily have the time to spend thinking about how these impacts on their life. Has a broken leg? And I think you're getting into your house, out of your house. So, it's more about the person not the condition stuff.” (Nurse 1)*

The participants interviewed felt blamed when SSED was not met and felt pressurised to meet this target, which always resulted in an inadequate quality of nursing care and incomplete essential nursing tasks. Many ED nurses were already busy meeting the target and felt they did everything they could to deliver but were blamed for all breaches. This level of stress, unhappiness and being blamed for breaches was also mirrored in another participant, who felt it was wrong that ED nurses are always held to account for breaches. Nurse 4 sounded angry about this issue:

*“This breach it's never a nurse's reason for this breach because we straight away do an assessment, do the lines, and then they will wait couple of hours for the doctor to be seen and then they go in for a CT scan or X-ray and they come for physio! So, it's always other specialty who responsible for this delay because, once the doctors have seen, they do some medication charts, we straight away give it, we as nurses we never delay anything. So, our bosses are ACC and for the flow coordinator they do the breach report. Why is that? Since we are not the reason of the breach, the reason maybe radiology, the doctor shortage or seen late and the nurses are accountable; never the doctor get stressed because of the breach!” (Nurse 4)*

This was also felt by Nurse 6, who stated that the reason for introducing SSED has now changed to another key performance indicator (KPI) with ED nurses carrying the full responsibility. Her remarks showed the pressure to move the patient and disruption to holistic care which left her stressed and humiliated for not meeting this target.

*“The six-hour rule was initially instituted because we were forgetting people and it was a way for management and coordinators to flag these people or who are maybe sort of needing to be reviewed and moved on, or maybe to be let out of hospital again, but the problem is that it's just been turned into another KPI which means that it comes back on the nurses who are the ones that are, we are MDT, we are escalators, we are advocates and I mean sometimes even to be doctors because our docs are so busy. ... And so that six-hour breaching rule is actually being used as a punishment, you'll be in the middle of a code. There wasn't an allowance for that and we weren't full but it was purely the six-hour breach rule. And so sometimes they'll even move patients to ADU [Assessment and Diagnostic Unit] and we're just essentially moving musical chairs. Whereas well I can't tell you the amount of time wasted where someone hasn't just stood for a minute and thought to themselves, okay, instead of following this breach rule, why don't we call x-ray and say do you mind just bumping them one early so they can go straight to x-ray and then straight to the ward.” (Nurse 6)*

Nurse 6 explained in detail about the pressure to move patients to meet the SSED and lack of time with patients, especially when diagnosed:

*“You’ll be in the middle of a code, and I had a coordinator come up to me right in the middle of me walking over to this alarm and she said you know your patient is breaching they’ve got 40 minutes; have you contacted the doctor? Have you done their notes? Have you talked to the bed coordinator? Have you booked an orderly? And I just, stood there thinking to myself if she could have just gone and read the notes for five minutes instead of sort berating me is what it felt like because you’re very stressed. So, everything sounds 10 times more intense, And so she was like well you’ve got to get her out of here. And I’m like, excuse me, she, you know, family is 20 minutes away and there’s no point me moving them up out of beds and they need a scan and when I could just let the husband in here right now. There wasn’t an allowance for that, and we weren’t full, but it was purely the six-hour breach rule.” (Nurse 6)*

Furthermore, one participant revealed that systems are used to hide patients so that the department meets their requirement standard. She described how patients are often shunted into other areas before they are stabilised because it is busy (Nurse 8).

*“They [organisation] brought in a rule that there has to be no patients in the corridor. When they first opened the new department a lot of the senior staff recognised that it was gonna be too small to accommodate the numbers that were starting to come through and almost from the first week there were patients in the corridor. Now they use systems to hide patients so that they meet their requirement standard, so patients are quite often shunted in other areas before they are stabilised.” (Nurse 8)*

### **“Are we getting more staff?”**

Most participants reported that short staffing was a major problem, and an obstacle on almost every shift that affected the ability to provide care. Early in the interview process, a senior nurse sounded angry and frustrated when she commented that many nurses were hastily moved from an area that was equally busy, leaving other areas with staff unable to fulfil their professional obligation to perform duty of care. The organisation had been informed that staffing was a major issue on most shifts:

*“So short staffing, is ... I would say is 80% of my shifts and it is an issue for me as a manager. (Nurse 1)*

She referred to the department as a “traffic jam” and described sick patients having nowhere to go. This was coupled with the fact that there is a current nurse shortage causing delays in medical assessment and treatment. This meant that many patients were waiting for an initial assessment by an ED nurse who was often busy, but also ambulance staff were waiting to hand over their patients at the entrance to the hospital. Nurse 1 felt the nursing shortage placed these newly arrived patients at risk of further deterioration and possible agitation in an already stretched department.

Similarly, Nurse 12 commented about nurse specialists stepping in to cover staffing.

*“At the moment we’ve got the nurse practitioners and, clinical nurse specialist not working as a, as their clinical role they’re actually gone back to a nursing role in order*

*to help cover the staffing because we don't actually have the staffing required at the moment. So out the front is predominantly all of them so we've got very kind of senior out the front so it kind of works alright out the front area but I think the rest of the department probably is struggling with enough senior staff, the main area predominantly because resus is generally well, and the COVID area has got all the senior staff so like I say, said before, you're ending up with junior staff in the main area which is not ideal." (Nurse 12)*

Participants also reiterated the impact of unpredictability with huge patient volumes.

*"Sure, I think that for me personally, I do feel quite stressed when we have a huge influx of very sick patients. They do tend to all come at once, and it's how to not, not how to deal with it, but just allocating stuff." (Nurse 5)*

*"Other wards they are expecting a certain number [of patients] and if it gets over a certain number, they can always close their door and close their beds; you stop taking patients but in emergency department you can't do that, so you never know how many presentations you'll be getting in the next hour. It's always highly unpredictable, you can get a huge queue at any time of the day and then all in that queue certain number can be really critical and you know, like [life] threatening patients, so it's also highly unpredictable. That's our challenges and on top of it you are not fully staffed. So, because it comes in waves, the presentation comes in the waves, so you have to have fully staffed all the time unit. You can't never predict how many patients you will be getting next." (Nurse 4)*

Similarly, Nurse 4 must constantly rethink, plan and shuffle workloads when help from other ED nurses was not readily available. Nurse 4 found it unfair that ED nurses must adjust their workloads to meet this shortfall when others do not have to. At times, management would send nurses to ED, but he commented further that ED patients have specific needs. He felt frustrated from having to check work done and complete outstanding tasks in a busy ED:

*"If there is a sick call, it is taken for granted you can adjust, you can shuffle staff. We are asked to adjust to do two, three staff jobs. Team nursing – we are asked to adjust. You will not get staff straight away, never constant, ever changing. We are helped by management, but staff come to task but not of great help – we need trained, ask for IV cannulation, assessment, general medication. Not enough of ED nurses." (Nurse 4)*

Nurse 7 consistently signalled issues with short staffing on many shifts. Moreover, there was the need to adjust but was clearly unhappy when working with very junior staff. Despite asserting herself, she felt her issues were not answered. Limited funding was marked as the reason for gaps in staffing putting more pressure on her the team.

*"At staff meetings, you know, we would be told we are two staff down or shift changes and then we would regular team meetings staff would bring up the issues of are we having the staff replaced. "Are we getting more staff?" was one of the mostly asked question and management would say we do not have funding to reemploy or add another FTE [full-time equivalent] to the teams." (Nurse 7)*

Nurse 7 continued to vent her feelings about limited staffing and how stressful it was managing junior staff. Her comments echoed some of the frustrations experienced by other nurses overseeing other staff:

*“So, basically, I guess it was funding they just could not afford the staff that was needed. you know, management, but it basically came down to lack of funding were the answers that we used to get, where they could have put staff where they were unable to because of the lack of funding for the staffing. To me it was not ever prioritised that adequate staffing would actually benefit the department.” (Nurse 7)*

*“I think that there were a lot of times that there was not enough of staff, so staff shortages, which was stressful for – while you worked on the floor – for obvious reasons and at times, it felt unsafe to give good safe care to everyone you were in charge of, basically. There was often you know, a poor skill mix, many new staff, a lot of staff were inexperienced or new grads, did not have the experience to prioritise as a more experienced staff member, which was stressful whilst you worked on the floor for obvious reasons.” (Nurse 7)*

Nurse 10 spoke about the inability to perform care due to short staffing and being unable to replenish staff numbers in response to low numbers:

*“Short staffing, obviously that impacts patient safety, that’s massive. Probably just about every shift now. I mean we do address it through the risk pros [incident reports], like, how far that goes I’m not quite sure. I know that management work hard to try and hire more staff, but it just never seems to, staff leave and the amount that we hire don’t kind of match up! That’s probably the biggest one and I guess that just puts a strain on personally your practice not being able to provide the care that you would like to provide for every patient.” (Nurse 10)*

Nurse 6 felt anxious and morally challenged when it was considered normal practice in her ED for healthcare assistants (HCAs) to check on sick patients. She felt this norm was unsafe and gave an example of sick patients hooked up to a cardiac monitor and when the alarms were set off, all HCAs could do was go to the bedside. HCAs would be unable to interpret the readings on the monitors and assess whether a patient was experiencing a life-threatening event or not (Nurse 6):

*“As well as the fact that I find in this hospital, I’m not sure if it’s been going on for long time but they seem to think that healthcare assistants are an okay replacement for filling in nursing gaps. They’re lovely, but I can’t rely on someone else to do my assessment. So, it wouldn’t be my first time I’ve had three people almost coding, and I’ve got arrhythmia alarms going off on my monitors in rooms that I can’t actually get to and I’ve got nurses sending or charge nurses sending healthcare assistants over to see what’s wrong and I’m just like what’s the point of that?” (Nurse 6)*

Participants described shifts where there were unexpected and uncontrollable high volumes of sick patients brought in by ambulance and waiting for long periods to be assessed by a doctor. Nurses 1 and 11 were concerned that these patients were undiagnosed and stuck in the ambulance bay because of a backlog of earlier patients. Nurse 11 witnessed a growing number of patients who had not been seen and the effect that this had on staff (ED nurses and ambulance crew), patients and their families. Patients and families were unhappy and upset that they were waiting. This scenario was perceived as a risk for this group of newly arrived patients who were very sick, and the only option for ED nurses was to communicate and escalate to their seniors who are also incredibly stressed (Nurse 11):

*“So we have not dropped our patient in-coming so we can hear ambulances waiting in a line outside to come in, which impacts all of [city], not just our hospital because those ambulances are not out delivering patients and seeing patients out in the community anywhere else because they’re stuck at our hospital trying to offload and we might have eight sometimes; the most I’ve heard of, I wasn’t on shift for this, was 15 people in our ambulance bay which is very dangerous. It’s very risky and these are undiagnosed, unseen patients until a doctor can come out and quickly look at them all. So, it’s a high-risk area when you have them there – patient surges are a problem.” (Nurse 1)*

*“Some days it can be a very toxic working environment. For example, the other night we came on to at 7 o’clock at night to 10 patients that hadn’t been assessed by a nurse with more patients flooding through the doors and lots of angry and aggressive patients, visitors, relatives because they can’t come in, ambulance staff because they’ve had to sit and wait. I mean all you can do is keep escalating it and saying it’s not safe. But, yeah. I mean, sometimes there’s just nothing that can be done and people are very stressed and taking it out on each other because it’s a, not a good environment. I find it easier to bring it up with the charge nurse because then it’s their responsibility to take it up with the person, but sometimes they’re very stressed as well so, it’s, it’s very difficult working situations at the moment.” (Nurse 11)*

### **“Feeling as though management does not hear us”**

Participants were frustrated and saddened that their escalation to those in management roles were not considered. They felt unheard despite repeated communication around resources, behaviours, training, requests for rosters denied, etc:

*“If we actively filled out incident reports for every near miss or every issue we’ve seen, and if management supported that, and used it as evidence. When I went on a crusade to fill in incident reports every shift I stayed 40 minutes longer, I filled in other person’s incident reports and, and this included everything from poor skill mix to coordination and poor patient outcomes. A shift manager came up to me and said why are you sending me these incident reports? And I said I’m not, I’m putting them through risk pro, it goes to everyone doesn’t it? And she said no it just comes to my desk. And then I have to give them reasons. Can you just stop? I got told by more than one manager, to stop flagging problems. Because they couldn’t fix them.” (Nurse 6)*

*“I think people just burnt out I think the workload is massive, the constant understaffing and the stressful nature of you know, of ED being chaotic is a factor in people leaving and unfortunately most of them are quite senior staff as well and I think they’re just fed-up of feeling like they’re not being listened to.” (Nurse 10)*

Participants’ prior nursing experience was not acknowledged and whatever opportunities for growth and other promises made to them as an ED nurse were diminished or not fulfilled. It was suggested that even though there were repeated attempts to progress and signal to management, they appeared to not listen. This again influenced their decision to remain in ED or move to another speciality where prior knowledge and experience would be appreciated in the form of career progression.

Nurse 3 did not feel happy, as shown below, because of lack of progression:

*“I have got to be honest, I find sometimes the more you work in ED, it can become a bit stagnated because the opportunities and scope to develop aren’t really there; so, I have to say, up until recently, the last 18 months, I have really pushed my career forward. I*

*went for an interview for a senior position which I was already doing, and I did not get and now I am in this limbo. So, from a rewarding point of view, I do not feel that rewarded at the moment because I feel like I am filling a gap for when they need senior staff and I acted as a senior staff but I am not being paid or respected as one sometimes. So, I think it is not as rewarding as I would like to be, so I think that it definitely has an impact.”* (Nurse 3)

Nurse 13 and Nurse 12 felt unappreciated and shared their experiences:

*“I expressed to the clinical educators and the manager that I would really appreciate some sort of accelerated trajectory in terms of progressing through the emergency department as a new graduate nurse who came with a lot of experience. That was not identified, there was no, sort of, recognition of my previous experience, I wasn’t put to use with what I assumed, or I clearly can see now, would have been very useful, would have been beneficial to them to use but nothing happened despite me continuing asking and, sort of, and, and still nothing has happened after I’ve only been there one year but nothing has changed in despite me trying to move things forward.”* (Nurse 13)

*“Yeah, so I think we’ve lost a lot of senior staff where they should have probably gone up the ladder and due to probably well, I would think personalities they haven’t, and just to respect people for their experience and their past experience. Sometimes it doesn’t get done and people feel undervalued and not really respected and all, for example, they come with lots of ED experience and it takes them forever to get from one, one stage to the other of the department and they’ve got all the thing it’s just the [orientation] which actually doesn’t take long to, to do to quickly whiz through because like when I first started, I was in triage I think after a week. So, I’d gone really quickly, through ED. They need to look at the management and everything, like, they’re not that good. And I think that’s a reason that a lot of people have left. You need to feel supported, and you need to feel listened [to]. I think management has made a lot of senior staff leave, sometimes they aren’t treated probably fairly and uniformly across the area and people haven’t progressed probably as they probably should have progressed, due to a variety of reasons.”* (Nurse 12)

Working with limited resources, feeling unheard, increasing patient acuity, time pressures, and high patient: staff ratios left many participants worried that patient lives are in their hands. For most of the participants, the sparse number of nurses on each shift and ever-increasing number of sick patients had a profound impact on their lives, both at work and at home, so much so that they felt that patient safety was compromised, which caused worry, unhappiness and dissatisfaction.

*“And just being realistic about what you can and can't achieve you know, I'm one person and we're all just one people, and we can only do what we can do but sometimes I must admit I do go home thinking, oh dear I hope I haven't forgotten anything. Yeah, it does it does play on my mind. I think you probably learn to manage it over time, but it does creep up on you – you know, there were some nights where I could not sleep, you are thinking what could have got wrong, what could have got, you did not have the time to – the resources to do a certain thing it would often play on my mind. I think because I am bit of a perfectionist, so I like to get things, I like to get things done properly and when I can't do that that tends to make me feel a bit stressed.”* (Nurse 5)

As Nurse 12, a senior nurse, commented: “You arrive in the morning, we lucky to have one bed – volume has increased, we do not have simple patients.” This scenario repeats itself in

most shifts, which was overwhelming and added strain on their practice, leading to suboptimal care.

This sixth main theme spoke to dissatisfaction with organisational systems and processes, and the impact of this on staff. Participants reported on the struggles with the government's health target, the six-hour rule, the ongoing lack of staffing, problems with how patients are nursed in ED, and lack of appropriate remuneration for ED nurses. Participants illustrated examples of feeling unheard at times. They also pointed to an old-fashioned hierarchical structure and how this affected them. Overall, staff felt they were not listened to, which led to staff leaving or considering leaving. Under this theme, issues covered included unsuitable rosters (shift scheduling), ongoing lack of nursing staff, and feeling unheard when issues were raised with the organisation. Overall, theme six revealed participants' perceptions of the existing hospital system as hierarchical and outdated with an unsupportive culture leaving nurses dissatisfied and fed-up. According to participants, this negative experience regarding structures had caused some nurses to leave the organisation in pursuit of a supportive organisation while some participants were considering leaving the organisation shortly.

## **Conclusion**

This chapter presented the findings of the thematic analysis from 13 interviews, resulting in the construction of six main themes. These themes were further broken down into subthemes capturing participants' perspectives. Participants provided reasons for selecting ED nursing. Some of these reasons were personal: ED work is rewarding, and meaningful. In contrast, participants within this cohort also described their negative experiences (stress, undesirable behaviours, time pressures, performing non-nursing duties, left out of communication) and feeling unheard while working within the practice environment, with the consequent impact on their professional responsibility to provide a standard of care. The importance of ongoing professional development, teamwork and support for junior staff was also discussed. Many participants shared examples of working with short staffing, inexperienced staff, and inadequate equipment, which stressed them and affected their work. It was clear that some nurses felt disrespected and undervalued, hopeless and anxious when concerns raised felt unheard, but they continued to prioritise their patients' safety. The next chapter, the discussion chapter, is where these results are compared with international and local literature.

## Chapter Five: Discussion

### Introduction

This research aimed to examine the key factors contributing to successful retention of ED nurses employed by a DHB in NZ. The research questions were, firstly, “What are the perceptions of ED nurses in relation to retention?” and, secondly, “What are the success factors contributing to retention?” The analysis of qualitative data from interviews with 13 ED nurses was presented in the previous chapter. The research findings are summarised in this chapter and framed in relation to the research aim and questions. A critique of the findings in the context of the literature then follows. Recommendations for practice, policy, education and the future are provided in Chapter Six.

### Summary of Key Findings

Six themes were identified in the data collected in this study. Theme one, ‘personal satisfaction from being an ED nurse’, captured multiple reasons participants provided for taking up the role of an ED nurse, for example, the nature of the work and being in a unique position to offer psychological support to ED patients. Theme two, ‘ways of coping’, captured individual coping strategies when faced with stressful experiences or challenging situations. The third theme, ‘workplace tensions’, captured the experiences of ED nurses and their concerns about the work environment. This theme highlighted the condition of the department, and the stress and moral distress faced by ED nurses when unable to offer a safe standard of nursing care to ED patients. Theme four, ‘professional development is important’, captured the importance ED nurses placed on professional development and called for investment in education and training. This theme reflected the advantages of study days together with the mentoring of junior nurses for themselves, patients and the nursing team. Theme five, ‘we all chip in’, captured the importance of supportive relationships between team members. Theme six, ‘dissatisfaction with organisational structures, processes, and systems’ captured participants’ perceptions of hospital structure, processes and systems. Overall, nurses were unhappy with organisational structures, and many felt they were not heard in relation to concerns and issues such as inadequate rosters, depleted numbers of ED nurses, low salaries, inadequate equipment, and limited time spent with patients.

The findings suggest that nurse retention and success factors are complex and a matrix of many interlocking pull and push factors, as described in the introduction and literature review chapters. This study showed similar views and concordant themes amongst junior and senior nurses, and some variations in this small cohort of participants. Therefore, understanding ED nurse retention within New Zealand's current EDs is complex and challenging.

In this next section the pull factors, and push factors are discussed. During iteration, after a few interviews and discussion, initial pull and push factors associated with retention emerged. These factors also arose because of my epistemological and ontological positioning within this

research, my previous clinical and leadership experience, my anecdotal and empirical knowledge of working in public EDs across New Zealand over many years, and my current role as a nursing lecturer within the BN degree. Bronfenbrenner's (Bronfenbrenner, 1996) organisational framework is used to structure the discussion, under the headings: micro level (personal and professional), meso level (interpersonal), and macro level (organisational). Table 4 illustrates this mapping across the six major themes and subthemes with colours identifying pull and push factors. Pull factors are green, push factors are orange whilst Theme 4, professional development is important, which is both a push and pull factor, has no colour.

**Table 4**

*Themes and subthemes using pull and push factors arranged according to Bronfenbrenner's (1996) organisational framework*

	Major Theme	Subthemes
M I C R O	<b>Theme 1. Personal satisfaction</b> PULL	Taking the scariness out. Seeing results quickly and making a difference. ED nursing is never boring.
	<b>Theme 2. Ways of coping</b> PULL	Looking after myself. Keeping your empathy tank full. Someone to talk to and vent.
M E S O	<b>Theme 3: Workplace tensions</b> PUSH	It feels like a third world department! Finding more solutions for mental health patients. Feeling horrible from patient verbal and physical abuse. Covid-19 is game changer for nursing. Treating each other in a different way.
	<b>Theme 4: Professional development is important</b> PUSH & PULL	Study days need to be protected. Knowledge is power. Being a fairy godmother for junior staff.
	<b>Theme 5. We all chip in</b> PULL	A sense of humour. Relying on each other. Everybody just mucks in.
M A C R O	<b>Theme 6: Dissatisfaction with organisational structures, processes, and systems</b> PUSH	Feels like old school. Rosters that put me off. Life is expensive-you cannot save here. Health target is a conveyor belt like a Toyota factory. Are we getting more staff? Feeling as though management does not hear us.

The following section explains the pull and push factors related to job satisfaction and dissatisfaction (Roth et al., 2022; Sasso et al., 2019), respectively, framed by Bronfenbrenner three level framework of micro, meso and macro levels . The participants' intentions to stay or leave are explained as being intricately linked to consistently positive or negative experiences at micro,

meso or macro levels (Daniels et al., 2024; Muir et al., 2024; Sawatzky et al., 2015; Van Osch et al., 2018). This next section answers both research questions, which are:

“What are the perceptions of ED nurses in relation to retention?”

“What are the success factors contributing to retention?”

### **Pull and Push Factors**

Pull factors, as highlighted in green in the table above, are associated with job satisfaction and refer to those experiences which are perceived by nurses as positive and beneficial, leading to job satisfaction (WHO, 2021), which optimises the likelihood of nurses staying (Roth et al., 2022; Sasso et al., 2019). On the other hand, push factors, as highlighted in orange in the table above, refer to those experiences which are perceived by nurses as negative, potentially harmful and causing unhappiness (WHO, 2021) and stress, leading to job dissatisfaction (Alharbi et al., 2022; Roth et al., 2022; Sasso et al., 2019). Taken together, the pull and push factors, correlate with other earlier studies on job satisfaction from positive, healthy workplaces, staff recognition, healthy interprofessional relationships and, dissatisfaction from unhealthy workplaces, exclusion of nurses in organisational policies and decision-making, which are associated with nurse retention and turnover respectively (Helbing, 2017; Nantsupawat et al., 2017). Recent studies on ED nurse retention and turnover (Gorman, 2019; Horvath & Carter, 2022; McDermid et al., 2020; Staempfli & Lamarche, 2020) reinforce these earlier studies that, job satisfaction increases the chance of a nurse remaining, whilst job dissatisfaction increases ITL and turnover.

When pull factors are reinforced, the risk of turnover is lower. In this study, an illustration of pull factors is evident in the theme of ‘personal satisfaction’ which referred to the nature of the work. As discussed, in this study, a significant number of participants, both junior and senior nurses, found autonomy and, at times, working with colleagues satisfying, appealing, rewarding, and meaningful. Van Osch et al. (2018) employed an ID design in interviewing nurses (n=13) in western Canada and exploring success factors that encourage nurses to stay and, found that positive experiences influenced their decision to remain in the department. Nurses interviewed in that study enjoyed the nature of work (autonomy, use of skills, learning new concepts), strong bonds between colleagues and teamwork within the work environment. The authors found that many nurses felt respected and acknowledged because there was level of trust amongst nurses and doctors which motivated them to stay. The professional image of the nurse as perceived by the public was described by Van Osch et al. (2018) as important to most participants, which was not mentioned by any of the ED nurses interviewed in this study. Findings from Van Osch et al. (2018) study differed from other studies where nurses reported being stressed and burnt out due to challenging work conditions such as low staffing, high workloads, emotional and physical exhaustion (Clark et al., 2022), and lack of support from team members (Elder et al., 2020; Nunes Machado de Oliveira Santos et al., 2019).

Highlighting the theme of ‘personal satisfaction’, a couple of senior nurses in the present study loved the nature of the work, were motivated, and chose to work for personal and professional reasons such as wanting to offer a high standard of care. The theme of ‘workplace tensions’ showed that their expectation of the role had changed over time due to issues associated with the work environment and some team members. Senior nurses reported unexpected stress due to huge workloads and scant staff. The effect of this negative experience was that one nurse reduced her hours to work part time. The implication of this experience needs further investigation as to the root cause of problems, so that nurse leaders can address issues within the work environment and relationships between team members. In addition, organisations can explore ways to value staff by providing resources, such additional nurses and more equipment, and by reducing workloads. These findings are consistent with previous studies (de Wijn et al., 2022; Sawatzky & Enns, 2012; Van Osch et al., 2018) that show a negative relationship between stress and the demands of the job on the one hand, and the overall well-being of nurses on the other. Supportive leadership within the organisation, nurse leader engagement with nurses, team cohesiveness, a healthy work environment (suitable working conditions), and valuing and respecting staff consistently influence nurses’ intention to remain working in ED or leave; this was found in the present study and evident in other studies (de Wijn et al., 2022; Sawatzky & Enns, 2012; Van Osch et al., 2018).

Push factors highlighted in the table above are linked to stress, lack of support and moral distress leading to job dissatisfaction. Sasso et al. (2019) completed a cross-sectional quantitative study in Italy with medical and nursing staff (n=3,667) looking at job satisfaction, work environment, stress, and burnout. The authors found push factors were linked to stress from staff inability to offer a safe standard of care and from having to perform non-nursing duties. In contrast, pull factors were related to the ability to perform essential nursing duties coupled with a positive attitude towards quality nursing care.

Roth et al. (2022) interviewed German nurses (n=21) in South Germany at four hospitals, two university hospitals and two smaller public hospitals between September 2019 and August 2020. The participants were from acute, cardiac, gastroenterology and intensive care wards and inpatient care. The study sought to understand factors that would keep nurses working and factors that would cause them to leave. Two main themes came out of this study, firstly, pull factors that would motivate nurses to remain working or what they hoped for and, secondly, push factors that cause nurses to leave. The one main pull factor to keep nurses was supportive relationships, while some of the push factors were poor public perception, stress, reduced staffing, time constraints, not being able to provide adequate patient, generational barriers between young and older nurses, reduced career opportunity, inadequate remuneration, especially in younger nurses. Similar to Van Osch et al. (2018) study, which referred to public perception of nursing, a pull factor mentioned in the study by Roth et al. (2022), was the image of nursing; how nurses view

themselves, the public perception and recognition of nurses by other professionals. Younger nurses placed importance of obtaining a nursing degree but felt there were no prospects for career advancement. The authors concluded that the organisation must invest in career pathways, offer remuneration (fair pay) and improve the work environment for colleagues to support each other. Such organisational investment from managers and leaders will encourage nurses to remain but if the work environment becomes pressurised, job dissatisfaction leading to turnover is inevitable (Nantsupawat et al., 2017; Roth et al., 2022; Sasso et al., 2019).

### **Micro Level**

In this section the micro level, both of the themes discussed below, personal satisfaction and ways of coping, are pull factors.

#### ***Personal satisfaction***

The theme of ‘personal satisfaction’ included the subthemes (“taking the scariness out”; “seeing results quickly and making a difference”; and “ED nursing is never boring”), provide context to what ED nurses enjoy about their work. The variety, autonomy, unpredictability, ability to intervene early, and use critical thinking and clinical reasoning, were seen as rewarding and appealing. A supportive efficient team gave nurses many opportunities to learn new concepts. The subtheme of “taking the scariness out” cannot be excluded from the positive aspects of the ED nurse role. In this study, many participants expressed satisfaction from offering psychological support to patients and families. Personal satisfaction was heard in using therapeutic communication skills, such as offering empathy, and listening to patients who were anxious, worried, shocked and afraid from sudden, unexpected admission. Most participants appreciated that they were in a privileged position to engage in therapeutic communication with vulnerable patients. Authors refer to this experience as ‘compassion satisfaction’ (Hooper et al., 2010; Rantung et al., 2022; Simon et al., 2005).

Staying with the theme of ‘personal satisfaction’, compassion satisfaction is recognised as a positive experience from feeling satisfied by saving patient lives and assisting patients and family members in need, which can replace any negative clinical experience in the work environment (O’Callaghan et al., 2020). This experience may lead to job satisfaction and nurse retention. ED nurses in this study were satisfied when they could counsel patients and offer empathy in stressful situations. Conversely, ‘compassion fatigue’ is caused by repeated stress rendering staff emotionally and physically exhausted (O’Callaghan et al., 2020). Some studies explain how nurses can deal with compassion fatigue (O’Callaghan et al., 2020; Sacco et al., 2015), also known as ‘self-compassion’ (Duarte et al., 2016). Findings in this study do not suggest the nurses in this study suffer from compassion fatigue. A possible explanation for this is that they use coping strategies to ensure that they show compassion towards patients (Francis-Wenger, 2024; O’Callaghan et al., 2020). What stood out was that, despite feeling stressed and tired, these

nurses consistently offered their best in terms of physical and psychological support to patients. Patients were always put first, validating the nurses' commitment and a strong sense of duty of care.

Additionally, the theme of 'personal satisfaction' revealed a small number of participants in this study shared their personal reasons for continuing to work in ED for a long time. Some of these reasons were that the location of ED was convenient, which reduced travel time but also aided nurses caring for their children. It is possible that work-life balance may not be possible elsewhere. Some participants felt that the team is supportive and that everyone helps when things are chaotic. Studies have shown that work-life balance and job fit maybe a motivating factor for nurses to stay in an area (Boamah & Laschinger, 2015; Chen et al., 2015; Moloney et al., 2018; Suárez et al., 2017). Nurses who can fit their jobs around their personal commitment to families may be happier in their professional role and therefore remain in that role.

The findings in this present study demonstrate the importance of nurses' family connections and relationships. Studies have shown that when workplaces encourage connections with work colleagues and families at home (Loft & Jensen, 2020; Staempfli & Lamarche, 2020; Suárez et al., 2017), nurses are happier within their roles.

### ***Ways of coping***

The theme of 'ways of coping' and two of its subthemes ("looking after myself"; and "someone to talk to and vent") is a pull factor for nurse retention because they highlighted the ways nurses cope with stress. Several senior nurses outlined the strategies they adopted in stressful situations. Nurses benefit from conversation with other nurses following exposure to repeated stress, primarily from witnessing traumatic experiences like the death of a child in ED (Evans et al., 2017; Shimoinaba et al., 2021). Furthermore, regular chats with colleagues were helpful when experiencing verbal and physical abuse from patients and their families (Adriaenssens et al., 2012; Shimoinaba et al., 2021). The use of coping skills such as talking to friends and family helped alleviate any stress (Gifkins et al., 2017). In this study, nurses in leadership positions were good listeners, allowing staff to offload within a shift, which was, at times, the only way to informally debrief due to time pressures. These findings are supported by other studies on supportive leadership, debriefing and peer support (Abraham et al., 2018; Xu et al., 2019).

Peer support is important for nurses exposed to stressful situations as they have first-hand clinical experience and work together closely, and therefore they understand when colleagues are affected and can offer empathy, which others may not be able to do. This is also a form of unstructured debriefing (Elder et al., 2019; Yuwanich et al., 2015).

The theme of 'ways of coping' and the subtheme of "keeping your empathy tank full" placed importance on ED nurses' attitude towards ongoing stress and how they prepared for increased patient complexities. One of the other ways of coping was having a positive mental

attitude towards demanding scenarios. With reference the subtheme of “feeling as though management does not hear us,” some participants who were more senior showed an attitude of acceptance and a recognition that ED is always busy and demanding, and that the work is never complete. This mindset helped nurses cope even though they may have unknowingly missed something due to excessive workloads and time pressures. Looking at the subtheme, ‘someone to talk to and vent’ nurses in this present study were always to be honest with superiors during these times to reduce or mitigate risks to patients and themselves. Nurses can only offer what they are capable of with the resources available. Furthermore, good open communication was essential during challenges, such as long waiting times and bottlenecks. Many of the experienced participants were transparent, honest with patients and realistic about a nurse’s ability to achieve goals in a hectic ED. Honesty and transparency with patients and family shows respect and dignity, and maintains professional relationships between patients, nurses and superiors.

A novel finding showed that some senior participants coped by having a strong grasp of all ED clinical policies, procedures, guidelines and protocols but also drew on vast clinical experience and operational knowledge of the ED. They are confident to know when and how to use the information in these policies to tackle a difficult scenario and safeguard themselves, other staff and patients. This is consistent with studies where nurses use clinical experience and information to problem-solve (Jackson, 2022), and to coordinate with other teams such as radiology and doctors (Lapierre et al., 2019).

Junior and senior nurses differed in their attitude towards stress. Senior nurses seem to cope on demanding and pressurised shifts, in contrast to junior staff who are still learning, unsure and unable to work independently. Alzghoul (2014) concluded that older or more experienced nurses have experience from childhood and from being exposed to different situations, which helps them deal with challenges. The ability to work under stressful conditions and act in highly pressured and demanding places must be shared through professional development workshops, thereby providing much needed education to nurses. This may help with staff retention and thus become a pull factor.

Some senior nurses in this present study are motivated and confident because of their experience with ED work. This attitude is evident in their desire not only to help patients but also to see junior nurses learn and flourish. This may be a part of a nurse’s identity, which is unique to this group. Many participants adopted ways to deal with stress, such as having an attitude that ED has its challenges and that there is only so much that one can do. When some participants were unable to cope, the only option was to escalate problems to nurse leaders and doctors. The findings of this study are consistent with other studies exploring stress and coping strategies. Senior nurses supporting junior nurses (Shimoinaba et al., 2021), using previous experience, seeking information from others, discussion of issues and exploring solutions, looking at the

problem objectively, and having a sense of humour (Abraham et al., 2018; Xu et al., 2019) have helped stressed nurses relax and less experienced nurses cope.

Another possible explanation presented here is that this cohort of nurses are experienced, and some have adapted to this environment over time (Kilcoyne & Dowling, 2007) with an attitude of hope for change. The theme of 'we all chip in' showed staff support each other. Some staff are hopeful that things will change, but also constantly maintain positive attitudes and use coping skills. Nurses are hopeful that their efforts, and whatever was promised, will eventually bear fruit, that conditions will change and improve and that, eventually, the organisation will be able to take responsibility.

The findings corroborate the ideas of Rantung et al. (2022) and Hu et al. (2022) who explained that hope is important for nurses because it can motivate nurses to remain (Hu et al., 2022; Rantung et al., 2022).

With workplace tensions and dissatisfaction with organisational structures, the environment negatively impacted nurses, but nurses continue working to meet patient needs. Continuously working in a stressful and emotionally charged environment is unsustainable because there are risks and serious health issues when nurses are repeatedly stressed. PTSD and poor relationships between nurses and their families are some consequences. As mentioned in the literature review, studies have shown that nurses who overextend themselves will tap into depleted energy levels and overcommit, which can be harmful to their health (de Wijn et al., 2022). Nurses may not be aware of the amount of stress they are carrying and the effect on them (de Wijn et al., 2022), and there may be an expectation that, as ED nurses, they should be able to cope with trauma (Hetherington et al., 2024).

Furthermore, there should be a balance of compassion satisfaction (positive experiences) and compassion fatigue (negative experiences) within nurses' work, which may assist them to continue working (Francis-Wenger, 2024; Hooper et al., 2010; O'Callaghan et al., 2020). Thus, it is paramount that ED managers ensure that compassion satisfaction is strengthened, are vigilant for signals of stress, and respond by reducing workloads to minimise the risk of compassion fatigue (Drury et al., 2014; Hegney et al., 2014).

As mentioned, participants identified negative experiences within the work environment affecting personal, professional, interpersonal, and organisational areas, but it appears that senior nurses who have been working in ED for a considerable length of time are motivated and resilient. A few studies have found that some nurses appear to thrive in ED (Brown et al., 2018; Jackson, 2022; Rantung et al., 2022; Tubbert, 2016). Some senior nurses' attitudes towards current problems related to the work environment, for example, heavy workloads, scant staff and undesirable behaviour of staff within ED, are novel findings and not reported elsewhere in the literature. Two participants mentioned not getting stressed but drawing on in-depth knowledge

and experience to deal with situations and cope under pressure. While some participants signalled, they were leaving ED because of these problems, one senior nurse commented that leaving ED does not resolve a problem; instead, her attitude was one of persistence in that, by constant agitation of the issues, attention will be drawn to that problem. She chose to stay hopeful for change in the environment. This finding was unexpected. A possible evaluation of these attitudes or viewpoints is that senior nurses managing staff can support inexperienced staff exposed to these problems but also have the confidence and take responsibility and challenge situations.

An ED nurse's characteristics may be associated with pull factors, job satisfaction and retention. A nurse's age, postgraduate qualifications and nursing experience are some of these characteristics. Senior nurses in this cohort with extensive experience seemed resilient and tenacious. They overcame difficult situations and continued working in a busy shift. Several studies have identified a link between resilience, motivation, coping skills and nurse age and experience (Clark et al., 2021; Gorman, 2019; McDermid et al., 2020; Phillips et al., 2022). Positive coping strategies can be offered in training sessions with junior staff because these will build resilience. Studies have found that coping strategies build resilience which can reduce the effects of stress, and thus burnout (Guo et al., 2018; Xu et al., 2019.) Learning from these rich and unique experiences, coupled with positive attitudes, values, and coping skills, is a positive attribute and thus, a pull factor. Attributes like these create opportunities for junior nurses to emulate positive behaviours within the professional role of an ED nurse (Roth et al., 2022; Sasso et al., 2019). Adopting these values and positive attitudes may encourage and equip junior nurses to cope when faced with stressful situations, thereby offsetting any push factors. This also highlights the possible benefits gained from senior staff mentoring junior staff to overcome any obstacles or close gaps in their clinical performance amid challenges. Such characteristics should be further investigated so that other nurses can learn coping strategies and attitudes which mean that they are encouraged and motivated to stay.

Some studies commented on hope, motivation and coping skills, and how these can help nurses stay in ED (Hu et al., 2022; Rantung et al., 2022; Tubbert, 2016). As mentioned earlier, further examination is needed to understand these characteristics/traits so that other nurses can learn motivation and hope, coping skills and the reasons why some nurses may thriving in these conditions (Jackson, 2022; Rantung et al., 2022). Various coping skills are related to nurse resilience and tenacity. An integrative review by Rantung et al. (2022) found that nurses should be supported, which could lead to motivation and use of coping skills to manage stress. Similarly, in an earlier study, Tubbert (2016) interviewed nurses (n=16) as part of a qualitative study and found that tenacity, and the ability to use skills, teamwork, honesty, and self-control, helped with resilience. After experiencing stressful situations, nurses can use protective mechanisms to bounce back and thrive, reducing the risk of compassion fatigue and burnout (Flarity et al., 2013).

Offering debriefing to nurses can lower compassion fatigue. A study by Schmidt and Haglund (2017) found that debriefing can reduce compassion fatigue and promote resiliency. But the challenge for ED nurses in the present study is the lack of opportunity to debrief. The findings were around the lack of debrief after witnessing many traumatic incidents and that staff were not able to vent. This lack of debriefing meant staff continued to work in a busy environment without any chance to debrief. Studies have confirmed that debriefing, whether immediately after the incident or later, is helpful because debriefing builds resilience in nurses (Caulfield et al., 2023; Power et al., 2022). One participant was told that there is no time, and one must just keep going, which is not healthy.

The second theme of ‘ways of coping’ showed that nurses used social media to support each other. Besides talking to each other, some participants used social media platforms, such as Facebook Messenger and WhatsApp, though unofficial, as a current way of debriefing. The subtheme of “keeping your empathy tank full” showed most nurses engaging in social events outside of work, which were at times difficult to schedule due to shift work, restrictions under COVID-19 and exhaustion, but many attempted to connect when able. The COVID-19 pandemic has led many people to connect, for example, through WhatsApp. A recent study (Daniels et al., 2024) has shown that WhatsApp can be used as a way of storing information, offering solutions and communicating and learning from team members (junior nurses) often in isolated settings (Abiodun et al., 2020). But there is a problem: if WhatsApp is going to be used, then there must be robust guidelines, protocols and government policies on the nature of the information shared, and how confidential data is handled, because currently there are no best practice policies in NZ. This means that there could possibly be security breaches, leakage of private ED patient and nurse data, breaches of privacy and confidentiality, and even cyber security threats and scams (Khan et al., 2023; Morris et al., 2021). Therefore, organizations’ social media policy and guidelines need to be regularly shared with staff.

### ***Summary of micro level analysis***

In this section the micro level, two pull factors, personal satisfaction and ways of coping skills were discussed. Pull factors are important since they refer to those experiences which are perceived by nurses as positive and beneficial, and leading to job satisfaction, which in turn optimises the likelihood of nurses staying (Roth et al., 2022; Sasso et al., 2019). The next section covers the meso level.

### **Meso Level**

In this section on the meso level, the themes “we all chip in” and “professional development is important” are pull factors while the theme “workplace tensions” is a push factor and, notably professional development, was both push and pull. Professional development, teamwork, the

impact of nurse roles, the impact of physical and verbal abuse, solutions for mental health patients, the impact of COVID-19, and the effects of unwarranted behaviour on ED nurses are discussed.

### ***Professional development***

The theme of ‘professional development is important’ covered how opportunities, whether education or skills acquisition, were viewed by participants in this study. The subtheme of “knowledge is power” referred to nurses who chose to stay in ED because of the opportunity to learn and develop their knowledge and skills since they have no prior acute nursing experience. One participant admitted to not having confidence and experience like other senior nurses and appreciated what they could teach on the floor. Conversely, most senior nurses were upset about the cancellation of booked study days and inadequate professional development within ED. Even though they were experienced, they needed ongoing education and development to offer good care to patients. Patient acuity and increased workloads and short staffing were the main reasons for cancellation, yet complex patients require well-trained nurses.

The subtheme of “being fairy godmother for junior staff” relates to senior nurses supporting junior staff through teaching and constant supervision. This subtheme focuses on the pull factors related to junior nurses only. Studies have observed a correlation between professional practice opportunities sought by junior nurses and autonomy within their role and job satisfaction (Roth et al., 2022; Sawatzky & Enns, 2012). From my experience of working in several public EDs in NZ, junior staff often lack knowledge, experience and skill and therefore are not as confident as trained and experienced ED nurses in making decisions around managing sick ED patients. Many junior staff stay for professional development as part of their orientation phase over several months, extending into mandatory study days with core ED topics. This level of training is appealing because it is free of charge; moreover, taught assessment skills develop technical skills (cannulation, medication administration), critical thinking and reasoning, and can be used with tangible benefits for patients (Evans et al., 2017; Roth et al., 2022). Junior staff are often grouped to attend training, which enhances confidence, skills, teams and social connection. Evans et al. (2017) developed a training model in which a training pathway was offered to newly qualified nurses to attract them to work in ED, resulting in a progression and retention. Similarly, Power et al. (2022) interviewed nurses (n=11) and concluded that junior nurses were happy when there were opportunities to learn and grow in ways that were initiated by senior nurses, who regularly created an environment for learning whilst working closely followed by junior nurses recapitulating content through self-study.

Some junior nurses in this present study acknowledged the value of professional development; if they left ED without rigorous training or mentorship, they would be ill-equipped to handle increasingly complex patients. Untrained junior nurses put patients at risk and put nurses in a vulnerable position because of the lack of knowledge about managing sick patients.

Therefore, remaining and completing a structured and tailored programme for junior staff is imperative; junior nurses are ultimately signed off as safe and competent, and can manage sick ED patients prior to the arrival of a doctor and without a mentor or any supervision (Evans et al., 2017; Power et al., 2022). Promoting professional development and teaching offered by senior nurses to junior staff may be a pull factor for nurse retention. It is not just time for teaching and learning, but “protected time” for professional development, whether formal or informal must be evident to retain staff (Evans et al., 2017; Power et al., 2022).

Under the theme of ‘professional development is important’, being busy did not allow some nurses to learn skills and develop in the work environment. Here, limited or absence of professional development is a push factor. One participant was frustrated from not being able to go to meetings, for example – meetings where the team would discuss cases which enabled nurses involved in emergency care to regroup and investigate possible reasons for patient deaths, to review actions and ways to improve. Mandatory ED drug calculation tests for standing order medication and assessments were cancelled which meant junior staff were working without this qualification/certification. This cancellation poses a risk of medication error but also creates a false sense that one is safe and competent. Regular training, upskilling, and mentoring of junior nurses in particular builds their confidence to nurse patients and possibly teach others, which in turn will help reduce workload and take off the pressure that exists when only one staff member has certain skills. Inexperienced nurses must be mentored at every step of the way; professional development must be embedded into the orientation and transferred onto the floor for junior staff. Studies suggest that junior nurses are at risk of stress and burnout, so it is important to ensure ongoing training and education with support throughout their journey (Van Osch et al., 2018). Professional development offered to nurses will increase job satisfaction which, in turn, will lead to nurse retention.

### ***Teamwork***

The fifth theme of ‘we all chip in’ with its three subthemes (“a sense of humour”; “relying on each other”; and “everybody mucks in”) centred on positive experiences from working with nurses having either recent or extensive clinical experience. A supportive ED team is a pull factor for nurse retention. The key message from this study was that nurses cannot work alone in a busy ED. Nurses depended on each other and a supportive ED team which extended to other members of the MDT: doctors, physiotherapists, social workers, discharge coordinators and occupational therapists. The subtheme “sense of humour” reflected the humour shared on a shift between nurses, which took the seriousness out of a situation, but also provided an opportunity for nurses to chat, vent any frustrations or anxieties, and, at times, explore the best course of action for challenging clinical situations. These situations occurred during times of high patient acuity, low numbers of nurses and unseen patients awaiting evaluation by a nurse and treatment by a doctor. These findings are consistent with other studies on teamwork’s significance and impact on patient

care (Ghezeljeh et al., 2020; Lapierre et al., 2019; Milton et al., 2022; Mohammadi et al., 2024; Rezaei et al., 2021; Zaheer et al., 2021).

Mohammadi et al. (2024) conducted a descriptive qualitative study interviewing nurses (n=23) in Fars Province in southern Iran and found that tensions and poor communication between staff can affect teamwork, ending in lower standard of care. The researchers recommended ongoing initiatives to improve communication and teamwork for patient safety. Likewise, Zaheer et al. (2021) conducted a mixed methods study with surveys (n=185) followed by nurse interviews (n=15) in southern Ontario, Canada, and found a correlation between leadership, teamwork, ITL and patient safety. The researchers recommended the organisational development of nurse retention strategies to reduce ITL which was linked to poor teamwork and safety of patients; more support for leadership and for nurses working directly with patients to improve teamwork. Rezaei et al. (2021) surveyed ED nurses (n=230) and noted the significance of teamwork when staff needed help, plus positive values with regard to teamwork, and an improvement in patient outcomes, and recommended professional development to enhance the understanding of teamwork. Milton et al. (2022) interviewed healthcare professionals (n=28) to understand the perception of critical incidents in relation to the barriers to and enablers of teamwork in Gothenburg, Sweden. Lack of communication, clinical experience, and management support resulting in poor teamwork and compromised care were among the findings. As before, a suggestion was for management to offer suitable working environments and educate staff on teamwork. Likewise, Ghezeljeh et al. (2020) conducted a cross-sectional study with nurses in ED (n=231) in Iran and concluded that teamwork, leadership, trust, and positive mental attitude lowered the risk of missed care. Ghezeljeh et al. (2020) recommended nurse managers foster more training around nurses working together, centred on trust, interpersonal relationship and identifying challenges to teamwork.

These four studies confirm an earlier study by Lapierre et al. (2019). The researchers conducted a qualitative descriptive exploratory study in Montreal, Canada, interviewing seven healthcare professionals, one of whom was a nurse, and found factors that promote and prevent interprofessional teamwork. Team members who get along, and demonstrate trust and respect, were found to promote interprofessional teamwork, whereas rushing, heavy workloads and lack of communication resulted in fragmented teamwork. Recommendations were to inform nurses about positive factors that facilitate teamwork in preparation for work. In fact, interpersonal relationships, effective communication, supportive management, leadership, and team cohesiveness amongst ED nurses and teams operating to deliver of acute care in a busy ED were important to the nurses interviewed. These studies echoed the previous findings of a study by Grover et al. (2017) where, for example, communication and training on teamwork were found to help build teams. From a professional perspective, the ability to work cohesively as a part of a team is determined by the values of each team member and encouraged by senior nurses, and by

team members' experience, positive attitude and willingness to help each other, along with strong leaders and organisation, and good design of the ED. Professional development centred on communication, leadership and what to do in complex stressful situations through simulation will be invaluable to staff in promoting effective teamwork.

Being on a shift with like-minded experienced nurses who share supportive relationships established camaraderie amongst members, even though shifts were often stressful, challenging and exhausting (Alzghoul, 2014; Van Osch et al., 2018). Good teamwork results in enhanced quality of patient care (Zaheer et al., 2021), the safety of patients (Aiken et al., 2014), a reduction of incidents (e.g., drug errors, patient falls) (Han & Roh, 2020), and fewer mistakes in the work environment (Grover et al., 2017; Zaheer et al., 2021). In addition, good interpersonal relationships, communication between nurses and members of the MDT lead to satisfaction and happiness, which in turn leads to job satisfaction. Participants in this study reported that supportive colleagues were one of their most significant reasons for continuing to work in ED, leading to team cohesiveness. These relationships, based on mutual trust, the desire to offer help or even teach other nurses, effective communication and respect for each profession are important elements for the effective teamwork that leads to job satisfaction (Lapierre et al., 2019). As mentioned previously, a supportive ED team is a pull factor for nurse retention.

On the other hand, the present study's findings show high levels of stress, fear, frustration and anxiety amongst some team members. In alignment with Lapierre et al.'s (2019), this study shows that low number of nurses and high patient: nurse ratios stressed the whole team, causing unhappiness, frustration and anger amongst team members. One senior nurse commented that staff become "snippy and snappy" because of the high demands (high acuity, heavy workloads, lack of space, inexperienced nurses, exhausted teams and moral distress). Thus, it can be seen that several elements inhibit teamwork, for example, stress, interpersonal conflict, communication breakdown, working with inexperienced staff and, at times, limited numbers of staff due to financial constraints (Lapierre et al., 2019).

It is important that an organisation values and acknowledges nurses faced with work environment stress (short staffing, inexperienced staff, poor equipment, heavy workloads). In the present study, when team leaders escalated the problem to the organisation, help was sent to assist nurses, but it consisted of inexperienced nurses. Team leaders had to recheck that work allocated to these nurses was completed correctly and promptly to meet ED requirements. This increased team member work, which was seen as time consuming and another layer of responsibility and stress. Overseeing the work of less experienced health professionals meant team leaders could not devote time to team members and watch patients too. Added work puts increased pressure on already stretched team members working in an unpredictable workplace (Han & Roh, 2020), leading to exhaustion and burnout (Grover et al., 2017; Zaheer et al., 2021).

In addition, working beyond normal working hours and skipping breaks hinders teamwork. Participants in the present study spoke of not adequately resting and being unable to take bathroom breaks due to work demands. Studies have concluded that a lack of break time and working excessively can affect nurses' health and impact the entire team (Dewanti et al., 2022; Gifkins et al., 2017).

Therefore, factors that inhibit teamwork (Ghezeljeh et al., 2020; Grover et al., 2017; Lapierre et al., 2019) generate a push factor increasing nurses' likelihood of leaving ED. Even though many nurses experienced stress and are exhausted, nurses found relief through conversation with team members, colleagues, and doctors. Identifying and reinforcing these positive interpersonal experiences and teamwork consistently leads to job satisfaction (Grover et al., 2017), increased quality of care, the protection of patients from harm (Rezaei et al., 2021) and the reporting of errors to seniors (Han & Roh, 2020). The negative experience of stress, lack of debriefing, poor organisational culture and problematic shift work raise questions about how these impact relationships between nurses and teamwork. Therefore, the factors that inhibit teamwork must be addressed and the promotion of teamwork must be further investigated, understood, and encouraged. Professional development days offered to experienced nurses must incorporate team-building strategies and understanding team dynamics within ED. More must be done by organisations about interpersonal relationships for respect, value and trust through professional development. Effective teamwork is a pull factor pivotal to the role of an ED nurse for staff retention (Ghezeljeh et al., 2020; Han & Roh, 2020; Lapierre et al., 2019; Milton et al., 2022; Mohammadi et al., 2024; Rezaei et al., 2021; Zaheer et al., 2021). Therefore, organisations should invest in professional development around effective teamwork and teambuilding sessions.

### ***Workplace tensions***

The following themes reflect the push factors. The theme of 'workplace tensions' and its five subthemes ("it feels like a third world department"; "finding more solutions for mental health patients"; "feeling pretty horrible from patient verbal and physical abuse"; "COVID-19 is a game changer for nursing"; and "treating each other differently"), along with theme six, dissatisfaction with organisational structures, processes and systems illuminate some of the influences on participants' desire to stay or leave ED. This study reveals negative experiences: stress, workloads, tensions within the role, risk of violence and harm from patients and families, long wait times resulting in agitated mental health patients, and some unprofessional/undesirable behaviours reported by nurses. While nurses were able to enjoy working in ED, due to positive factors [pull] such as teamwork, humour, colleagues, making a difference, and at times, learning opportunities, many participants were unhappy, angry, exhausted, and frustrated by that issues remain unsolved. These experiences negatively impacted on their personal lives, professional roles, interpersonal relationships and perceptions of the organisation.

Occupational stress is associated with job dissatisfaction and nurses wanting to leave an organisation (Lee et al., 2021; McCormick et al., 2023). Studies conclude that when there is a disproportionate number of patients per nurse coupled with nurses being exhausted from working long shifts, negative emotions are inevitable. When there are worries about patient safety (Clark et al., 2021; Clark et al., 2022; Elder et al., 2020; Wolf et al., 2016), nurses become morally distressed (Gómez-Urquiza et al., 2017; Van Osch et al., 2018). Stress leads to nurse burnout, lowering the quality of patient care and overall patient outcomes (Miller, 2011). Therefore, organisations must address every possible cause of stress within the work environment through ongoing team meetings with nurses (Miller, 2011). Although nurses who participated in this present study have individual coping skills, supportive colleagues and family to help them remain working, this is not enough to withstand the ongoing moral distress and pressures nurses face; rather it is the responsibility of organisations to urgently address issues related to stress (McCormick et al., 2023).

As mentioned before, another finding was that participants who were often busy may be unaware of the amount of stress they are carrying. The participants acknowledged an ongoing lack of debriefing after traumatic experiences intensifies their stress, which is an extremely dangerous situation for nurses, teams, and patients. Therefore, early intervention by the organisation is needed so that there is an awareness of stress together with engagement of staff to gather evidence of stress and highlight its causes. Organisations must focus on training and education around debriefing and distress strategies (Basu et al., 2017; Elder et al., 2020; McCormick et al., 2023). Stress will not disappear from EDs; if anything, demands at the coalface will increase because of population growth, sicker ED patients, the chronic shortage of skilled nurses, and time pressure (Daniels et al., 2024; McIntyre et al., 2024; Muir et al., 2024; Rantung, 2025; Ren et al., 2024), not forgetting the effect of COVID-19 (Hodgson et al., 2024). However, better informed and equipped nurses, for example, through the provision of regular debriefing and training on how to manage stress, will help decrease the likelihood of further negative impacts of the work environment on nurses (Basu et al., 2017; Elder et al., 2020; McCormick et al., 2023).

The next section covers the impact of the workplace on nurse roles, for example, nurse specialist deviating from the normal roles, nurses taking on non-nursing duties and inability to offer quality nursing care due to lack of time. This is followed by effect of violence, solutions for mental health patients, and COVID-19 on participants.

### ***Impact on nurse roles***

This section covers the impact of workplace factors on nurse roles. The theme of ‘workplace tensions’ and the subtheme “it feels like a third world department” suggest that the busy workplace resulted in four major tensions in the roles of ED nurses. These are: the role of specialist nurses; ED nurses’ performance of non-nursing duties or deviation from the role; time

constraints preventing senior nurses from offering holistic care; and overall role expectation change leading to moral distress.

#### *Nurse specialists not working in their normal roles*

High acuity, time pressures, COVID-19 and limited numbers of experienced nursing staff caused nurses in advanced nursing roles – CNSs and nurse practitioners – to leave their assigned duties and help to clear backlogs and support junior staff. From participants, it was heard that nurse practitioners and CNSs were not in their normal roles but had gone back to their ‘clinical role’ when the ED was short staffed. CNSs were also mentioned under the theme ‘personal satisfaction’ and the subtheme “ED nursing is never boring”, where it was noted that junior staff are supported by nurse specialists during busy times. In this study, CNSs were referred to as “good” and willing to jump in and give a hand and teach junior staff, such as orientating new graduates to resus and triage. Studies identify that nurse specialists also take on a supervisory role (Fowler et al., 2019; Geller & Swan, 2021; Williams, 2017).

But herein lies a problem. Tensions within the nurse role and environment revealed that nurses working in advanced roles, for example, CNSs and nurse practitioners, had to change roles to a regular nurse role to help clear workloads. Low staffing and increased patient acuity pressurised team members into signalling a need for help. Nurse specialists working in this ED primarily attend to patients who require complex care, for example, casting and wound dressing. Studies have shown that advanced nursing roles such as nurse specialists and nurse practitioners optimise patient outcomes and improve movement through an ED, reducing overcrowding and gridlocks (Fowler et al., 2019; Geller & Swan, 2021; Williams, 2017). Boman et al. (2020) interviewed nurses and found similarities between scope of practice and competence with nurses and specialists. Experienced acute care nurse specialists possessed prioritisation skills and knowledge and recognised when patients needed urgent care and when they did not. What was common in these studies (Fowler et al., 2019; Geller & Swan, 2021; Williams, 2017) was that both nurses and specialised nurses found time pressures prevented them from good communication and offering more support to patients, especially care at home, once patients were discharged. The inability to offer more to patients is reflected in this study and is discussed in the next section.

Nurse practitioners and nurse specialists working in ED have been reported to clear backlogs and improve patient outcomes, with reports of higher scores of patient satisfaction (Geller & Swan, 2021). Nurses with specialist roles can perform good patient assessments, commence treatment and facilitate seamless discharge, mentor other nurses and thus lower costs for the hospitals (Fowler et al., 2019; Geller & Swan, 2021; Williams, 2017).

When specialist nurses loaded with extra work in a busy ED, it may lead to poor patient outcomes. Specialist care normally done by these nurses with advanced training, knowledge and

experience were not done, for example, pain relief or FIBs for patients recently admitted with a fractured hip, or suturing of wounds (Gawthorne et al., 2021). Studies have found that nurse specialists performing FIBs were as effective as ED doctors, leads to efficiency and personal satisfaction (Gawthorne et al., 2021; Randall et al., 2008).

This extra work also meant that patients would be waiting until specialist nurses were available to them, but also that specialist nurses were at risk of increased workloads and stress when returning to complete outstanding specialist tasks. Another interpretation of this finding is that elderly patients with fractured neck of femur may develop delirium and therefore need prompt identification and treatment by nurse specialists (Gawthorne et al., 2021). The findings of this study suggest that while nurse specialists are preoccupied with helping and teaching junior staff, patients may have worse outcomes. Therefore, the organisation must explore ways to ensure nurse specialist and practitioners work within their scope by increasing staffing levels and promoting more nurse specialists, and by extending the nursing scope of practice to deal with FIBs. There is no quick solution to this tension because patient care always comes first, which causes nurses to adjust or step outside their role to clear backlogs. Future research involving nurse specialists and nurse practitioners is needed to understand this phenomenon.

The findings indicate that junior staff are often at risk when left alone whilst specialised nurses are deployed to the front of ED. The subtheme of “COVID-19 is a game changer for nursing” revealed that senior staff being preoccupied with COVID-19 patients led to junior staff working alone in other parts of ED. Furthermore, the theme of ‘professional development is important’ validated the need for all junior staff to be constantly mentored and supervised because of inexperience and limited knowledge. Both nurse practitioners and nurse specialists are assigned to triage which then results in the rest of the department operating without senior staff. This places new graduates in ED at risk of mistakes, stress, burnout and ITL. Consistent with other studies, this research has found that there must be support for junior staff through mentoring, onboarding, and robust pathways for education and training to handle ED scenarios (Lapierre et al., 2019; Lee et al., 2021; Van Osch et al., 2018; Zaheer et al., 2021). Therefore, the organisation must plan and set aside resources, such as funding and staffing, for professional development and offer ongoing support for junior staff.

#### *Performance of non-nursing duties*

The subtheme of “it feels like a third world department” revealed tensions caused by nurses undertaking non-nursing duties such as orderly tasks, cleaning, and administrative work. The performance of non-nursing duties places nurses in a vulnerable situation because important nursing tasks (the assessment of newly admitted patients or the administration of urgent treatments) are left undone, which may affect patient outcomes or cause delays in treatment. Studies have commented on nurse unhappiness and stress due to deviation from their professional

role and performing non-nursing duties (Grosso et al., 2019; Sasso et al., 2019). Committing to non-nursing duties is time consuming, which again devalues and disrespects the professional role of nurses. Orderlies working in a busy ED are also pressurised to move patients quickly. This rapid movement of ED patients from ED is common due to health targets, and to create a space for an influx of patients and reduce gridlocks. However, little consideration is given to the impact on nurses' professional role and patient ramifications. Cleaning beds, stretchers and spaces used by unwell patients in preparation for new admissions is a time-consuming responsibility, taking nurses away from attending to other patients. This practice may also create a culture that non-nursing duties are expected of nurses in ED, which can create unhappiness and confusion amongst busy nurses, especially inexperienced staff. This negative experience can change the expectation of nurses who have recently started work in ED. Taken together, confusion and change in role expectation can lead to job dissatisfaction, which increases the risk of ITL.

#### *ED nurses' inability to offer holistic care due to time constraints*

Another subtheme of "workplace tensions" was that even though some nurses loved the fast-paced nature of ED work and making a difference, many senior nurses wanted more time, and moments with patients that were not brief, abrupt and intense moments; instead, they wanted ample space to offer a better standard of care. Some nurses felt they did not offer holistic care due to time constraints. This study's findings align with other studies on nurse dissatisfaction from time constraints (Daniels et al., 2024, p. 259), perceptions of inevitably poor care (Hetherington et al., 2024), and pressures in ED. Studies have shown that ED nurses are pressurised due to low staffing levels and high patient volumes, and therefore do not have enough time to provide more for their patients (Blank et al., 2014; Eriksson et al., 2018). Spending quality time with patients results in better outcomes such as education about recent investigations, checking on follow-up post-discharge, and preventing incidents like fluid loss and missing regular medication whilst waiting in a busy ED. These actions help alleviate any fears or anxiety (Blank et al., 2014; Eriksson et al., 2018). Senior nurses recognised that comprehensive care for ED patients is essential because senior nurses draw on clinical knowledge and extensive experience and can see beyond the immediate acute needs.

Another interpretation is that engaging with and spending quality time with patients in ED adds to better patient outcomes like improved interaction, communication, discharge and rehabilitation. The impact on patient outcomes in the future is reduced risk of readmission or deterioration, and better quality of life and thus decreased expenditure for the health system. Therefore, the organisation must explore ways to allow nurses "protected time to complete tasks" (Daniels et al., 2024, p. 259) to offer quality nursing care.

### *Change in expectation of the role*

The subtheme of “it feels like a third world department” suggests that one of the biggest concerns raised by nurses was the high level of anxiety and fear that they may cause harm to patients due to challenging working conditions. These negative emotions played on nurses’ minds, causing sleep disturbance and a sense of hopelessness and moral distress. As mentioned earlier, some senior nurses felt that their expectation of the role had changed since starting in ED. Participants felt their negative experience was not what they signed up for and their expectation of the role had changed over the years. As mentioned, participants worked in ED for satisfaction, variety and being able to help but, recently, they were “basically tasking” because of time constraints and limited numbers of staff. The disconnection between time constraints and perceived lowered quality of patient care creates more stress among nurses (Hetherington et al., 2024).

Others are hopeful and chose to wait and see how the role developed, even though they were currently unhappy. The expectation of the role meant taking on more work amid busy and complex work environments. When there is disharmony between the expectation and reality once work starts, nurses are unhappy. This is particularly important for junior staff. Miller (2011) found that when nurses’ expectation of the role changes and this causes a mismatch, they feel unhappy; they question whether they want to remain in the role and are therefore more likely to leave the organisation. Many nurses interviewed felt they were not valued and respected and therefore unhappy. These negative emotions lead to job dissatisfaction influencing nurses thinking about leaving. The organisation needs to monitor staff levels for stress and attitudes towards the role, and intervene early to reduce the risk of attrition. The ongoing presence of nurse leaders on the floor, effective communication and a culture that encourages open discussion without any fear of repercussions is needed.

It was clear that many of the participants interviewed felt ill-equipped and unprepared to offer emergency care and were angry, frustrated, and unhappy. Patients were at risk of delayed treatment or errors in assessments (vital signs and ECGs) due to a lack of equipment and old equipment, which is the responsibility of an organisation to tackle. This is similar to observations in other studies on the responsibility of nurse leaders to ensure a good supply of working equipment (Adriaenssens et al., 2011; Lapierre et al., 2019; Zaheer et al., 2021).

This gap left many nurses extremely exhausted, frustrated and angry. Therefore, the organisation must take heed of the plight of nurses and ensure that there is funding for equipment, or implement quality control checks on ED equipment (Adriaenssens et al., 2011; Lapierre et al., 2019; Rantung et al., 2022).

### ***Verbal and physical abuse from patients and families***

The theme of ‘workplace tensions’ and the subthemes of “feeling pretty horrible from verbal and physical abuse” and “finding more solutions for mental health patients” suggest that violence and aggression is a serious concern for all ED nurses. Considering the subtheme related to violence and aggression, which is a risk that comes with ED, it was clear that mental health patients presented to ED when unwell, exhibiting behaviours such as agitation, psychosis, delirium, and personality changes, and, at times, were present in large numbers. Most participants spoke about different levels of verbal and physical abuse seen in scared and anxious ED patients and unhappy family members. To illustrate some examples, family members accompanying patients held different expectations of nurses, wanting immediate attention and expecting better results for their family members. For example, when ED staff were unable to save a patient’s life despite several attempts in the presence of family members, staff were physically abused. Findings are consistent with other recent studies that investigated the problem of violence and aggression amongst medical and nursing staff in ED (Davey et al., 2020; Doehring et al., 2023; Spelten et al., 2020). The impact of violence and aggression on ED nurses is added stress, burnout, and PTSD (de Wijn et al., 2022; Schablon et al., 2022). In addition, studies have established a strong link between abuse and job satisfaction and ITL amongst nurses (de Wijn et al., 2022; Li et al., 2019). The abuse experienced by ED nurses added an additional layer of stress and can also lead to poor patient outcomes, medical errors, and ineffective communication between nurses and patients, which again increases the likelihood of further verbal and physical abuse (Hsu et al., 2022; Yang et al., 2021). ED nurses can also become anxious and worry about the danger to their children, leading to then being hypervigilant with children (Hetherington et al., 2024).

Job dissatisfaction increases the likelihood of staff leaving. In this study, not all participants commented on verbal and physical abuse. There are two reasons for not discussing or reporting abuse. The reason may be that nurses may not have experienced or witnessed episodes of violence and aggression, or it is accepted as a norm and part of the role (Pich et al., 2017). A cross-sectional study stated that violence is “often downplayed as just part of the job for nurses” (Pich et al., 2017, p. 107); while another phenomenological study found that nurses’ perceptions and understanding of violence differed and they often failed to report episodes (Hogarth et al., 2016). This failure may be due to acceptance of violence as being part of the ED culture. An argument put forth in a qualitative descriptive exploratory study is that sound actions are negated due to the “normalization of this phenomenon in both the healthcare and law enforcement systems” (Wolf et al., 2014, p. 309). Despite violence and aggression not being portrayed by all the participants in this present study, the incidence of violence is worrying and unless something definitive is done, staff and patients are at risk. Organisations must prioritise the safety and well-being of all ED nurses – junior and senior – to reflect the organisational culture. At the same time, any form of abuse must be reported.

Doehring et al. (2023) gave reasons for not reporting negative behaviour, citing paperwork around reporting that may be complex and cumbersome, and concurring with findings elsewhere that negative behaviour is accepted as a norm (Doehring et al., 2023). Furthermore, the absence of robust protocols and guidelines in ED and an attitude that the reporting of such incidents would be futile were other reasons (Doehring et al., 2023). The issue of not being able to fix a problem and perceived dread of increased paperwork is reflected in some of the findings in this study. This is not a healthy environment for existing staff, or for new and junior staff coming onboard. This attitude and the experience of it need further investigation and escalation to management because nurses exposed to violence will be confused, and it appears that the integrity of the entire process of monitoring such incidents is now questionable.

As mentioned previously, a lack of debriefing was reported by all participants. This can be an opportunity to justify regular debriefing in ED but also provide ongoing education and training on debriefing for all staff. Richardson (2017) argued that staff do not report incidents, but there must be awareness of this behaviour. Training in de-escalation using effective communication techniques in the form of simulation for all staff is important.

The evidence presented under the subtheme of “feeling pretty horrible from patient verbal and physical abuse” showed nurses in this group have received support from the organisation and continued to work in ED, yet the emotional load and the physical evidence described in study, are powerful reminders of the psychological and physical effects of violence and aggression. These findings have a great influence on burnout and job satisfaction (Yoon & Sok, 2016) and despite the presence of highly experienced and skilled senior staff, the incidents of aggression, whether verbal or physical, are increasing (Hyland et al., 2016). Similarly, in Spain, a retrospective cross-sectional study, sampling 70 pre-hospital emergency care services, found that staff were frequently abused more than five times in a single shift (Bernaldo-De-Quirós et al., 2015).

As established, a stressful work environment can cause patient handover between ED nurses to be brief and rushed, resulting in important information like psychiatric history, treatment or management plan to be omitted. In addition, inexperienced staff and a lack of staff mean that staff cannot always identify a potentially volatile situation. In this study, findings revealed overworked and stressed staff who often must perform non-nursing duties like transporting patients. Therefore, patient: nurse ratios must be reviewed and staff must receive training to mitigate risks of violence and aggression; they must be equipped with tools to prevent verbal and physical abuse, such as a system to monitor signs of violence and aggression early (Reißmann et al., 2023).

Looking at the peak times for abuse risk, Richardson et al. (2022) conducted a prospective longitudinal study looking at audits over a seven-year period and confirmed that there is higher incidence of abuse on weekends and night shifts. Similarly, a study on understanding violence

and aggression towards nurses conducted in India spoke about situations at night that make perpetrators “feel emboldened by the lack of security personnel” (Davey et al., 2020, p. 6). There were differences in the contributory factors to violence and aggression when the present study is compared to the study by Davey et al. (2020). This study spoke to abuse of alcohol and drugs, mental illness contributing to violence and nothing about affordability. The literature indicates the culture in NZ is more accepting and tolerant of alcohol consumption and sees it as a regular part of socialisation whereas the culture of participants in India may lead to strong views about alcohol and substance use which may restrict usage (Davey et al., 2020).

The subtheme of “feeling pretty horrible from patient violence and abuse” reflects a risk that comes with ED. This justifies the need for patient education in triage where participants reported increased abuse from patients and families. Due to the closeness of patients in triage, there is a perception of favoritism towards some patients in this space and unfairness from staff. When physical examinations must be carried out, patients are assisted in the triage area into a private space for examination or initial interview which again may be seen as some patients receiving fuller attention than others. The Australasian Triage Scale is used in NZ EDs and has three main categories. Patients in this study had not been educated on the triage system in ED, which warrants patient education around categories of patients and wait times in ED (Alomari et al., 2021). Prompt and ongoing education offered by organisations to patients and families who are waiting and anxious may enable a deeper understanding and appreciation of the nature of ED patients, nursing and processes in triage, which may decrease the risk of verbal abuse from patients and families.

The findings indicate senior staff have mentioned how junior staff at triage are confronted and yelled at, resulting in emotional outbursts. This behaviour may take away whatever little opportunity for growth and confidence they had in a new role and even change the expectation of the role they had earlier. A change in role will thus lead to ITL. Power et al. (2022) interviewed nurses who chose ED as an early career and found that exposure to violence and aggression from patients or family members may lead to uncertainty, and reflecting on whether the role was worthwhile. In the present study, participants expressed concern over the risk of violence and aggression from patients and families, and being more conscious of it. Their concerns were perceived as a psychological roadblock to caring for other patients (Power et al., 2022). From a professional standpoint, triage, being the first point of contact, has more episodes of violence than other points within the department, for example monitoring, acute care, or the resuscitation room (Pich et al., 2017). Junior nurses must always be shadowed with senior staff in these areas but also constantly monitored by CCTV cameras, CCNs, shift coordinators and security guards.

### ***Solutions for mental health patients***

Under the subtheme of “finding more solutions for mental health patients”, participants were distressed and felt hopeless. Participants were concerned about the large presentation of mental health patients but not enough resources, such as mental health staff, ED nurses and beds to meet this demand. As one participant pointed out, “It’s not the number of cardiac patients you have in but it’s the mental health patients.” The findings of this present study are similar to other studies on mental health patients waiting (Allison et al., 2021; Duggan et al., 2020; Judkins et al., 2019; Kuehl et al., 2022) which show poor outcomes for mental health patients, nurses and other patients. Findings in this present study show similar observations voiced by senior nurses about how much time, energy and staffing mental health patients take in a shift. These vulnerable patients wait for long periods for an assessment and treatment (Duggan et al., 2020) by an under-resourced mental health team (Kuehl et al., 2022). From personal experience, ED is a stimulated and unpredictable environment (Allison et al., 2021), and mental health patients waiting will often leave without informing nurses and/or progress into aggression, rendering staff morally distressed (Judkins et al., 2019). Therefore, the government must invest in more qualified and experienced staff to offer care to these vulnerable patients to keep themselves, ED staff and patients safe. Without these improvements, staff will continue to be stressed, morally distressed and frustrated. When ED nurses are well supported, and feel that they can offer quality care, this leads to compassion satisfaction and job satisfaction which leads to the retention of nurses.

### ***COVID-19 pandemic hostility***

A significant feature of this study was that interviewing commenced before and continued during the COVID-19 pandemic. The subtheme of “COVID-19 is a game changer” for nursing brought out many nurses’ experiences working under COVID-19 restrictions and highlighted patients and their family members’ hostility and anxiety, which was heightened when concerned family members could not visit (Ghanbari et al., 2022; Yang et al., 2021). Similarly, ED patients who were admitted were fearful of contracting COVID-19 due to their proximity to other patients and ED nurses. During the COVID-19 pandemic, many nurses received mixed messages about COVID; some nurses felt unprepared, which added to their stress. Also, the public was receiving information through social media and regular news broadcasts about the disease which was both overwhelming and confusing, adding to tensions between themselves and ED nurses (Yang et al., 2021). Even though participants in this present study attempted to calm and reassure patients and families, increased levels of anxiety and fear arising from getting assaulted were voiced by some participants. A quantitative study by Molero Jurado et al. (2022) found that nurses in the front line, in primary care, were exposed to more violence due to volumes of COVID-19 patients than nurses in EDs. A further finding was that nurses were also afraid of the risk of violence from families of patients, which affected their ability to offer quality patient care. A possible explanation for this lower incidence is that violence may be normalised and underreported. More

monitoring of staff and education around coping skills were some of the study's recommendations (Molero Jurado et al., 2022). Brigo et al. (2022) compared levels of abuse before and during COVID-19 and found that ED staff experienced increased levels of abuse during the pandemic compared to before. The reason for the increase was multifactorial. Some of these factors were around the increased strain on the entire health system, stressed ED staff whose work was complicated by adherence to the need for PPE, and other new rules in ED around designated spaces for COVID-19 patients and non-COVID-19 patients.

The subtheme of "COVID-19 is a game changer for nursing" revealed how participants felt about working with patients under COVID-19 restrictions and the COVID-19 framework implemented in ED, which was the use of isolated rooms for COVID-19 patients. A portion of the findings from this study are consistent with other studies (Ahorsu et al., 2022; Çınar et al., 2021; Yang et al., 2022). The lack of preparation and staff feeling afraid and worried about contracting diseases or unknowingly infecting their families and being laid off work was heard. It was reported that patient dishonesty regarding symptoms was a common occurrence in ED. Also, many migrant nurses were affected by the fact that some family members overseas were very sick and they were unable to see them. The recent literature on COVID-19 has highlighted nurses' attitudes, feelings around COVID-19 lack of preparedness, fear of getting infection, worry, fatigue, and concerns about mixed messages (Walton et al., 2020). Staff also had to also face angry patients' families and friends who were not allowed to see patients under these restrictions (Cornish et al., 2021). COVID-19 also led to challenges within the organisation in accessing allied teams such as physiotherapists and occupational therapists, because patients were missing out on extra support that they would normally have received before COVID-19.

A final point on COVID-19 experiences was that some participants felt that the second wave was handled better because of learning and experience; the team came together and adapted to cope with patients and short staffing (Bornstein et al., 2021). It is important to note that EDs across the globe experienced similar problems and there may have been a perception of errors and failures in working with COVID-19. As nursing is constantly changing, one should consider the unique experience during COVID-19 and learn from any shortcomings to better prepare nurses in the future.

### ***Dealing with unprofessional, unwarranted, adverse and undesirable behaviours from other staff***

The subtheme of "treating each other differently" suggests that some nurses experienced unprofessional or undesirable behaviours from other staff. This resulted in numerous negative emotions: fear, unhappiness, hopelessness, doubt, and mistrust between nurses. These challenging behaviours impacted ED nurses and the entire team. In several instances, ED was labelled as "toxic" by senior nurses because they perceived undesirable behaviours. This is combined with

the perceptions of inadequate rest periods before coming onto a shift or any opportunity for staff to have downtime or feel supported by the organisation. Staff were not given an opportunity to vent or attend a formal debriefing session after traumatic events. As mentioned previously, staff may not be aware of the stress they are carrying (de Wijn et al., 2022) and may unintentionally displace their frustration onto others, and thereby disestablishing existing good interpersonal relationships. Interpersonal conflict can lead to staff not working cohesively within a team.

In this study, participants voiced feelings of doubt, and being disrespected and undervalued, which are consistent with studies on adverse behaviours on staff (Edmonson & Zelonka, 2019; Gosselin & Ireland, 2020; Tabakakis et al., 2020; Wolf et al., 2021). The literature states that behaviours like non-collegial body language, yelling, and gossip lead to mistrust in a department and take confidence away from nurses (Edmonson & Zelonka, 2019; Gosselin & Ireland, 2020; Wolf et al., 2021). Some participants in this research chose to stay and adopted ways of dealing with the behaviour, for example, tolerance, whilst some hoped the staff member concerned would leave.

Several participants who were in clinical leadership positions acknowledged that when negative behaviours presented, they were difficult to identify as it was manifested as underhand, subtle, and slanderous. Others believed that staff are not aware of the impact of their behaviour on others. Negative communication, led to lack of confidence amongst some nurses and could lead to mistrust.

In keeping with the subtheme of “treating each other differently”, senior staff reported unfairness in the treatment of some staff and perceived favouritism shown by management towards some staff when a mistake was made. It was reported that some staff “appear to get away” with doing something wrong whilst others were held accountable. There appeared to be no consistency, which was upsetting to staff. For example, in regard to shift requests or roster changes, some nurses would receive what they wanted whilst others would not. Another example was funding for postgraduate study where some nurses could assert themselves and would receive support with professional development whilst some were unable to get the same opportunity to study further. Some seniors felt that nurses were affected by this lack of uniformity.

Studies found that unprofessional behaviour, such as dismissiveness, or threatening or undervaluing staff, leads to a negative workplace and lowered performance and productivity (Maddineshat et al., 2021; Parizad et al., 2018). Therefore, organisations must identify and confront unprofessional behaviour and intervene early to create a positive environment (Maddineshat et al., 2021; Parizad et al., 2018).

### ***Summary of meso level analysis***

In this section on the meso level, the importance of ongoing professional development, and teamwork was discussed. Ongoing professional development is a pull factor while unstructured, limited or absence of professional development is a push factor. Good teamwork is a pull factor leading to job satisfaction and retention. In addition, push factors, negative experiences in the workplace such as workplace tensions, the impact of physical and verbal abuse, solutions for mental health patients, issues arising from COVID-19, and the effects of unwarranted behaviour on ED nurses were discussed. Push factors are significant since they refer to those experiences which are perceived by nurses as negative, potentially harmful and causing unhappiness (WHO, 2021) and stress, leading to job dissatisfaction (Alharbi et al., 2022; Roth et al., 2022; Sasso et al., 2019). When push factors are present, the risk of turnover is higher.

The next level is the macro level.

### **Macro Level**

In this section, the macro level, the push factors which are identified as, the impact of the organisational structures, processes and systems on participants, is discussed. The negative impact of rosters, shiftwork, lack of remuneration, the effects of staff being deployed to assist and a call for an organisational culture change are discussed.

### ***Dissatisfaction with structures, processes and systems***

The sixth theme of ‘dissatisfaction with organisational structures, processes and systems’ indicated unhappiness with the organisation and was therefore identified as a push factor. The subtheme of “feels like old school” showed how the organisational culture and hierarchy can affect the morale of the team. Although the organisation, at times, offered some help in response to desperate pleas from pressurised senior nurses, many nurses in this group felt more could be done. Some nurses went even further, saying they felt that they were dispensable, easily replaceable, just numbers on a roll call and, therefore, angry, frustrated, and feeling undervalued. Also, it was perceived that there was an ongoing lack of organisational commitment when their many concerns and anxiety about the safety of patients and staff were mostly not addressed, and issues were not resolved. The hierarchical structure of the hospital and its culture was referred to as ‘old-fashioned’, and some participants signalled ITL because of the lack of appreciation of their previous experience or training.

Recent research around the retention of staff has shown that when the organisation (leaders, managers) engages with staff to foster a stress-free, healthy and positive environment that supports the role of nurses, retention of nurses is higher (Alomari et al., 2021; de Wijn et al., 2022; McDermid et al., 2020; O’Callaghan et al., 2020; Roth et al., 2022; Sasso et al., 2019; Wubetie et al., 2020; Yu et al., 2021).

In contrast a participant who was junior nurse had some acute nursing experience in another health profession signalled she was leaving because she felt her skills, prior education and experience were not recognised or utilised. With no opportunities to apply her past technical skills and knowledge, she chose to leave. According to her account, the “escalated career trajectory” initially promised at the start of her employment was unfulfilled and there were delays to and cancellation of professional development days. This can be interpreted as her expectation of the role changing through a lack of acknowledgement of prior learning. This may have influenced her ITL and is therefore a push factor in relation to ED nurse retention. The literature (Efendi et al., 2019; Moloney et al., 2018; Wubetie et al., 2020) also reflects that when nurses lose autonomy, and fail to develop skills, and there is a lack of organisational support towards career development, they are more likely to leave their current place of employment in search of better opportunities as part of development within their professional role.

Other factors that caused stress for participants were organisational information overload (“sea of posters”), lack of communication, constant changes, and not being part of decision-making. It is important that communications or information provided to all members of the team are distributed in a way that permits them to digest information, absorb and apply it. Studies have shown that when staff receive better communication from the organisation, their satisfaction rates are higher and therefore they intend to stay (Adriaenssens et al., 2015; Blackburn et al., 2019; Phillips et al., 2022). The negative experiences or push factors described here cannot be ignored, cause dissatisfaction and influence ITL.

These findings in this study are in line with recent studies on: organisational commitment (Wubetie et al., 2020); change in culture, and perceptions of leadership and management (Daniels et al., 2024); inspiring and motivating staff and their career progression (Rantung, 2025); and the retention of nurses and ITL (Roth et al., 2022; Sasso et al., 2019; Wubetie et al., 2020). Muir et al. (2024) researched ED nurses who perceive their workplace as unsafe, signalled they were leaving because of a nonresponsive leadership, unsafe working conditions, poor communication, and lack of guidance. Similarly, in another study, staff wanted a supportive culture and leadership for change and staff well-being (Daniels et al., 2024). In contrast, an earlier study in 2022 on leadership and ITL suggested that “no leadership strategy directly influenced intention to stay, retention, intention to leave or turnover” (Horvath & Carter, 2022, p. 11). However, from a personal perspective, a leader who is responsive to the needs of nurses in a challenging environment demonstrates respect towards nurses. This attitude can make nurses feel valued and appreciated. Leaders who support, listen, and handle stress, can similarly make nurses feel valued and appreciated. These nurses are more likely to be satisfied with their job, which in turn retains staff (Rantung, 2025; Van Osch et al., 2018). This positive feeling can have a positive flow-on effect on the entire nursing team, enhancing team motivation, job satisfaction and productivity.

### ***Rosters and shift scheduling***

The subtheme of “rosters that put me off” shows there were different participant experiences with rosters/schedules and shift work. On one hand, some nurses appreciated the flexibility and choices around rosters because they were in control of their rosters (Gifkins et al., 2017) which offered opportunities to cater for their young families and meet their lifestyle needs. Suitable rosters, options for full-time or part-time work, and flexible working schedules which benefitted participants in this small cohort were identified in the literature as significant factors for job satisfaction amongst nurses (Gifkins et al., 2017; Sawatzky et al., 2015; Staempfli & Lamarche, 2020).

On the other hand, many of participants described many challenges which left them unhappy and dissatisfied. Some of these challenges were around poor communication around rosters, insufficient hours, irregular shifts, night shifts and the expectation they would work longer shifts. The literature cites challenges, unhappiness, or dissatisfaction with inflexible rosters. It is a fact that longer working hours is a significant factor in nurses being exhausted, and the risk of medication errors (Han & Roh, 2020), especially night shifts (Di Muzio et al., 2019). Some nurses in the present study have voiced anger, frustration and ITL, or have resigned. At times there was an expectation of working beyond rostered shift to help. COVID-19 placed more stress on ED nurses since many other staff members were stood down due to restrictions, and staff who were not rostered had to pick up shifts to meet this shortfall.

These findings must be considered by organisations and action taken to explore and resolve challenges nurses face with rosters. It is important for nurses to have regular shifts, to be able to plan their social and family obligations, particularly nurses with families who, in this cohort, found it challenging to maintain energy and continue working. These experiences, increase the likelihood of them leaving.

It is unclear why some nurses shared positive feelings whilst some were clearly frustrated with rosters. What remains clear is that unsuitable or inflexible rosters/schedules have influenced nurses to leave ED because, as one participant exclaimed, “They have given up!”

Therefore, training and education regarding the development of rosters and review of how rosters are created in consultation with staff might improve communication. Literature suggests night shifts rostering should allow sufficient rest and recuperation to minimise adverse events (Han & Roh, 2020).

### ***Impact of rosters and structural layout on teams***

Another novel finding was the effect the structural layout of the department, and of rosters, on nurses and their ability to work as a team, their well-being and the team’s cohesiveness. Participants raised concerns over shift work and the impact of 12-hour shifts which meant that

staff had less contact with each other and may not be working regularly with colleagues. Other studies emphasised the significance of social connection or support from colleagues in the department (Gharaveis et al., 2019). In the present study, some of the senior nurses felt that the design of the ED impacted on staff members' ability to communicate with each other. This disconnection meant that there were long periods where staff did not work with some team members, reducing unity, bonding, and camaraderie, which did not facilitate teamwork. Crucially, this resulted in colleagues being unable to support each other during stressful times and limited opportunity for debriefing and socialisation during breaks. Literature supports ED nurses benefitting from regular conversation with colleagues because of their constant exposure to stress, challenges, and horrifying experiences (Adriaenssens et al., 2011). Therefore, from an organisational perspective, unsuitable rosters, and poor layout may be a push factor. Consultation with experts in the ED design may facilitate team cohesiveness.

### ***Lack of reward or remuneration***

A perception of a lack of adequate tangible and intangible remuneration was evident in the group participating in the present study, and has been seen in studies where nurses displayed low morale (Wubetie et al., 2020). Low morale leads to job dissatisfaction which leads to nurse turnover. One example in the present study was the issue of nursing mental health patients in an overstretched ED. Nurses were unhappy about the lack of reward which was evident when they worked tirelessly to stabilise and treat distressed mental health issues, while mental health nurses are paid more than ED nurses. In addition, there were no robust processes and systems to ensure better management of mental health patients, which left ED nurses to deal with challenges related to mental health patients. This led to tired and dissatisfied nurses and again reinforced the perception of a lack of appreciation.

The failure of the government to deliver the agreed pay equity back pay again illuminated the perception of a lack of reward and respect, because participants were eagerly looking forward to this pay rise and lump sum payment to cope with the rising living costs. Nurses who had, out of "good faith", picked up extra shifts to help when short staffed during the pandemic, felt let down and were seeking employment overseas. Many participants were committed to nursing and hopeful for promotion, but felt other nurses were recognised; for example, new nurses are now classed as senior nurses after a mere two years. These negative experiences described by nurses would push nurses to leave or consider leaving.

When this study was being undertaken, New Zealand was experiencing a labour shortage in the health sector, increasing numbers of sick people admitted to EDs, and a lack of bedspace and hospitals which has been exacerbated by COVID-19. It is important that issues raised by the nurses within the small cohort that participated in this study are not taken lightly because of the risk of losing further staff. Almost all participants flagged that there had been several incidents

related to the exodus of staff, citing actual numbers (14 at one time) which were affecting work, adding stress and creating an inability to cope with the constant turnover and retraining. Although the detrimental effect of short staffing was acknowledged by some nurse leaders, it appeared to be a hopeless situation. The constant turnover affected the team because they were unable to consult with each other due time spent through constant supervision of inexperienced new staff; and senior staff did not feel safe to delegate certain tasks to new staff. A recent study Hodgson et al. (2024) conducted in Ohio, USA, investigated strategies for ED nurse retention, especially novice nurses, showed that the organisation can increase salaries to increase job satisfaction, improve flow through ED, use fast track, technological advancement for diagnostic tools, and explore using float nurses to help during patient surges (Hodgson et al., 2024). This recent study was consistent with other studies on job satisfaction. Therefore, the organisation needs to take immediate action in offering remuneration, improving patient flow in collaboration with all ED nurses, and exploring ways for other nurses in other areas of the hospital, for example, the ICU, to assist ED.

### ***Impact on staff deployed to help with workloads***

The subtheme of “are we getting more staff?” raised concerns around quality of care. The findings suggest nurses often reshuffled and adjusted their work in response to chronic staffing shortages and supporting junior staff while managing complex patients. The lack of professional development, education and training meant that many junior nurses were not prepared to handle complex tasks or patients in the busy ED environment. Other studies confirm that experienced and skilled ED nurses can make sound and quick decisions when treating patients (Bijani et al., 2021). It is important that skilled staff are sent to ED because of the nature of work and the expectations of ED nurses; however, the availability of skilled nurses is a global problem. For now, and as discussed earlier under the meso level topic of “Teamwork”, it should be noted that working with skilled staff strengthens an ED team, improves morale and patient outcomes (Grover et al., 2017; Lapierre et al., 2019; Zaheer et al., 2021).

The lack of staff reported in the present study meant patients were delayed in receiving test results and medical treatment, and experienced extended length of stay. Short staffing often results in essential information being missed during verbal handovers, putting staff and patients at risk. A delay would also mean breaching the six-hour target set by the government. Organisations must escalate to the government to ensure that qualified and experienced nurses are deployed to ED. Furthermore, a robust training and education pathway for inexperienced and new ED nurses is needed that includes ongoing supervision.

Within the current study, the theme of ‘workplace tensions’ and subtheme of “feels like a third world department” described the effect of low staffing on patient care, teams, and individuals (personally and professionally). Senior nurses pointed out the difficulty in trying to

fill vacancies due to constant staff turnover, and how exhausted and morally distressed staff were when they were unable to offer a good standard of care (Clark et al., 2021; Clark et al., 2022; Elder et al., 2020). At times, team members could not account for patients, felt unsafe, could not take care of themselves, and often took out their frustrations on each other during busy times. Even though many senior nurses voiced concerns about staffing, which was known, the lack of money was a significant factor when it was not possible to provide adequate staff. The subtheme of “are we getting more staff?” highlighted the problem of lack of funding for nurses. This meant that fewer staff would take on more patients whilst mentoring junior staff affecting their interpersonal relationships and personal health. Recent overseas research about nurse turnover reinforces these observations, noting the negative effect on four key areas, namely, nurses, teams, hospital and, invariably, the entire health sector (Bae, 2022; Huang et al., 2021). Considerable financial losses from constantly trying to fill vacancies, the cost of recruitment and training new staff, loss of nursing expertise, knowledge and skills are some of these effects (Nantsupawat et al., 2022). Turnover also results in staff who are stressed, tired and burnt-out, and a team that does not bond together, which creates more stress. A further consequence of low staff numbers, high turnover and exhausted staff is poor patient outcomes, increased risk of infection, incidents and mortality (Aiken et al., 2014; Yun & Yu, 2021). Previous studies have indicated how the retention of nurses saves money for an organisation (Efendi et al., 2019; Helbing, 2017) whilst losing just one nurse can double costs for an organisation (Shaffer & Curtin, 2020; Wubetie et al., 2020). Turnover invariably leads to a vicious circle adversely affecting not only the department but the entire organisation, plus interpersonal relationships between nursing teams and, finally, the professional role of a nurse. A healthy ED department relies on robust resources, staffing and equipment (Alajmi et al., 2021; Cattani et al., 2022; Dewanti et al., 2022).

### ***Need for organisational attitudinal change***

Looking at the organisations, nurses felt more could be done to help with workplace problems, and that there must be attitudinal changes to keep nurses inspired and happy within their roles. Organisational culture, the hierarchy, and not engaging with staff, hearing concerns or closing gaps were cited as unpleasant, prompting staff to leave. As mentioned previously, nurses are already stressed from working with fluctuating or rapidly deteriorating patient conditions. Under the subtheme of “treating each other differently”, experiencing poor communication is identified as another layer of stress which is unhealthy.

The theme of ‘dissatisfaction with the organisational structures, processes and systems’ and the subtheme of “feeling as though management does not hear us” revealed the difficulties faced by participants wanting to progress when there are not many opportunities for advanced roles like nurse practitioners, nurse specialists, or leadership roles. Some senior nurses hoped for a senior position, for example, a charge nurse position, but there was no opportunity. Under the subtheme of “knowledge is power”, senior nurses offered other ways to inspire nurses, because

nurses get “itchy feet” and consider leaving ED. Some nurses have chosen to move on due to a lack of inspiration. ED nurses thrive when the organisational culture can consistently offer a career pathway that is stimulating or motivating (Hignight et al., 2024) to keep them interested in their work (Adams et al., 2019; Dawood & Gamston, 2019; Evans et al., 2017; Lee et al., 2021). Senior nurses and CCNs in this present study acknowledged the difficulty in keeping nurses’ spirits up and felt that there was no planning or forward thinking around this issue.

### ***Summary of macro level analysis***

In the macro level analysis, the push factors: impact of organisational structures, processes and systems on participants was discussed. Dissatisfaction with existing rosters and shiftwork, lack of remuneration, the effect of deploying staff to help other ED nurses, and organisational culture change were analysed. Low morale, unhappiness from dissatisfaction leading to turnover are identified as push factors at the macro level.

### **Summary**

The discussion chapter covered the interpretation of the themes and subthemes in relation to the three levels of Bronfenbrenner’s framework and push and pull factors. International literature supported analysis of the pull factors for ED nurse retention and identified key factors as work–life balance, the nature of ED work, teamwork, feeling valued and appreciated, beneficial coping strategies, debrief, humour, and professional development. Push factors were related to workplace tensions: unhappiness, stress and dissatisfaction with some of the organisation’s structures, processes and systems. The next chapter draws out some recommendations and presents the conclusion to the thesis.

## Chapter Six: Recommendations and Conclusion

In the previous chapter, I discussed findings in the context of the research questions, aims and objectives. In this final chapter, I offer my reflections, followed by implications for practice (clinical and workforce development), education, and research. Strengths and limitations of the study are also discussed. The pull factors identified as positive experiences, personal satisfaction from the nature of ED work and ways of coping. The push factors identified were negative experiences related to workplace tensions and dissatisfaction from organisational structures and processes. The pull and push factors are explained, framed as micro, meso and macro levels.

A key recommendation from this study is valuing and respecting ED nurses at all three levels. This means at the micro [physical and psychological experiences of an ED nurse], meso [interpersonal relationship between the ED nurses and the MDT], and macro [organizational] levels. The findings highlighted an ED nurse's desire for career progression in emergency nursing. Further, while sharing personal and professional reasons for wanting to continue working in ED, nurses were stressed and dissatisfied with working conditions. Based on these findings, these push factors should be considered. The expectation of an ED nurse's role should be consistent throughout their tenure. Pull factors should be encouraged to offset any push factors. Media reports available at the time of writing showed that three patient deaths have been attributed to long wait times and staff shortages (Bathgate, 2024; Boynton, 2024; Hill, 2024; Morrah, 2024a).

The fact that many NZ EDs have asked patients to only attend if critically unwell reflects ongoing staff pressures. In addition, there are detailed media reports about patients with long waits who left without treatment. This reality puts more patients at risk of complications and has a cascade effect; sicker patients returning to the ED and increased pressure on staff. This also impacts community GP practices picking up overflow from EDs. This scenario has the potential to cause nurses further stress and dissatisfaction. Despite the medical (ASMS) and nursing unions (NZNO), and emergency nurses college (CENNZ) releasing a position statement calling for immediate government action to improving staffing levels, the problems of overcrowding and patient long wait times are not resolved (Association of Salaried Medical Specialists, 2019; College of Emergency Nurses New Zealand, 2024b; New Zealand Nurses Organisation, 2024).

From a macro-level, effort is needed by organizations to demonstrate to nurses they are valued, appreciated, and respected, and that it is concerned about the stress and moral distress they face. Organisational effort is needed to ensure the workplace is a safe and enabling environment, with zero tolerance for unwarranted or unprofessional behaviours by staff members and/or violence from patients and families. An organisational culture that is supportive and encourages staff to express their concerns freely and without fear of reprisal should be promoted. These contribute to pull factors and retention of nurses.

## Reflections

I believe that a pertinent question to be asked here is, “Why should anyone be concerned about ED nursing retention?” I recall hearing someone in a leadership position commenting, during my initial years in ED, “staff confrontation, rudeness ... it comes with the territory” and “it’s normal to have about 10–12% of nurses leave ED.” In this study, participants expressed unhappiness about the loss of nurses and shared reasons which have not been captured by previous published research in NZ. Ongoing media reports show that patients are impacted by the poor working conditions, the inadequate number of beds, patient surges, high bed occupancy, and the underachievement of the SSED six-hour target. This scenario does not appear likely to change unless at a macro level, recommendations for policy and practice are acted on (Morrah, 2024a).

From the discussion in Chapter Five, changes at the macro-level, organisation and government, are needed to improve the micro-level [emotional, cognitive, social and personal aspect of the ED nurse] and meso-level [interpersonal and interprofessional, teamwork]. Immediate change is needed at the macro-level to retain nurses.

My research has contributed a greater understanding of the pull and push factors related to ED nurses’ retention at the micro, meso and macro-level. Participants in this study have similar values and principles to the healthcare organisation, Te Whatu Ora, but are experiencing moral conflict and distress and want action. The Pae Ora Healthy Futures Act 2022 endorses the development of the Te Mauri o Rongo – The New Zealand Health Charter, which was officially accepted in August 2023 (Te Whatu Ora, 2023b). The four pou (values and principles) within the charter, wairuatanga, rangatiratanga, whanaungatanga, and Te Korowai Ahuru laid out in Te Mauri o Rongo emphasise respect, connection, safe culture, value and care for all healthcare workers (Te Whatu Ora, 2023b). This charter was developed in consultation with unions, providers and iwi, and is underpinned by the principles within the Treaty of Waitangi. Te Mauri o Rongo runs parallel to the Health and Disability Code of Rights and the Health Quality and Safety Commission (HQSC) principles.

Nurse retention is linked to a supportive organisation, leadership, the provision of professional development, effective communication, safe staffing ratios, teamwork, trust, acknowledgement and respect. Nurses should feel valued and appreciated and the expectations of their role should remain consistent throughout the duration of employment. Any dissonance between expectations of the role and reality will lead to unhappiness, job dissatisfaction and ITL. A recent study showed that ITL and low staffing are linked to patient mortality (Catania et al., 2024); therefore, ED nurse retention is essential.

From a personal perspective, a nurse must be skilled, well prepared, both technically and emotionally. Education and training are imperative for all staff before commencement. Also, a roster that includes regular shifts, and adequate rest and recuperation between shifts, is essential.

Alongside these expectations are teamwork and a leader who is trustworthy, accessible and approachable. It is normal to experience stress in ED but is unnecessary to have an added layer of stress, worry and anxiety caused by lack of professional development and poor working conditions.

On reflection, the fact this research took place during the first and second wave of COVID-19 and the Omicron coronavirus variant, affected the participants' responses but also the first-hand experience of working in ED under COVID-19 and lockdown restrictions was heard and is therefore important. Whilst the perceptions of the participants are consistent with literature on ED nurse retention, what was unique was the response to COVID-19 and way this cohort of ED nurses coped under intense pressure. ED nurses must be applauded and recognised for how they coped during COVID-19.

In the next part of this section on reflection, the role of the government and nurse leaders addressing issues like the overcrowding, lack of space, SSED six-hour target, incentives and violence and aggression is outlined.

Firstly, at a macro-level, the government should consider reviewing the capacity and capability of EDs, the infrastructure, and develop robust systems and processes to improve patient flow through EDs. While it is appreciated that funding has been allocated to the DHBs, EDs should be regularly assessed for safe staffing levels and appropriate patient: nurse ratios. Additional funding that enables more training is needed due to the constant migration of nurses to other countries. There is ample media coverage around the state of EDs with reports from ED doctors, unions, the public, HDC and ED nurses. A collaborative approach at national, regional, and local levels is the way forward.

Secondly, the SSED six-hour target which is used as a performance indicator needs review because quality time with the patient is lost when staff are pressured to move patients. Therefore, an improved system for progressing patients with the help of extra staff, and dedicated nurses able to intervene whilst not compromising patient care, should be considered.

Thirdly, incentives such as professional development funding schemes and remuneration (transport, childcare, annual leave, bonuses, and better salary) may help improve ED nurse job satisfaction.

From presenting to the CENNZ Conference in October 2023, I learnt about the value of junior and senior nurses coming together to share ideas and solutions because there were common problems experienced (violence, stress, burnout, workloads, scant staffing and need for professional development). Therefore, using a meso lens, I feel that, locally and regionally, charge nurse managers should attend regular planning meetings with other nurse leaders in charge of an ED to work collaboratively to address nurse retention, workloads and gridlocks, and to identify

models of professional development. Improved processes and pathways for vulnerable patients, ways to improve throughput of, for example, mental health patients, and ways to improve management are suggested. Recently there was an important meeting between the former Minister of Health and Minister for Pacific Peoples, Dr Shane Reti, and the members of CENNZ on May 23, 2024 (Miller, 2024). Dr Reti acknowledged the problems in ED (Miller, 2024). Following the meeting there was an increase in funding for security over four years, and for training, and a new mental health target in ED. The next section outlines the implications of this study for nursing practice.

### **Implications for Nursing Practice**

This section covers some of macro, meso and micro approaches for recommendations. The section discusses the role of the organisation, the identification of stressors, rosters, staffing levels, the protection of staff from violence and aggression, staff engagement, professional development, career progression, the role of senior nurses, and mentoring early career nurses or new graduates.

#### ***Macro Level - Organisational role***

A priority for the organisation should be establishing a taskforce to tackle concerns raised by this research. The committee members should possess effective clinical leadership skills (sound interpersonal and communication skills; an understanding of ED and current ED processes, systems, health targets, local policies and protocols; and technical skills). The next step would be detailed plans with goals, priorities (identification of stressors, deliverables, resolving low staffing, improved processes, and systems for mental health patients). Key standing concerns that need to be resolved by the established committee are staffing, rosters, funding scheme for professional development, career progression, and pathways. Additionally, an external monitor for quality improvement would be beneficial to assess and report on the outcomes. This also means workforce planning and development, and looking at staff engagement and monitoring, recruitment, and retention strategies and models.

#### ***Identification of stressors***

Once the taskforce committee is established, stressors identified from this study (albeit there may be other causes of stress) should be explored and processes set up to address these stressors. The first step is identification and addressing any ongoing occupational stress. This is an organisation's highest priority and sole responsibility. The WHO is clear that an ED must be a safe and healthy working environment with adequate resources, for example, trained staff and equipment (WHO, 2020a). Likewise, the ILO has proposed a legal framework to ensure that all staff are safe and treated with respect and dignity whilst working (ILO, 2019). Similarly, in NZ the Health and Safety at Work Act 2015 stipulates that the organisation must protect all employees and ensure that there is no risk to their physical and mental health, while WorkSafe Mahi Haumaruru

Aotearoa provide strategies and tools for organisations to identify and manage stress and ensure employees work safely. Without action to mitigate the risk of stress, ED nurses will continue to be physically and psychologically affected, which will lead to job dissatisfaction and ITL. A review of the root cause of stress within the work environment is a first step. In addition, addressing stress and the risk of burnout amongst nurses should be prioritised.

The second step is the magnification of all positive experiences. This action will invariably enhance the micro-level. Positive experiences [pull factors] such as personal satisfaction, teamwork, nurses working within their professional scope of practice, opportunities for professional development, keeping staff inspired, work–life balance, and time with colleagues, should be continuously strengthened. One way to do this would be to share and celebrate accomplishments inclusive of written feedback to those involved. This intervention will increase ED nurse confidence, morale, interpersonal and interprofessional relationships, team cohesiveness [meso-level] and productivity. Incentives and remuneration would encourage and improve job satisfaction.

It is natural that ED has stress since there is pressure, for example, when many resources such as staff, energy, time, and equipment and attempts to save lives are depleted quickly and all at once. The participants' voices make it clear that a healthy working environment translates into a department where there is adequate time and space to offer good nursing care, good communication, and respect, a setting that is well equipped with experienced and knowledgeable staff, operates suitable rosters, ensures there are adequate rest periods before shifts, there is working equipment, and ED nurses are working within their scope (no deviation from role). Therefore, the initial step is that the organization's taskforce committee, as suggested above, investigate the root causes of unwanted stress, reviews the structures and systems to minimise stress and promote all positive experiences.

### ***Rosters that allow for rest and recuperation***

The multi-employer collective agreement (MECA) for nurses, in line with Health and Safety Work Act 2015, sets out clear guidelines for shifts and rest periods for health and safety of workers (Te Whatu Ora, 2023c). Nurses work under the NCNZ Competency Framework (NCNZ, 2019) need to feel safe and able to perform all duties. Under the collective agreement between Te Whatu Ora – Health NZ and the NZNO, the organisation has an obligation to offer suitable shifts, sufficient hours and minimum break times and rest periods, and to ensure that staff never go beyond their rostered shift (NZNO, 2023). The impact of lack of rest, fatigue and exhaustion and inappropriate shift work have been well documented as having a negative impact on patient outcomes (medication errors and poor-quality care) and peer relationships and taking a toll on families with children. As previously identified, nurses who are tired from shift work are

at an increased risk of making medication errors (Han & Roh, 2020), especially where long night shifts are involved (Di Muzio et al., 2019).

### ***Setting safe ED staffing levels for staff and patient safety***

Organisations should demonstrate accountability for patient: nurse ratios, staffing levels and models of care that affect the safety of patients and staff. As part of the SSHW priorities, the governance framework known as the CCDM programme, which addresses staffing levels across acute settings, was developed and implemented. It can be compared to the Australian SSL Taskforce, which rolled out the government boost to staffing of 2,480 over the next few years, including a transition period (NSWG, 2024). This has resulted in a healthcare policy change in Australia where, for example, in an ED where in resus, staffing is one on one, and mostly one nurse for three patients. The new policy stipulates that triage is fully staffed 24/7 plus one additional nurse completing an eight-hour shift (NSWG, 2024). Adequate staffing improves the quality of nursing care, creates happiness within nurses, strengthens teamwork, and reduces the risk of mistakes (Anderson et al., 2021; Javanmardnejad et al., 2021). In NZ, despite the NZNO releasing a statement on May 28, 2024 on safe staffing, calling for the government to address these issues, and attempts to resolve them, there has been regular short staffing (New Zealand Nurses Organisation, 2024). Likewise, on May 2, 2024, a media release about a report by Toi Mata Hauora-ASMS showed that ED presentations have risen from half to two-thirds (ASMS, 2024).

### ***Staff safety***

The protection of staff from violence and aggression in any form is a priority for organizations. Verbal and physical abuse is a serious global problem that is affecting EDs and must be prioritised and acknowledged through several strategies. WorkSafe Mahi Haumaruru Aotearoa and the Workplace Violence and Aggression Management policy sets out a clear statement around assessment, risk, training, and documentation. Similarly, the NZNO and CENNZ have issued position statements stating that violence and aggression in any form is never acceptable (College of Emergency Nurses New Zealand, 2024a; New Zealand Nurses Organisation, 2019). They propose an organisational commitment to and investment in resolving issues, changing the culture and mindset, and offering support via vigilant monitoring, training and education for all ED staff.

Security surveillance camera monitoring areas and the presence of more security on the floor are needed. Extra staff should be deployed to areas where agitated patients are admitted. An improved strategy is the provision of body-worn cameras, two-way radio systems of communication, cellphones and an increased presence of security guards around all parts of ED, not only triage (Li et al., 2019). A recent study found a reduction in the incidence of violence

following the introduction and use of body-worn cameras, which resulted in nurses feeling safe to carry out work, leading to job satisfaction and retention (Carver & Beard, 2021).

On July 1, 2024, the Minister of Mental Health Matt Doocey announced new mental health and addiction targets for EDs. He acknowledged the challenges faced by ED nursing and medical staff and had allocated funding for training of peer support workers in EDs. Funding for ED security has been increased (Doocey, 2024).

### ***Engagement with ED staff***

The next step is to regularly engage with staff to raise staff morale, with face-to-face weekly meetings with both online and drop-in sessions integrated into them. Engagement with all ED nurses falls under the meso-level. Studies have shown that engagement with staff by leadership leads to job satisfaction and retention (Rantung, 2025; Sawatzky & Enns, 2012). Also, studies have concluded that a caring culture, collective responsibility and team cohesiveness are important for workplace well-being and staff retention (Daniels et al., 2024; Enns & Sawatzky, 2016; Rantung, 2025). Parallel to this, is promotion of a workplace culture that is enabling, inclusive and empowering, where staff feel safe and that they are treated with respect and dignity. An open-door policy is suggested where staff can freely communicate without fear of retribution.

### ***Commitment to ongoing professional development***

A national commitment to a framework for professional development is to be considered so that staff feel opportunities are equitable. Time to complete all education and training must be protected (Daniels et al., 2024). There must be energy centred around developing a model of professional development, clear progression, ways for mentorship, training needs analysis, a team of educators, and feedback cycles. This translates into ensuring all planned study days are “locked in”, not cancelled; and once education sessions are implemented, staff coverage should be available for ED staff enrolled into these mandatory sessions. As per the NCNZ Guidelines for Competence Assessment, all nurses must complete 60 hours of professional development over three years and complete 450 hours of clinical practice to maintain an annual practising certificate (NCNZ, 2019). There is a positive correlation between professional development opportunities and job satisfaction and retention for nurses. Nurses enjoy work when professional development is offered, staff can attend training and education and are professionally challenged. Professional development allows for sharing of knowledge, and is linked to better quality of care, job satisfaction and intention to stay (Catania et al., 2024; Evans et al., 2017; Loft & Jensen, 2020; Power et al., 2022; Roth et al., 2022; Van Osch et al., 2018).

A starting point for the development of an annual training plan would be to initially conduct a training needs analysis so that nurse educators have a sense of what ED topics are important, so that these can be prioritised when planning a yearly training calendar. For the delivery of a training plan, adequate time, space, funding, venue, materials, and staffing must be

allocated to run all sessions seamlessly. Equally important, is all forms of professional development having the evaluation or testing of knowledge and skills post-session to gauge understanding, so that future sessions can be developed to cater to identified needs.

Furthermore, a professional development scheme where funding is allocated and distributed to staff should be considered to develop technical and de-escalation skills. As funding is limited, all other avenues for professional development funding such as trusts, government research projects, non-governmental organisations, nurse unions, professional bodies, scholarships, awards, and incentives to maximise the potential for ongoing and accessible financial support for staff, should be explored.

### ***Career progression***

When orientating and training all new staff, junior staff, or inexperienced staff, it is important that nurse leaders ensure a professional teaching and learning environment of encouragement, care, support, ongoing learning and instilling of confidence. Nurses may feel anxious when not living up to the expectations of senior staff (Daniels et al., 2024.) Therefore, the education and training of staff should be scaffolded on their prior knowledge and skills as this will encourage them to progress.

### ***Role of ED senior nurses***

In the future, professional development sessions could focus on pull factors identified in this study: stress-reducing techniques; strategies for debrief; scenarios covering de-escalation; therapeutic communication; and simulation teaching of aggressive patient management and assessment skills. Senior staff who have worked in ED for some time could share their techniques to manage stress. Similarly, when any ED nurse attends a conference, course or seminar, learning can be shared with other staff, for example, paediatric assessment or coordination during a busy shift. Senior nurses also need to attend professional development workshops on preceptorship and mentoring early career nurses or new graduates.

### ***Mentoring early career nurses/new graduates***

Ideally mentorship agreements could be established by leaders. A supportive mentor who has been trained to precept new staff should be identified early for each new staff member and regularly buddied on each rostered shift, equipping them with relevant knowledge and technical skills to nurse ED patients.

A recent study (Hignight et al., 2024) found nurse internships increase competencies, positivity in the workplace and nurse retention. Short-term and long-term goals, realistic experiences (Daniels et al., 2024), timelines and evaluation should be documented for each mentor and staff. During the shifts, any teachable moment, bed side teaching within the patient zone, can be identified so that new staff can learn, for example, cardiac assessment of a patient

with chest pain and the performance and interpretation of an ECG. Positive reassurance and confidence building must be seen throughout the mentoring. The aim would be for junior staff to have supervision and support. From my professional experience, I suggest a contingency plan must be in place, should the mentor be unavailable; so that other equally qualified and skilled staff can take on the role of mentor. It would be undesirable that mentorship of early career nurses or new graduates be interrupted or cancelled.

### **Implications for Nursing Education**

There are two areas for discussion here for nursing education consideration, namely undergraduate and postgraduate education. Undergraduate curriculum could support ED nurse preparation such as coping skills in simulation to prepare undergraduate students for working as emergency nurses, together with communication, early recognition, escalation and documentation. Stress-reducing techniques can be included from first year to pre-registration but also training in assertiveness, resilience, and tenacity, and debriefing techniques. Emotional intelligence education inclusive of confidence and thriving in challenging environments is needed. Team dynamics and how to function as a cohesive team will also be beneficial to emergency teams working in demanding situations in public EDs. Further higher education will benefit nurses. For example, postgraduate courses on emergency nursing, patient assessment, leadership and communication are needed for nurses once the orientation phase as a new graduate is completed.

### **Recommendations for Future Research**

There were some novel findings arising from this study. The fact that the study was conducted during COVID-19 restrictions revealed challenges nurses faced and how they coped. A significant finding was that many nurses chose to stay for their own reasons, while some nurses signalled, they were leaving ED because of dissatisfaction and unhappiness. One senior nurse commented that leaving ED does not resolve a problem, instead her attitude was one of persistence – by constant agitation of the issues. She chose to stay hopeful for change in the environment. Another finding was related to perceptions of stress. Participants mentioned drawing on in-depth knowledge and experience to deal with situations and cope under pressure. These findings are novel and not reported elsewhere in the literature. Another finding was the effect the structural layout of the department has on teamwork. Participants raised concerns over shift work and the impact of 12-hour shifts on cohesiveness; rosters and shift work meant that staff had less contact with each other and may not regularly work with colleagues. These findings require further investigation to gain a deeper understanding of the impact of structural layout on nurse and team wellbeing.

Future research designs such as large mixed-methods studies with quantitative and qualitative phases in collaboration with all ED nurses and nurse leaders would be invaluable.

Research across public hospitals with a larger sample size (inclusive of nurse managers, nurse leaders and doctors) and varied demographic groups is needed, as is the inclusion of more early career nurses (new graduates and junior staff). A quantitative study that surveyed the success factors identified in this research would gain a broader and deeper understanding. Some of these factors would be support for junior staff, learning more from senior nurses on coping skills, how mentorship of junior staff would take place in a time-pressured ED, the approach to acknowledging any prior nursing experience, debriefing, and career progression.

### **Strengths and Limitations**

This study was conducted during COVID-19, capturing unique data on how EDs managed during COVID-19. Even though the sample size was small, there was rich data from nurses who had extensive New Zealand and overseas experience, and junior nurses. This study found that the retention of ED nurses is linked to personal, professional, interpersonal, and organisational factors, for example, being drawn to the excitement of ED work and feeling supported through colleagues, leaders, incentives and professional development. Even though the participants had a variety of demographic characteristics such as age, qualification, and years of experience, they all worked in all areas of ED, and were rostered on both day and night shifts, this provided similar experiences in the work environment. Qualitative ID served to deepen understanding of clinical nursing, and the use of this methodology in this study was an enabled in-depth understanding of the status quo and, the positive and negative factors associated with ED nurse retention.

Another strength is the hope that many participants have for action. Hope is a positive attribute that cannot be taken from anyone. The passion for emergency nursing, and duty of care towards all patients, camaraderie between colleagues and concerns around the implications of ongoing turnover, seen first-hand, may have influenced a portion of ED nurses to participate in this research and contribute, hopeful for definitive action to retain staff.

There are clear limitations in the research design, First, in the homogenous sample with only ED nurses and, in limiting the study to only two hospital sites in one metropolitan city, meaning other DHBs around the country with similar staff retention and turnover issues were not included. As an early career researcher, I was only able to conduct research at two public hospitals because of budget and time constraints. Secondly, another limitation was that only 13 RNs were interviewed through Zoom, even though 18 RNs were interested in the study. Despite regular communication through email to both EDs, only two new graduates participated. This poor response may be attributed to staff standing down due to COVID-19, low staff numbers and shift work. COVID-19 also placed stress on nurses caring for their families and children, not only in NZ but also overseas. It was reported by one participant that they had to pick up extra shifts and balance work life and families due to staff being stood down during COVID-19. Thirdly, the

COVID-19 pandemic, workloads, and existing staff shortages put considerable pressures on nursing staff. Staff rostering, increasing workloads, sick calls, minimal staffing, prearranged training days, and personal commitments can pose challenges for the ability of some staff to participate in interviews, whether it be face to face or online. Considering future lockdown uncertainties and staff pressures at the time the fieldwork was conducted, a videoconferencing platform, Zoom, was employed. Therefore, participants were not able to observe researcher gestures and facial expressions, and vice versa. Participant tone, volume and pitch in voice were heard during interviews. Fourthly, the findings revealed that nurses may have left possibly due to unhappiness and dissatisfaction.

Lastly, some of the other limitations of this design include the inability to test the findings with a quantitative study. There is the possibility of gender bias because only one male participated as compared with twelve female nurses. Four participants had worked extensively overseas and returned to NZ. These four participants may have worked in environments that were well-resourced with experienced ED nurses, adequate equipment, funding for professional development and incentives for nurses. Therefore, they may have held higher expectations of the work environment and organisation when returning from overseas.

Even though this research has several limitations, the findings are unique and beneficial because they are consistent with some previous studies related to ED nurse retention and, importantly, the study provides new data. The rich data, together with senior and junior nurses from different backgrounds and different levels of nursing experience adds to the body of literature around ED nurse retention and attrition in NZ and globally.

## **Summary**

In this chapter, the findings were discussed with recommendations for practice, policy, research, and education and reference to the micro, meso and macro levels. These recommendations must be seriously considered because patient care is compromised when negative (push) factors are present in ED. From a macro-level, changes to policy at a government level around patient: nurse ratios, funding for professional development, and extended scope of practice for senior nurses will incentivise ED nurses. When these macro-level changes are addressed, this would then benefit the micro-level and meso-level.

This research examined factors related to retaining ED nurses which arise from concerns about ED nurse turnover; this in turn impacts the delivery of safe nursing care to patients in the ED and the entire health system. An analysis of interviews with 13 ED nurses employed at two major public hospitals found pull and push factors. The study concluded that pull and push operated simultaneously to inform personal, professional, interpersonal, and organisational factors that lead to retention decisions.

This research provided an opportunity to understand the perceptions of ED nurses, an initial and crucial step in addressing nurse retention. The findings suggest that nurse retention and success factors are complex and a matrix of many interlocking push and pull factors. This study showed similarities and concordant themes amongst junior and senior nurses and some variations in this small cohort of participants. An organising framework of macro, meso and micro level was used for consistency and clarity. Therefore, understanding ED nurse retention within NZ's current EDs is complex and challenging. Understanding success factors is complex but what has been analysed is the expectation that the role be consistent, because when there is disharmony between the expectation of the role and reality, nurses are unhappy and dissatisfied. However, when there are positive experiences such as work–life and family balance, job fit, suitable rosters, good communication, and shift scheduling, strong connection between colleagues, coping skills, professional development, positive culture, and acknowledgement, nurses are happy. Happiness leads to job satisfaction and retention.

It is acknowledged that there are recent government and local workforce development models, programmes, initiatives and work, both visible and behind the scenes, is continuing, but the media reports ongoing challenges. Therefore, this research validates some excellent work and adds factors for investigation, analysis and discussion in future studies. At the beginning of this thesis, I covered my epistemological, ontological, and personal positions and expressed my concerns about how many ED nurses have left. Now, at the end of this study, I have reflected on the findings and the serious issues facing NZ EDs that continue to be evident in the media.

Lastly, more research using different methodologies are needed to investigate what can be done to retain ED nurses long-term and the reasons for turnover. I fervently hope that nurses who choose emergency nursing for personal and professional reasons stay and that leaders urgently act and ensure surveillance of staff for stress. Based on this research, I recommend that the role expectations nurses hold remains consistent throughout their tenure or careers. When there is a change in the expectation of the role, and negativity within the personal, professional, interpersonal, and organisational parts of an ED nurse's role, nurses are unhappy and dissatisfied, which leads to ITL.

In conclusion, there must be an acknowledgement of the problem and action to sustain nurses in the long term. I believe that this quote from a participant summarises the main point for ED nurse retention:

*“There is actually a problem, but at some point, there may not be anybody to replace ED nurses.” (Nurse 11)*

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## Appendices

### Appendix A: Search Alert and Subject Terms Used for Literature Review

Search Alert	Subject Terms
S1	("emergency nurse" OR "trauma nurse" OR "registered nurse" OR "nursing staff") AND ("perception" OR "attitude" OR "opinion" OR "experience" OR "view" OR "reflection" OR "beliefs") AND ("accident and emergency" OR "casualty department" OR "emergency care")
S2	("emergency nurse" OR "trauma nurse" OR "registered nurse" OR "nursing staff") AND ("retention" OR "job satisfaction" OR "intent* to leave" OR "intent* to stay") AND ("accident and emergency" OR "casualty department" OR "emergency care")
S3	("emergency nurse" OR "trauma nurse" OR "registered nurse" OR "nursing staff") AND ("out of scope" OR "deviation" OR "expectation" OR "non-nursing") AND ("accident and emergency" OR "casualty department" OR "emergency care")
S4	("Emergency nurse" AND TX ("job satisfaction" OR intention OR dissonance OR disharmony OR "role expectation
S5	("Emergency nurse AND TX (retention or attrition or turnover or intention) AND AB ("organizational culture" or "organisational culture" or "workplace culture" or "leadership or management")

## Appendix B: Permission from Professor Mark Saunders for Research Onion Use

Permission is granted and good luck with your doctorate

Mark

**Mark NK Saunders BA MSc PGCE PhD FCIPD FHEA FBAM FAcSS**  
Professor of Business Research Methods

+44(0) 121 4146697  
University of Birmingham  
Birmingham Business School  
Department of Management



**UNIVERSITY OF  
BIRMINGHAM**

**From:** Leslie Kistan <[leskis87@autuni.ac.nz](mailto:leskis87@autuni.ac.nz)>  
**Date:** Friday, 30 August 2024 at 14:12  
**To:** Mark Saunders (Management) <[m.n.k.saunders@bham.ac.uk](mailto:m.n.k.saunders@bham.ac.uk)>  
**Subject:** Fw: Research Onion Diagram

Good afternoon, Professor Mark Saunders,

I trust this email finds you well. This email bounced, so I am resending it now.

I am a doctoral candidate at the Auckland University of Technology (AUT) and a nursing lecturer at one of the nursing colleges in Auckland. I have lived and worked in New Zealand for the past 24 years, originally from South Africa, and in the final stages of thesis writing, I have already completed data analysis.

Recently, I watched your video on YouTube about the Research Onion in which you commented that anyone who wants to embed the Research Onion should seek your permission first. Therefore, I seek permission to use the research onion diagram in my methodology chapter to explain before I leap into the methodology. I used interpretive description (ID) as my methodological choice and completed the interviews and analysis. I'm happy not to use the diagram if there is a problem; instead, I will reference your work from textbooks. I have already referenced your work in my chapter, and we have some ebooks from our AUT library, such as

Saunders, Mark, et al. *Research Methods for Business Students*, Pearson Education, Limited, 2023.

Many thanks for reading my email and thank you so much for your books and videos.

I want to express an immense debt of gratitude for your time and expertise.

Warm regards

Leslie Kistan

021593930

## Appendix C: Interview Guide

### Introduction

To start with, I'd like to thank you for consenting to be part of this study on retention of Emergency Department Nurses. As you have read in the Participant Information Sheet (PIS), I am interested in the retention of Emergency Nurses. Please feel reassured that whatever is said in this Zoom interview is strictly confidential and that you will have an opportunity to review your transcript. A summary of the results will be emailed to you. Before we start with the interview, do you have any questions, or something you would like to first do to get comfortable, like a grabbing a glass of water?

Semi-structured Interview Guide    **Start Time:**    **Finish Time:**

- 1) What do you find meaningful or personally rewarding about working in the Emergency Department?

*Prompts*

- 1) *Personal - team work, camaraderie, moral support, humour, fast paced work, thrill - adrenaline rush, challenge of ED,*
- 2) *Professional - opportunities for upskilling, training and education, types of patient presentations.*
- 3) *Organisational - flexibility of hours, weekend work and/or overtime shifts, remuneration, pay scale, support for studies, leave, incentives if any.*

- 2) Can you please tell me about any challenges or issues you have recently faced within the Emergency Department environment?

*Prompts*

- 1) *Resources- manpower, equipment and time.*
- 2) *Patients- surges, acuity and turnover.*
- 3) *Physical ED Layout- space.*
- 4) *MDT- communication.*

- 3) How have you responded to these challenges? Have you resolved these challenges? Can you tell me how you resolved these challenges?

- What has helped or prevented you from managing these challenges?

- 4) Is there anything else you would like to comment on regarding these challenges?

*Prompts -Personal, professional or organisational*

5. Can you describe your relationship with  
*Patients, families or allied health teams*

6. What do you find stressful about working in ED? Does stress have an impact on you? If so, what is the impact on you, other nurses working and patients? How do you manage this stress?

7. What might make you consider leaving the Emergency Department? If so, are you comfortable with sharing your reason (s) for leaving/ why? What has stopped you from leaving?

What do you think is currently driving turnover of Emergency Department Nurses? Is turnover something you wish to chat about? Have you encountered nurse turnover within this department? Does turnover have an impact on your job?

8. Follow-Up Questions

During our chat, you mentioned.....please tell me a bit more about this.....

What was the circumstance or context around your experience or comment?

.....  
Can you explain a bit more about?  
.....

9. Thank you for your valuable contribution, is there anything else you'd like to add to or ask me? Please feel free to say anything regarding Emergency Department staff retention within New Zealand District Health Boards (DHBs).

## Appendix D: Peer Review and Tracking of Interview Questions

### New Questions Tracked Against Original Questions

The research question explored in this study is "What are the factors contributing to Emergency Department Nurse retention within a New Zealand District Health Board (DHB)?"

Original Questions	New Questions
<p><b>Concept 1: Job Satisfaction</b> What do you find meaningful or personally rewarding about working in the Emergency Department?</p>	<p><b>Change to:</b> What makes you happy or satisfied about being an ED Nurse? <b>Prompts – skills set, discretionary use of skills, teams, opportunities flexibility</b></p>
<p><b>Concept 2: Challenges</b> Can you please tell me about any challenges or issues you have recently faced within the Emergency Department environment?</p>	<p><b>Add:</b> COVID-19 has been in the news this year, and is ever changing, would you like to comment on your recent experience of COVID-19 in ED?</p>
<p>How have you responded to these challenges? Have you resolved these challenges? Can you tell me how you resolved these challenges? What has helped or prevented you from managing these challenges?</p>	<p><b>Keep:</b> How have you responded to these challenges? Have you resolved these challenges? Can you tell me how you resolved these challenges? What has helped or prevented you from managing these challenges?</p>
<p><b>Concept 3: Relationships</b> Can you describe your relationship with patients, family and allied health?</p>	<p><b>Keep patients, family and allied health but add:</b> Within ED nursing staff regularly supervise or precept new graduates, junior staff, inexperienced new staff and at times, student nurses whilst simultaneously carrying a patient load. Would you like to please share some of your experiences whilst precepting them?</p>
<p><b>Concept 4: Stress</b> What do you find stressful about working in ED? Does stress have an impact on you? If so, what is the impact on you, other nurses working and patients? How do you manage this stress?</p>	<p><b>Keep:</b> What do you find stressful about working in ED? Does stress have an impact on you? If so, what is the impact on you, other nurses working and patients? <b>Change to:</b> What works for you when you are faced with stress? Is there something you do during the stressful event or after? <b>Add:</b> Is there an opportunity to debrief after a stressful experience? If so, how often have you been debriefed? Is debrief done formally or informally? Have staff received any training on debriefing in ED?</p>
<p><b>Concept 5: Intention to leave</b> What might make you consider leaving the Emergency Department? If so, are you comfortable with sharing your reason (s) for leaving/ why? What has stopped you from leaving?</p>	<p><b>Keep:</b> What might make you consider leaving the Emergency Department? If so, are you comfortable with sharing your reason (s) for leaving/ why? What has stopped you from leaving? <b>Prompt:</b> has your expectation of working in ED changed since you've joined?</p>

## **Appendix E: Letter to ED Nurse Managers at Two Hospitals**

**From:** Leslie Kistan

**Sent:** Thursday, 11 June 2020 4:11 PM

**Subject:** Emergency Nurse Research

Dear XXX,

I hereby wish to inform you about my doctoral study into Emergency Department Nurse retention. I know we chatted informally, and it was challenging to communicate or meet during the COVID-19 pandemic, therefore I am informing you now. I have satisfied the requirements for the PGR9 and presently completing my ethics application which requires approval from the District Health Board Research and Knowledge Centre prior to this study/research. This research project is aimed at identifying factors which could help improve Emergency Nurse retention within New Zealand's District Health Boards (DHBs). While nursing turnover has been widely studied, research specifically on Emergency Department Nurse retention is limited. Therefore, this proposed project investigates what can be done to retain Emergency Department Nurses. The results will assist in providing empirical data for managers to help identify priority factors, nurses' coping mechanisms, and support policy guidelines for recruiting and retaining nurses deployed to Emergency Departments within New Zealand. All nurses working at the XXX District Health Board Emergency Departments at either XXXX or XXX Hospital will be invited to participate in this study. Therefore, nurses who are assigned to resuscitation, monitoring, assessment, triage, paediatrics and education and training areas within these hospitals are welcome to participate in this research.

Please find RM14733 Approval Research document. Could you please review this document and approve this research.

Many thanks

Kind regards

Leslie Kistan

## Appendix F: Locality Authorization

### Application for Approval of Audit/ Observational Research



**RM14733**      **Emergency Nurse Retention: Understanding success factors to help retain ED nurses in New Zealand District Health Boards**

**WDHB Contact:** *required*      External CI: Leslie Kissin, PhD Candidate, United

**Department:** Emergency Department

**Project Type:** Observational research

**Duration:** 30/06/2020 - 31/10/2020

**Description:** This research project is aimed at identifying factors which could help improve emergency nurse retention within New Zealand's District Health Boards (DHBs). Our public hospitals are losing nurses due to several inter-related reasons, namely, workload, staff reductions, stress and subsequent burnout. While nursing turnover has been widely studied, research specifically on Emergency Department nurse retention is limited. Therefore, this proposed project investigates what can be done to retain Emergency Department nurses.  
Emergency Department nurses (RNS) are involved in this study after they have consented to being interviewed. All nurses working at the Waitematā DHB Emergency Departments (North Shore or Waitakere Hospital) will be invited to participate in this study. Therefore nurses who are assigned to resuscitation, monitoring, assessment, triage, paediatrics and education and training areas within these hospitals will be involved.  
Once nurses have consented to participate, a suitable appointment for a virtual interview will be set-up. Interviews will be conducted off site from the DHB and not during nurses' work hours. The interview will last for 45-60 minutes using a questionnaire and will be recorded using ZOOM and thereafter transcribed. Interviewees will have an opportunity to review their transcripts before analysis.

#### Locality Review

The undersigned agree to the following

- The study protocol and methodology has merit and aligns with departmental/service area interests.
- The local lead investigator is suitably qualified, experienced, registered and indemnified.
- Conducting this study will have no adverse effect on the provision of publicly funded healthcare.
- There is a stated intent that results will be disseminated & the findings translated into evidence-based care (where appropriate).

Before this study is granted approval to commence, the Research & Knowledge Centre on behalf of Waitematā DHB will check:  
- there has been the appropriate level of ethical review by ethics committees wherever required.  
- cultural consultation have occurred or will be undertaken, as appropriate.  
- appropriate confidentiality provisions have been put in place.

Dept/Service	Role	Name (Print Clearly)	Signature	Date
Emergency Department	Charge Nurse Manager	Sue Lamb (NSH)		11/06/2020
Emergency Department	Charge Nurse Manager	Merja Peters (WTH)		12/6/2020
Emergency Department	Manager	Roslyn Steinbeck (NSH)		11/06/2020
Emergency Department	Manager	Kamini Ghosh (WTH)		12/6/2020

Return completed form to Research & Knowledge Centre Alternatively, email from approvers are acceptable as electronic sign-off. Enquiries to [research@waitematadhb.govt.nz](mailto:research@waitematadhb.govt.nz)

## Appendix G: Permission for Research from Research Manager at DHB

### Research and Knowledge

**From:** Lorraine Neave (XDHB) On Behalf Of Research & Knowledge Centre (XDHB)  
**Sent:** Wednesday, 07 October 2020 7:15 am  
**To:** 'Leslie Kistan' <  
**Subject:** RM14733 Emergency Nurse Research Approval to commence

Thank you for providing these documents. You have now completed Locality Approval for XDHB and may commence the conduct of your research.  
Just to advise you that you will need to update the PIS ICF with you AUTEK number and approval date.

All the best with your project... please advise [research@xdhb.govt.nz](mailto:research@xdhb.govt.nz) when you have finished and forward references to forthcoming publications and presentations.

Kind Regards,  
Lorraine

Dr. Lorraine Neave | DHSC; MHSC; RGON  
Manager, Research and Knowledge Centre

**From:** Leslie Kistan [<mailto:lkistan@unitec.ac.nz>]  
**Sent:** Tuesday, 06 October 2020 10:16 p.m.  
**To:** Research & Knowledge Centre (DHB)  
**Subject:** FW: Emergency Nurse Research  
**Importance:** High

Hi there,  
I now have ethics approval. Please find ethics approval letter, Participant Information Sheet and Consent Form.  
Are you happy for me to start data collection. I have taken PD leave to start this stage.  
Many thanks  
Kind regards  
Leslie Kistan

## Appendix H: AUTECH Approval

6 October 2020

Elissa McDonald  
Faculty of Health and Environmental Sciences

Dear Elissa

Re Ethics Application: **20/278 Emergency Nurse Retention: Understanding success factors to promote ED Nurse retention in a New Zealand District Health Board Hospital (DHB).**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTECH).

Your ethics application has been approved for three years until 6 October 2023.

### Non-Standard Conditions of Approval

1. Please ensure that verbal consent will be obtained by reading through each of the bullet points on the Consent Form rather than a single question focused on the participant's understanding of the Information Sheet and Consent Form.

Non-standard conditions must be completed before commencing your study. Non-standard conditions do not need to be submitted to or reviewed by AUTECH before commencing your study.

### Standard Conditions of Approval

1. The research is to be undertaken in accordance with the [Auckland University of Technology Code of Conduct for Research](#) and as approved by AUTECH in this application.
2. A progress report is due annually on the anniversary of the approval date, using the EA2 form.
3. A final report is due at the expiration of the approval period, or, upon completion of project, using the EA3 form.
4. Any amendments to the project must be approved by AUTECH prior to being implemented. Amendments can be requested using the EA2 form.
5. Any serious or unexpected adverse events must be reported to AUTECH Secretariat as a matter of priority.
6. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTECH Secretariat as a matter of priority.
7. It is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard and that all the dates on the documents are updated.

AUTECH grants ethical approval only. You are responsible for obtaining management approval for access for your research from any institution or organisation at which your research is being conducted and you need to meet all ethical, legal, public health, and locality obligations or requirements for the jurisdictions in which the research is being undertaken.

Please quote the application number and title on all future correspondence related to this project.

For any enquiries please contact [ethics@aut.ac.nz](mailto:ethics@aut.ac.nz). The forms mentioned above are available online through <http://www.aut.ac.nz/research/researchethics>

(This is a computer-generated letter for which no signature is required)

The AUTEK Secretariat

**Auckland University of Technology Ethics Committee**

Cc: leskis87@autuni.ac.nz; Eleanor Holroyd

## **Appendix I: Interview Protocol and Contingency Plan**

### **INTERVIEW PROTOCOL**

#### **Introduction**

The COVID- 19 pandemic together with winter workloads, and existing staff shortages has put considerable pressures on nursing staff at District Health Board (DHB). In light of future lockdown uncertainties, and staff pressures videoconferencing platform as opposed to face-to-face, interviews will be conducted. A digital platform ZOOM, with all virtual interviews audio recorded only is planned. This document will outline both advantages and disadvantages of virtual interviews, interview protocol and process, and contingency plan to mitigate any possible risks and interview guide. Ethical issues directly related to virtual interviewing such as confidentiality, privacy, power balance, and informed consent in relation to principles within the Treaty of Waitangi, have also been considered for this research, into retention of Emergency Department nurses.

#### **Advantages**

The advantages of ZOOM are the ability to record, secure information, and back up recorded interviews. Recording communication in real time has been cited as one of ZOOM's advantages (Archibald et al., 2019). In addition, ZOOM has management and security features such as "user-specific authentication and real-time encryption" (Archibald et al., 2019, p. 2). This means that only those Emergency Department nurses who are invited can participate; and excludes others from listening in or engaging in any conversation during the virtual interviews. A degree of practicality, user-friendliness and flexibility is also evident since participants can access an interview or join a meeting through any internet browser on any electronic device, smartphones, laptops and desktops in any place. This offers some level of convenience and ease, especially for those nurses with children (Irani, 2019). However, for this research all interviewees are to only use private connection at home, and not public WiFi in a shop or gym because of the risk of violation of privacy and breach of confidentiality.

#### **Disadvantages**

The disadvantages of using ZOOM are disruption due to technical glitches and connectivity problems such as pauses, screen freezing, poor audio and visual quality or image problems. Should any sensitive information be discussed, and the participants experience distress, the interviewer is not in close proximity to console participants. Taken together, these can create miscommunication and misinterpretation, which could be corrected through face-to-face interviews. The other disadvantage is the need for the online interviews to be conducted in a private and quiet space. Committing to an interview means time spent away from participants' current responsibilities before, during and after work. ZOOM requires devices to initiate and progress virtual interviews and can be challenging when devices are scant, so participants need to inform the researcher early on for these issues.

#### **Preparation for ZOOM**

Participants will be reassured that there is neither a financial obligation nor need to sign up for a ZOOM account. However, should a participant want to join ZOOM permanently; there is an option to sign up for a free account.

After reading the poster in the Emergency Department, the participant can contact the researcher, ask any questions and then set up a suitable appointment. Participants who are not familiar with ZOOM will be emailed a step-by-step instruction/ZOOM guide. They can also contact the researcher and/or visit [www.zoom.us](http://www.zoom.us) for more information and review useful tutorials in case they have any questions, or wish to review steps or troubleshoot. An invitation containing a password will be emailed to the participant. On clicking the link, they will be prompted to enter this password. At all times, participants are requested to use a private connection at home, instead of public WiFi available in a shop or gym. The instructions for accessing ZOOM via a computer, tablet or phone are as follows:

If you are using a computer, please click the blue link above which will take you to the Zoom website where you will be asked to install the software needed to engage with the meeting. You will then be able to join the meeting at the time given.

If you are using a tablet or iPad, you will need to download the Zoom App. Unless you want to create an account, the only detail you need after downloading the app is the Meeting ID and password above.

If you are using a phone, you can join from your mobile or landline by dialling the above phone number and then enter the Meeting ID above when prompted.

Should you experience any problems please contact the researcher, Leslie Kistan on 021593930.

### **Ethics of Online Virtual Researching**

Ethical issues directly related to virtual interviewing such as confidentiality, privacy, power balance, and informed consent in relation to principles within the Treaty of Waitangi, have also been considered for this research, into the retention of Emergency Department nurses.

To meet ethical principles specific to online interviewing, firstly, an application outlining risks and benefits will be made to the Auckland University of Technology Ethics Committee (AUTEK) for approval. Secondly, evidence of consultation with the DHB Locality Authorisation, Research and Knowledge Centre, ED Clinical Director and Nursing Service Manager will be evident. These parties will be informed about Emergency Department nurses participating in online interviews prior to the research. This shows respect and dignity towards them.

Two core documents such as the Consent Form (CF) and Participant Information Sheet (PIS) containing the ethics approval number will outline consent process and details about the research so that detailed information is available to interested nurses. To ensure that participants have complete knowledge of the study, these documents will discuss the research aim, expectation for the study, focus, importance and design and state clearly that participation is voluntary. The researcher's contact details will be displayed, so that anyone interested can contact the researcher for participation and/or clarification.

A discussion around their rights will be evident, which will satisfy the points within the Health and Disability Services Consumers Code of Rights (1996). After participants have read, understood all emailed documents, verbal consent to participate in this study will be obtained prior to the interview. They need to state that they have read and understood the expectations of the research, have been given time to ask questions and consider the research. This will be recorded separately on a Dictaphone and not included in the interview data. Participants are free to withdraw their consent at any time during the interview process. This will satisfy rights such as self-determination and autonomy which is linked to the principle of respect and dignity. If interviewees should experience any emotional distress before, during or after the interviews, the interviewee can communicate with the researcher, take a break during the interview or stop the interview. They can access counselling services at AUT, and/or DHB EAP programme. Interviewees can contact the researcher through AUT email or phone to set up another online interview appointment to discuss anything of concern. If the participant is unwilling to further meet, this will be respected, and no further communication is necessary.

The principle of beneficence which basically means doing good, and non-maleficence, that is, the right not to be harmed, ensuring respect and esteem of the participant will be upheld (Borbasi and Jackson, 2016). It is not envisaged that any harm will come to the participants because some of the risks and benefits of the research will be outlined in the ethics application to AUTEK. This will ensure that beneficence is met and that all interviewees are treated fairly which in turn meets the principle of justice. This statement will be reflected in the Participant Information Sheet (PIS) and the Consent Form (CF) to inform and reassure all participants. Correct ethical behavior such as researcher honesty, conducting interviews in a non-deceptive manner, transparency, and actively listening to the interviewee, will be evident at all times during the online interview process.

Privacy will be maintained by conducting interviews in a private room either at the participant's home or at chosen space. All Zoom interviews will only be audio recorded and the

recorded interview will be deleted from Zoom cloud after it has been downloaded onto an external hard drive. In terms of anonymity and confidentiality, pseudonyms will be assigned to each transcript to anonymise participants, and all transcripts will be destroyed after 6 years. All consent forms will download from a secure file and locked in a cupboard at AUT to maintain confidentiality. This meets the laws contained within the Privacy Act (1998). All data collected will be protected by storing them in password protected computer (Salmons, 2012).

As a researcher, one must be aware of one's attitude, values, biases and feelings when interviewing participants. Emergency Department nurses can disclose clinical experiences, which may trigger anger, frustration and flashbacks. Therefore, all parties will debrief after the interview through a phone chat if needed. Interviewer bias will be minimised through values clarification, reflective journal entries, keeping an audit trail, feedback from interviewees and ongoing discussion with supervisors (Holloway, 2008; Morse, 2012). To minimise any possible power imbalance, having a friendly chat with the interviewee about background of the researcher and social aspects may lighten any feelings of hierarchy especially with a researcher performing a doctoral study. Having chats offline before the virtual interview to establish trust and build rapport may alleviate any anxiety, fear and anger (Braun and Clarke, 2022; Salmons, 2012).

Lastly, the data collection and interview questionnaire remains the intellectual property of the researcher and AUT. To minimise third party reuse, I will use ZOOM management features and security options, identify authentication, end-to-end encryption, password protection, private connection, and ensuring safe storage of the data.

### **Contingency Plan**

Firstly, clear written instructions and links to the ZOOM website, on how to access and use ZOOM will be provided to all interviewees who have consented to participate in the research. This will prevent any confusion or difficulty when using the platform or interruptions/delays from answering questions around use of ZOOM during the interview.

An invitation with a link and password to access ZOOM will be emailed to participants once they have decided on a suitable time.

On clicking the link, participants will be prompted to enter a password. This will ensure that the data is protected, and confidentiality and privacy is maintained throughout the interview process.

Once data is collected, all passwords will be deleted.

Participants can also trial the system independently as ZOOM is intuitive and can prompt users to go to the step, such as clicking the audio icons.

### **Pilot**

Furthermore, piloting the interviews before the actual research with nurses not directly involved in the research will assist in testing the zoom management and security features available in this platform. Before the actual interview, two registered nurses will pilot ZOOM before the main study commences to test the guide, features and quality of audio recording. Secondly, just prior to the interview, a test meeting will occur. In the meeting the audio (microphone) featured on both parties' devices will be tested to check function and quality of voice. To avoid any disruptions or distractions which could lead to misinformation, all email notifications and phone texts at both ends, that is, researcher and interviewee will be requested to be muted. The space chosen should be private.

For issues during the interviews such as connectivity issues or problems like disconnection, pauses, and/or screen freezing, participants can call the researcher directly to troubleshoot these issues. An example, to resolve such issues is to bring the laptop or device closer to the WiFi router or access point in the home. During the interview, when there is violation of privacy through an uninvited person attending the interview, the interview will be immediately stopped, and rescheduled. Transcription confidentiality is included in the consent form and the opportunity for participants to review their transcriptions will reduce risk of misinformation or miscommunication. Emergency Department nurses work odd hours and are extremely busy, so there is a risk of poor uptake or not keeping an interview appointment. If Emergency Department nurses are willing to participate but unable to meet at a scheduled appointment then an alternative

suitable time will be set up, thereby acknowledging their role as an ED Nurse. There is a risk of the entire interview not being recorded. Therefore, recording storage is enabled before the interview commences together with the option of storing in local password protected computer. A portable hand-held Dictaphone will always sit close to the speakers during all interviewees as a backup measure should any data be lost.

### **Conclusion**

In summary, virtual online interviews will replace face-to-face interviews due to current complexities within Emergency Department environments. There are advantages and disadvantages of ZOOM videoconferencing. Overall, studies indicate that videoconferencing platforms can be used if clear instructions are given as they are convenient, user-friendly, practical, intuitive and flexible. This document has explored some of the risks with mitigation as best as possible. Ultimately, it is the responsibility of the researcher to behave ethically and be fully aware of attitudes and vulnerability. Therefore, ongoing checking, monitoring, values clarification and communication with supervisors is essential.

## Appendix J: Interview Checklist

The research question explored in this study is "What are the factors contributing to Emergency Department Nurse retention within a New Zealand District Health Board (DHB)?"

### Interview Checklist

<input type="checkbox"/> Verbal Consent Form (CF) <ul style="list-style-type: none"> <li>➢ Recorded Separately</li> <li>➢ Any questions</li> <li>➢ Location of interviewee</li> <li>➢ Demographic Data</li> </ul>	DATE DUE
	STATUS
<input type="checkbox"/> Participant Information Sheet (PIS) <ul style="list-style-type: none"> <li>➢ Any questions</li> </ul>	DATE DUE
	STATUS
<input type="checkbox"/> Dictaphone charged <ul style="list-style-type: none"> <li>✓ Dictaphone Tested</li> </ul>	DATE DUE
	STATUS
<input type="checkbox"/> Computer charged <ul style="list-style-type: none"> <li>✓ Microphone Tested</li> </ul>	DATE DUE
	STATUS
<input type="checkbox"/> Zoom Invite Sent <ul style="list-style-type: none"> <li>✓ Video Camera Feature Off</li> <li>✓ Audio Feature On</li> <li>✓ Automatic Recording On</li> <li>✓ Local Computer Recording On</li> </ul>	DATE DUE
	STATUS
<input type="checkbox"/> Interview Guide Clarification	DATE DUE
	STATUS
<input type="checkbox"/> Email Notification Off Cellphone Off	DATE DUE
	STATUS
<input type="checkbox"/> Post Interview Call Feedback Offline	DATE DUE
	STATUS

## Appendix K: Poster for Recruitment



### Emergency Nurse Retention: Understanding success factors to promote ED Nurse retention in a New Zealand District Health Board Hospital (DHB).



Have you got something to say about Emergency Nurses? We would love to hear it! We are conducting a research about retention of ED Nurses.



All XDHB Registered Nurses who have been employed in ED for a minimum period of six months at either XXX or XXX Hospitals are invited to participate in this study.

**If you are interested, please contact**

**Leslie Kistan email: [leskis87@autuni.ac.nz](mailto:leskis87@autuni.ac.nz)**

**Phone number: 021593930**

**We hope to hear from you soon.**

AUTEC Number: 20/278

Approval Date: 06.10.2020

## Appendix L: Participant Information Sheet (PIS) and Consent Form (CF)



### Participant Information Sheet

#### Date Information Sheet Produced:

17.07.2020

#### Project Title

**Emergency Nurse Retention: Understanding success factors to promote ED nurse retention in a New Zealand District Health Boards (DHB).**

#### An Invitation

Kia Ora,

My name is Leslie Kistan and I am interested in understanding the factors that lead to retaining registered nurses within Emergency Departments. I am working as a Lecturer teaching student nurses enrolled in the Bachelor of Nursing programme, run by Unitec Institute of Technology. You are invited to participate in a research study contributing towards my Doctor of Health Science degree on this topic.

Thank you for your interest in this study. Before you decide whether or not to participate, it is important that you understand more about this study and what participation involves. Please take time to read this information sheet carefully.

As a nurse for 27 years, I worked primarily in EDs both in NZ and overseas. During this time, I was exposed to the complex work of ED nurses and thus became deeply interested in factors that maximised the retention of ED registered nurses. While studies to date have focused on nursing turnover, research on factors promoting ED nurse retention are limited within NZ. Therefore, I would like to investigate what factors influence ED nurses retention and attrition. Would you be willing to help me?

#### What is the purpose of this research?

ED is the first point of contact for most patients seeking emergency help at a DHB. ED nurses are technically skilled, knowledgeable, perceptive and intuitive, knowing when to escalate a patient after independently assessing, however ED nurse numbers are declining. While there is research around general determinants or predictors of burnout, there is a need for more immediate research specific to ED nurse retention.

Firstly, this research aims to explore the perspectives of ED nurses within the clinical environment in which they work through interviews. Secondly, to identify factors which could help improve emergency nurse retention. This study is intended to help inform ED education and training, policy development, and strategic workforce planning around ED nurse retention within NZ's DHBs.

The findings of this research may be used for academic publications and presentations. I have received no financial support for this research.

#### How was I identified and why am I being invited to participate in this research?

You have responded to a poster about this research. All DHB ED registered nurses who have been employed in ED for a minimum period of 6 months at either the XXXX OR XXXX Hospitals are invited to participate in this research. Eligible participants include all ED nurses, ED nurse educators, ED consultants, specialists and practitioners, ED managers working clinically and also, ED nurses with dual roles such as DHB Transit Care nurses and ED nurses.

#### How do I agree to participate in this research?

If you are willing to participate in this research, please contact me by email or phone. Thereafter I will arrange a time suitable to conduct a virtual interview where you will give verbal consent to participate. Your consent



Internal

**Verbal Consent Form**

**Project title: Emergency Nurse Retention: Understanding success factors to promote ED nurse retention in a New Zealand District Health Board (DHB).**

Click or tap here to enter text.

**Project Supervisors:** Dr Elissa McDonald and Professor Eleanor Holroyd

**Researcher:** Mr. Leslie Kistan

- I have read and understood the information provided about this research project in the Information Sheet dated 06.10.2020
- I have had an opportunity to ask questions and to have them answered.
- I understand that notes will be taken during the virtual interviews, and that the entire interview will also be audio-taped/recorded via ZOOM and Dictaphone, and then transcribed.
- I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- I verbally agree to take part in this research.
- I wish to receive a summary of the research findings (please tick one): Yes  No

**Participant's Name :** .....

**Participants Contact Details and location :**  
.....  
.....  
.....  
.....

**Date :**

**Approved by the Auckland University of Technology Ethics Committee on 6<sup>th</sup> October 2020, AUTEK Reference number 20/278.**

*Note: The Participant should retain a copy of this form*

## Appendix M: Nominated Transcriptionist Confidentiality Form



### Confidentiality Agreement

For someone transcribing data, e.g., audiotapes of interviews.


Project title: **20/278 Emergency Nurse Retention: Understanding success factors to promote ED Nurse retention in a New Zealand District Health Board Hospital (DHB).**

Project Supervisor: Professor Eleanor Holroyd

Researcher: **Leslie Kistan**

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- I understand that all the material I will be asked to transcribe is confidential.
- I understand that the contents of the tapes or recordings can only be discussed with the researchers.
- I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber's signature:  .....

Transcriber's name: **Shoba Nayar** .....

Transcriber's Contact Details (if appropriate):

e-mail: **snayar19@gmail.com** .....

.....

.....

Date: **17 December 2021**

Project Supervisor's Contact Details (if appropriate):

.....

.....

.....

Approved by the Auckland University of Technology Ethics Committee on **06.10.2021** AUTEC Reference number **20/278**

Note: The Transcriber should retain a copy of this form.

## Appendix N: Initial Familiarisation Notes and Entire Dataset

### **Initial Statement of Participant**

This participant had read the entire contents of the PIS and understood.

### **Reflection**

On reflection, I felt that when questions were posed to her, her tone suggested that she did not want to give a response that I was looking for, for example saying that "I do not get stressed, never get stressed in any situation" She also wanted to get through all questions quickly. I sensed her frustration and anger over senior staff leaving but also leaving ED does not solve any problems, perhaps that is the reason she has not quit ED.

### **Statements in response to semi-structured guide**

#### **Her happiness or satisfaction working in ED**

Felt that's she loves working and growing staff, having a variety of presentations and quick, succinct care and teaching staff, extending other people's practice.

#### **Salient Features**

Undesirable behaviours?WPB

Recognised as an ongoing problem, felt that nothing gets done, no exit interviews

### **Question**

Why is this a problem and what has been done to date? What tools, processes, systems are there to mitigate behaviours? Is it normalised?

### **Reflection**

#### **Assumptions**

I felt that this participant being a charge nurse would have small percentage of stress, but she indicated that she does not get stressed, she is a leader and spends time dealing with the problem, allowing staff to vent.

#### **Main Features**

What leaps out here is short staffing, workloads, perception of being treated unfairly, people leaving without exit interviews, fear of retribution after speaking up?

#### **Questions for me**

1. How are her responses different to the other nurse leaders?
2. Why are there no exit interviews?

### **Familiarisation Notes from Interview Transcript**

#### ***Initial Statement of Participant***

*This participant clarified whether the meeting was being recorded, if the recording will eventually be deleted.... if was it normal to not see me on screen.*

#### ***My Response***

*Reassured participant and explained about pseudonym, privacy, anonymity, confidentiality, and reiterated reason for camera feature off (Ethics Committee).*

*I felt that it was reasonable for the participant to ask these questions, even though it was covered in the PIS and we discussed this prior to the interview. Perhaps her narrative would reveal personal experiences that she was worried about sharing and wanted to ensure safety prior to her interview. My other thought was that the participant is in a leadership position and often very busy, so it's only human for her to forget details. This shows the nature of ED. Her tone of voice indicated that she "really wanted a summary of the research findings."*

#### ***Statements in response to semi-structured guide***

#### ***Her happiness or satisfaction working in ED***

*Felt that's it was mostly the team that she works with which was important for satisfaction or happiness.*

*Culture is also important because people thrive and learn in a supportive practice environment.*

*Came across like a leader that is caring and values her team (sounded like she had sound leadership traits, engagement with staff, fair, good communication, open-door policy, caring but firm, seeing potential in her staff and wanting them to flourish).*

*As a leader she acknowledges and respects staff but also values teams and ensures teams values diverse culture and ethnicities specific to her region- out west.*

*She stressed that patient care was most important with right resources.*

*Love for ED, compassion, being part of changes and processes*

### **Resources**

*Repeated resources- manpower when staff shorted and concerned about upper management perception.*

*Felt like two opposing forces – management versus operational level, poor insight into lack of staffing.*

### **Question for me**

***Has there been recent experience where staffing has influenced patient outcome?  
Is staffing more at site than the other?***

### **Her experience with Covid-19**

*Expressed mixed feelings around Covid- on one hand change was quick whilst on the other hand her experience of Covid-19 posed a lot of frustration with poor communication, constant change.*

*Strong leadership evident as ability to be flexible and adjust within a short space of time having a good team.*

*Aware, sensitive, and responsive to team members anxiety, supportive (good leadership traits)*

*Comes across positive amid problems.*

*Realistic and honest about being a manager.*

*Migrant nurses are stressed (after Covid-19) because they have to support families and cannot get home.*

### **Question for me**

***To date, what support has been given to those specific group of nurses?***

### **Her response to stress**

*Her strategy coping with stress was to compartmentalise, exercise, talk to her family and not take stress home.*

*Boundaries around stress.*

*Vented frustration with tension between her own personality and upper management- having a mentor is helpful.*

*Appreciates change as healthy but upset over lack of insight by upper management as to what's on the floor (lack of resources- staff, equipment)*

*Management can be lonely as she is constantly evaluating.*

*Migrant nurses work hard to support families.*

### **Question for me**

***Besides EAP is there anything else for staff around stress or systems to monitor early signs or at-risk situations in the practice environment?***

### **Her relationship with ED staff**

*Appreciated fear and anxiety new staff experience and supports them at all levels.*

*Demonstrate empathy to new graduates*

*Recognises tricky situation when new grads are supervised by junior staff; shows vulnerability of staff, both new recruits and old staff.  
Feels that she provides support to staff and intervenes early on for any problems.  
Encourages staff to move on (“very healthy to move”)*

***Question for me***

***Is this a reasonable action to encourage junior staff to move on?***

? Able to express some positive aspects but also negative aspects, courage to share-  
Openness to vulnerability  
Able to recognise triggers to a hostile situation, de-escalate.

***Question for me***

***Has debriefing occurred for staff post stressful events?***

***Workplace – Unwarranted behaviour***

*Recognised as an ongoing problem, culture within DHB*

***Question for me***

***Why is this a problem and what has been done to date?***

***Reflection***

***Assumptions***

***What leaps here is teamwork, unwarranted behaviour and lack of trust.***

***From my understanding and experience, I thought that the participant would be able to cope. She has good relationship with others but she appreciates how vulnerable they are as well.***

# FAMILIARISATION NOTES FOR THE ENTIRE DATASET

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## Familiarisation Notes for Entire Data from the Emergency Nurse Retention Study

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### Some thoughts post nine interviews

Several nurses placed emphasis on resources/lack of (staffing, junior staff, time, equipment). Staff feel that there is an element of **adverse behaviour** ? discrimination, ? selective treatment, therefore worried, afraid and helpless.

Seems to be many positive responses around wanting to be an ED nurse because of **mates, autonomy, skills, and intense quick care**. ED Nurses are viewed as "special" than ordinary nurses.

Appears to be a presence of mixed feelings/experiences around Covid-19.

Other issues/challenges: mental health patients and accountability re: health target breaches.

Differences between staff perception of **stress**.

Similarities around lack of respect for staff, acknowledgement and at times, feeling undervalued.

Further questions needed to be asked around debrief-need probing if both sites debrief post trauma.

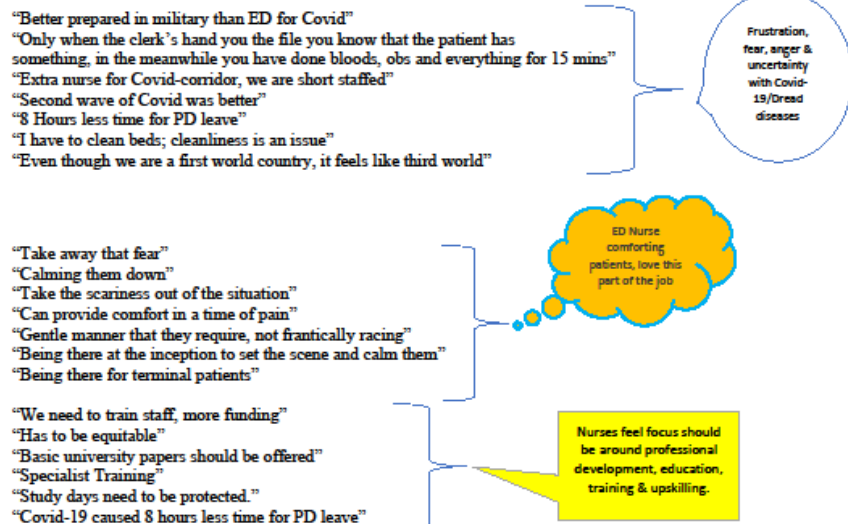
Concerns about opportunities professional development, training, education, and upskilling?

Perceived inequalities.

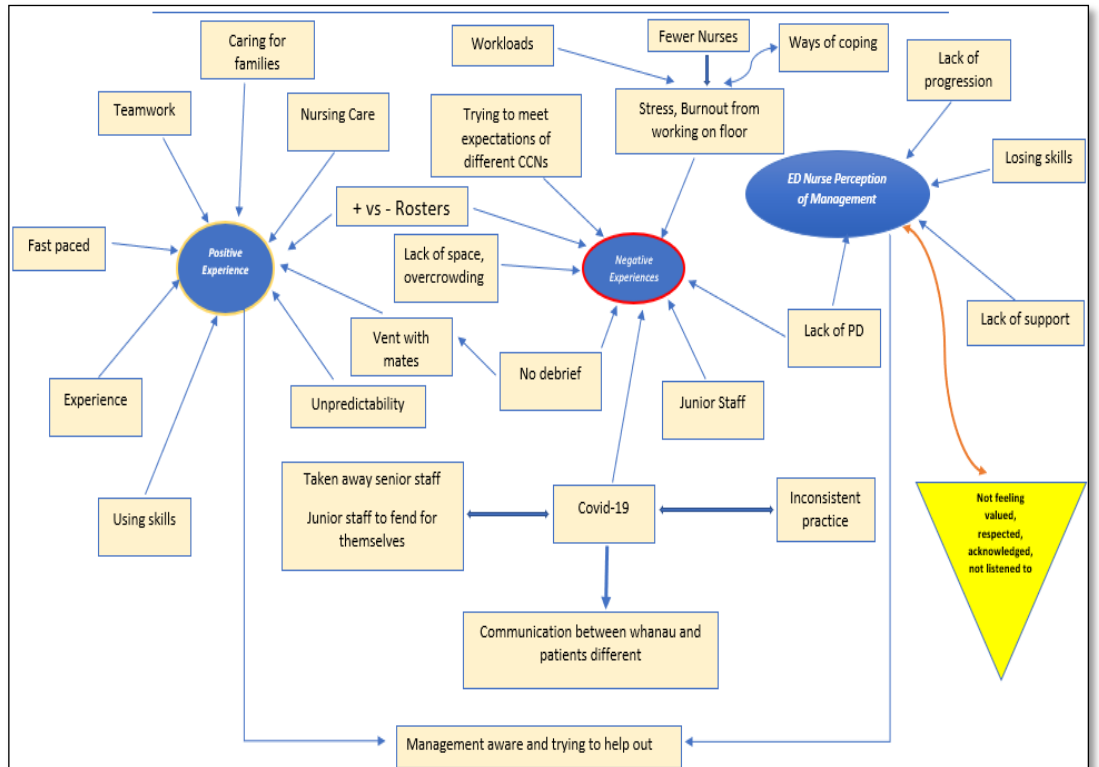
**Coping with stress** through mentor-if around- work-life balance, communication, exercise, and reasonable rosters.

Staff **feeling helpless** due to repeated experience of sicker patients, heavy workloads.

Staff are **vulnerable with uncertainty, fear and anxiety of unknown and Covid-19 on top of existing stresses within the ED**

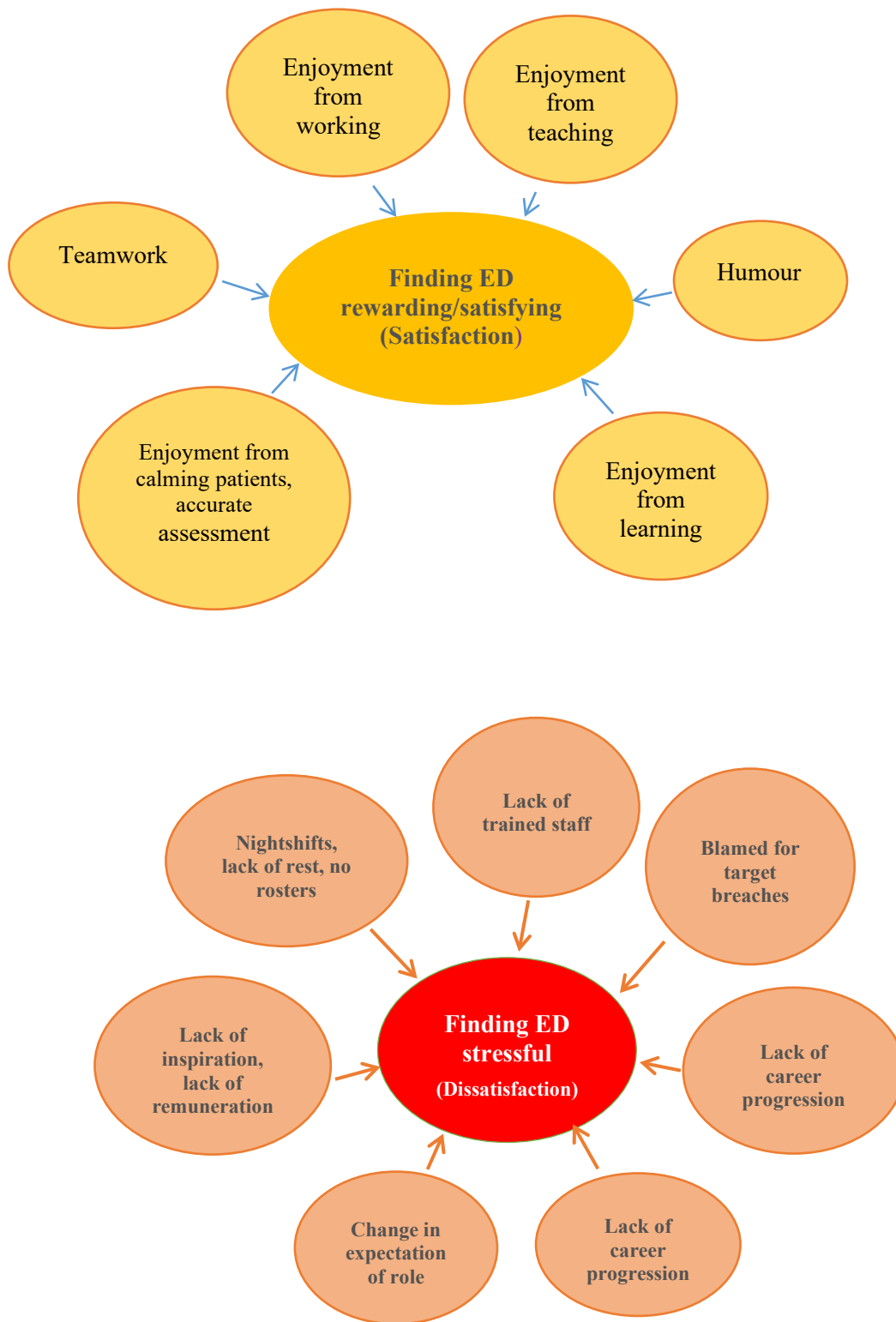


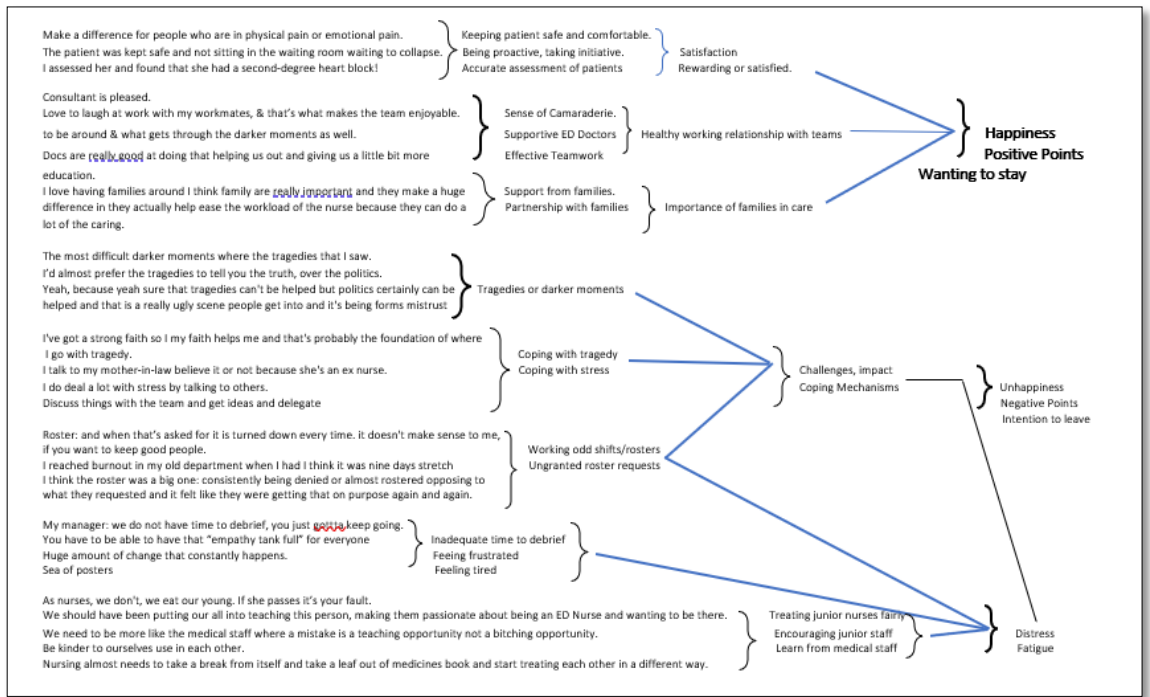
## Appendix O: Mind Map and Coloured Diagrams





## Appendix P: Early Thematic Map





## Appendix Q: Development of Themes

Box 1 shows a decision was made to collapse several overlapping subthemes under one theme, ED practice environment and tensions in ED. Decisions about each subtheme is coloured in red for the theme of tensions while green meant that the subtheme had to move another theme pertaining to health target and purple meant moving to a theme about teamwork. This development or process was before Box 2. Box 2 shows the refining of the themes of workplace tension and five subthemes.

### Box 1

#### Before revision first round

**Theme: Perception of the current ED practice environment and tensions within ED** *[shorten]*

Feeling that even though we are a first world country; it feels like third world department. *[collapse, overlapping of subthemes]*

Carrying a chunk of the workload and patient safety ends up on our shoulders. *[collapse, overlapping of subthemes]*

Nursing almost needs to take a break from itself and take a leaf out of medicines book and start treating each other in a different way. *[shorten, keep treating each other differently as a separate subtheme]*

I never got over tragedies- I'd almost prefer the tragedies to tell you the truth. *[collapse into treating each other, overlapping of subthemes]*

Verbal and physical abuse a risk that comes with ED *[rename, relook at quote, keep as a standalone subtheme]*

Finding solutions for mental health patients *[keep as a standalone subtheme]*

Covid-19 is game changer for nursing - feeling better prepared in military than ED for Covid. *[keep as a separate subtheme but remove some words]*

Feeling helpless and hopeless; nurses do everything for the patient but blamed for the breaches. *[breaches must move to? another theme around? targets]*

Feeling bombarded, snippy and snappy and not working as a team. *[collapse, move to another subtheme under the theme of teamwork]*



#### After revision second round

**Theme: ED practice environment and tensions within ED**

**Feeling that even though we are a first world country; it feels like third world department**

**Finding solutions for mental health patients**

**Verbal and physical abuse a risk that comes with ED**

**Covid-19 is game changer for nursing**

**Start treating each other in a different way.**



[contd. on next page]

**Box 2**

<b>Major Theme</b>	<b>Subthemes</b>
<b>Theme Three: Workplace tensions</b>	It feels like a third world department. Finding more solutions for Mental Health patients. Feeling horrible from patient verbal and physical abuse. COVID-19 is game changer for nursing. Treating each other in a different way.
<b>Theme Six: Dissatisfaction with organisational structures, processes, and systems.</b>	Feels like old school. Rosters that put me off. Life is expensive- you cannot save here! <b>Health target is a conveyor belt like a Toyota factory.</b> Are we getting more staff? Feeling as though management does not hear us.