Organizational Culture in Emergency Departments and the Older Adult:

A Modified Scoping Study

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Pal Skar

Student # V00728063

University of Victoria

Faculty of Human and Social Development

School of Nursing

NURS 598

Supervisor: Dr. Anne Bruce

Committee member: Dr. Debra Sheets

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Content

Abstract

What does the literature tell us about the elements of the organizational culture—or micro culture—in emergency departments that may impact the care provided to the older adult who presents in the emergency department with what is perceived by staff as a non-acute condition or complaint? In the U.S. and Canada, the population 65 years of age or older accounts for between 15% to 20% of all emergency admissions. Older adults stay in the emergency department longer than younger adults, and therefore potentially consume more of one of the limited resources in emergency departments—time. The older adult is also more at risk for adverse effects from admissions to emergency departments, and this can impact length of stay in hospital and levels of functioning at discharge. The aim of this scoping study is to map the presence of the three levels of culture (artifacts, values and beliefs, and assumptions) in Schein's (2010) organizational culture assessment framework in the literature on organizational culture in emergency departments. The methodology used was the Arksey and O'Malley framework for scoping studies. The main finding on the artifact level was that emergency departments are not designed with the older adult in mind. The main findings on the values and beliefs level were that emergency departments are for urgent cases, that older adults do not receive the care and respect they should be given, that there is not enough time in the department, that teams are important, and that emergency nurses feel competent providing emergency nursing but were not focused

on good nursing care, particularly not traditional bedside nursing care. The main assumptions underlying these values and beliefs were that older adults did not belong in the emergency department, most visitors to the department were not really critically ill and therefore could wait, and that staff needed to be available for acute cases at all times. A systematic review of a variety of literature on this topic is warranted in order to bring the findings from separate research efforts up to the evidence level of a summary. This review could then support changes to improve care provided to older adults in the emergency department through evidence.

Health care providers are challenged by how to provide the best possible environment for delivery of care to older adults—defined as 65 years and older—when they are admitted to emergency departments (Hwang & Morrison, 2007). In the countries represented in this study; Australia, Canada, New Zealand, Sweden, Switzerland, the United Kingdom, and the United States, emergency departments were often perceived as the front door to the hospital. The population of older adults seeking care in emergency departments in Canada and the United States is already substantial, while the number of older adults in Canada is projected to double by 2039. There is a growing realization that the most common emergency department design found in North America does not serve the needs of older people (Adams & Gerson, 2003) and that admissions to these departments can lead to adverse effects for the older adult.

Although there could be many solutions on several levels to these challenges, perhaps we as health care providers could look at changes to how we practice our professions in this environment. We are, however, increasingly required to base changes to our practice on evidence such as research. One way to bring individual research to a higher level on the evidence hierarchy is to summarize the findings through a systematic review (LoBiondo-Wood, Haber, & Cameron, 2013, p. 55). In using a systematic review the researcher explores the literature based on a defined clinical area or research question and "evaluates those articles as a whole" using pre-determined "criteria and methods" (p. 62). LoBiondo-Wood et al. (2013) lists "meta-

analysis, integrative reviews, and metasynthesis" (p. 62) as examples of systematic reviews.

An alternative to a systematic review is a scoping study. A scoping study differs from a systematic review in several ways. First, scoping studies are ideally rapid in order to get an overview of the literature prior to defining the direction and content for further research. Anderson, Allen, Peckham, and Goodwin (2008) suggest six months as being sufficient to conduct a thorough scoping study. Second, scoping studies include a wide range of literature by not incorporating requirements for inclusion—such as peer review—in the literature search strategy; all literature on the topic can be used to inform the intended reader. Third, scoping studies do not attempt to evaluate the articles in the study, and can be used for mapping literature, concepts, and policies for a given area of interest. A scoping study can also be limited to consultation with stakeholders regarding a particular issue (Anderson et al., 2008; Arksey & O'Malley, 2005; Levac, Colquhoun, & O'Brien, 2010; Valaitis et al., 2011).

One frequent user of scoping studies is the National Institute for Health Research (NIHR) Service Delivery and Organization Research and Development Programme of the UK. From 2001 to 2007, 205 projects were commissioned and of those 24 were identified as scoping studies. In a review, Anderson et al. (2008) state the following about scoping studies:

> They are an extremely valuable tool, and in many cases are an essential prerequisite to more detailed empirical research. They provide the opportunity to map a wide range of literature, and allow researchers to identify where gaps in our knowledge may lie, along with any particularly inventive or innovative approaches that may have been missed. (Anderson et al., 2008. p. 9).

Used in this way the findings from scoping studies can be disseminated and used to guide future research, planning, or policy development (Levac et al., 2010, p. 5).

I chose to conduct a scoping study as my intent was to examine information that went beyond a very limited number of research articles on organizational culture in emergency departments and the treatment of older adults. A scoping study approach allowed me to include a wider variety of literature and to provide a more diverse background for future research and planning for delivery of emergency services to older adults than a systematic review. In addition, this process allows an assessment of the literature for the feasibility of conducting a systematic review at a later date.

The experiences of the older adult in emergency departments have been documented in systematic reviews either conducted or proposed (Gordon, Sheppard, & Anaf, 2010; Hoon, Mackey, & Hong-Gu, n.d.). However, no systematic review of the literature documenting the experiences of emergency department staff working with older adults has to date been done. These experiences could shed light on the impact of the organizational culture in emergency departments on the care of the older adult. The

purpose of this scoping study is therefore twofold: to determine if such a systematic review might be warranted, and to map the presence of the three levels of culture (artifacts, values and beliefs, and assumptions) in Schein's (2010) organizational culture assessment framework (see Table 1, p. 14) in the literature on organizational culture in emergency departments.

Background

The Canadian population is aging rapidly and the population 65 years and older is projected to grow from around 4.8 million in 2010 to between 9.8 million and 10.8 million in 2039 (Statistics Canada, 2010). As the population ages, the demand for hospital services is expected to increase. This will have an impact on both flow through the hospital front door—the emergency department —and bed utilization.

In the United States older adults represented approximately 14.9 percent of the total population visiting emergency departments in 2009 (Center for Disease Control and Prevention, 2012). In Canada this number ranged from around 20% of all emergency room visits in Ontario and around 15% in Alberta for the 2010-2011 reporting period (Canadian Institute for Health Information [CIHI], 2012a). Canadian data also indicate that length of stay in Canadian emergency departments is longer for the older adult compared to the younger population (CIHI, 2012a), effectively consuming more resources per admission.

Demand for beds in Canadian and U.S. hospitals is increasing and admitted clients are commonly waiting in emergency departments for hospital beds (Liu et al., 2012). In Canada the number of hospital beds (Quebec data not included) has been reduced from 3.5 per 1000 population in 1999 to 3.1 per 1000 population in 2008 (CIHI, 2011). At the same time a large number of clients classified as Alternate Level of Care (ALC) clients— those who no longer require hospital services—are unable to leave the hospital due to functional levels that prevent an immediate return to home or a loss of functional abilities that makes a return to home impossible. In a five year study of hospital admissions and discharges of older adults from April 2007 to September 2011 conducted by the Canadian Institute for Health Information, 6.8% (342,119 admission of a total of 4,999,105) were discharged with ALC days. Of patients with ALC days (342,119 admissions), 53.5% (183,051 discharges) were discharged to long-term care facilities after having waited a total of 5 million days in hospital during the study period (CIHI, 2012b). These data point to a need to both limit emergency department admissions of the older adult and to make these visits as short and non-traumatic as possible when they do occur.

Admission of the older adult to the emergency department has the potential to set the stage for both the length of stay as an inpatient and the functional level the individual may be able to return to. Older adults are more susceptible to the noxious impacts of hospital environments (Inouye, 2006) and are at risk for adverse impacts and

outcomes from admissions to emergency departments. One example is the common failure to diagnose delirium. Voyer and Sych-Norrena (2003) reviewed the literature on delirium and concluded that between 10% and 16% of elderly clients in emergency departments experience delirium while only 5% to 23% of elderly clients with delirium are diagnosed while in the department. This lack of diagnosis has been linked to "its fluctuating nature, its overlap with dementia, *lack of formal cognitive assessment, underappreciation of its clinical consequences, and failure to consider the diagnosis important* [emphasis added]" (Inouye, 2006, p. 1157-1158). This frequency of undiagnosed delirium may be seen as both a lack of understanding and—more importantly for the purpose of this study—a reflection of health care providers' values and beliefs, and underlying assumptions that shape providers' interaction with the older adult. Such values and beliefs, and underlying assumptions combined with artifacts such as architecture and building design reflect the prevailing organizational culture (Schein, 2010).

In addition to an overarching hospital organizational culture, the presence of nursing subcultures within specialty areas such as emergency departments has been identified by Mallidou, Cummings, Eastabrooks and Giovannetti (2011) and the existence of different work cultures on different nursing units has also been documented by Khokher, Bourgeault, and Sainsaulieu (2009). Consequently, in order to understand the impact of an admission to the emergency department on the older

adult we need to know more about organizational culture found in emergency departments.

Organizational Culture

The term organizational culture has many meanings and interpretations and I have chosen to use a theory developed from a social science perspective by Edgar Schein (2010). Schein defines culture as

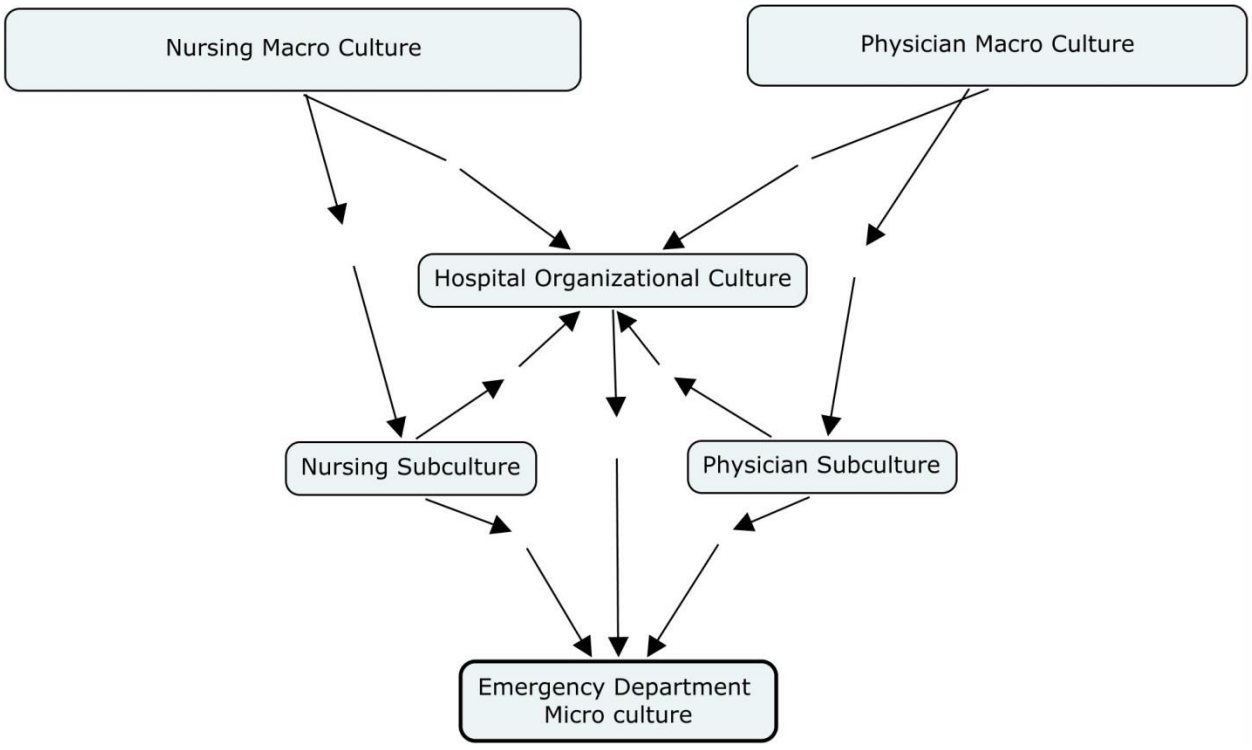
> a pattern of shared basic assumptions learned by a group as it solves its problems of external adaptation and internal integration, which has worked well enough to be considered valid and, therefore, to be taught to members as the correct way to perceive, think, and feel in relation to these problems. (p. 18)

Organizational culture can further be broken down into four groups (see Figure 1). *Macro culture* is culture on the level of the nation or state, ethnic or religious groups, or within professions, such as nursing, that exists globally. *Organizational culture* is the culture that exists within organizations. *Subculture* is the culture that can exist within occupations within organizations—one example is within a hospital—such as a nursing subculture or physician subculture. Finally, within organizations we can find *micro cultures* which are the culture of microsystems such as an emergency department or an outpatient laboratory (p. 2). Schein's theory suggests that these departments may have cultures that are separate from and possibly different than the hospital organizational culture. It can be seen that these micro cultures are influenced by the cultures of the

professionals that work there—both the macro culture on the global level as nurses or physicians—and the subculture the professionals bring with them as employees of the hospital. I will use the term micro culture to describe the culture in emergency departments in this paper.

Figure 1

Proposed Relationship Between the Different Levels of Organizational Culture in a Hospital Environment



Schein (2010) sees culture as an abstract concept which needs to be observed through an anthropological lens in order to explain phenomena that otherwise would remain unexplainable (p. 12). He defines three levels in which culture is observed (see

Table 1). The first level is artifacts, such as buildings, organization of offices, etc. The second level is the values and beliefs that the group has become attached to (espoused). The last level is the underlying assumptions that are taken for granted. Schein uses these levels for assessment of organizational culture and I used these three notions to chart and collate the data extracted from the literature in this study.

Table 1

The Three Levels of Schein's Organizational Culture Assessment Framework

Artifacts, such as buildings, organization of offices, clothing etc. that can be observed.
Values and beliefs that group members are attached to.
Underlying assumptions that are taken for granted.

Methodology

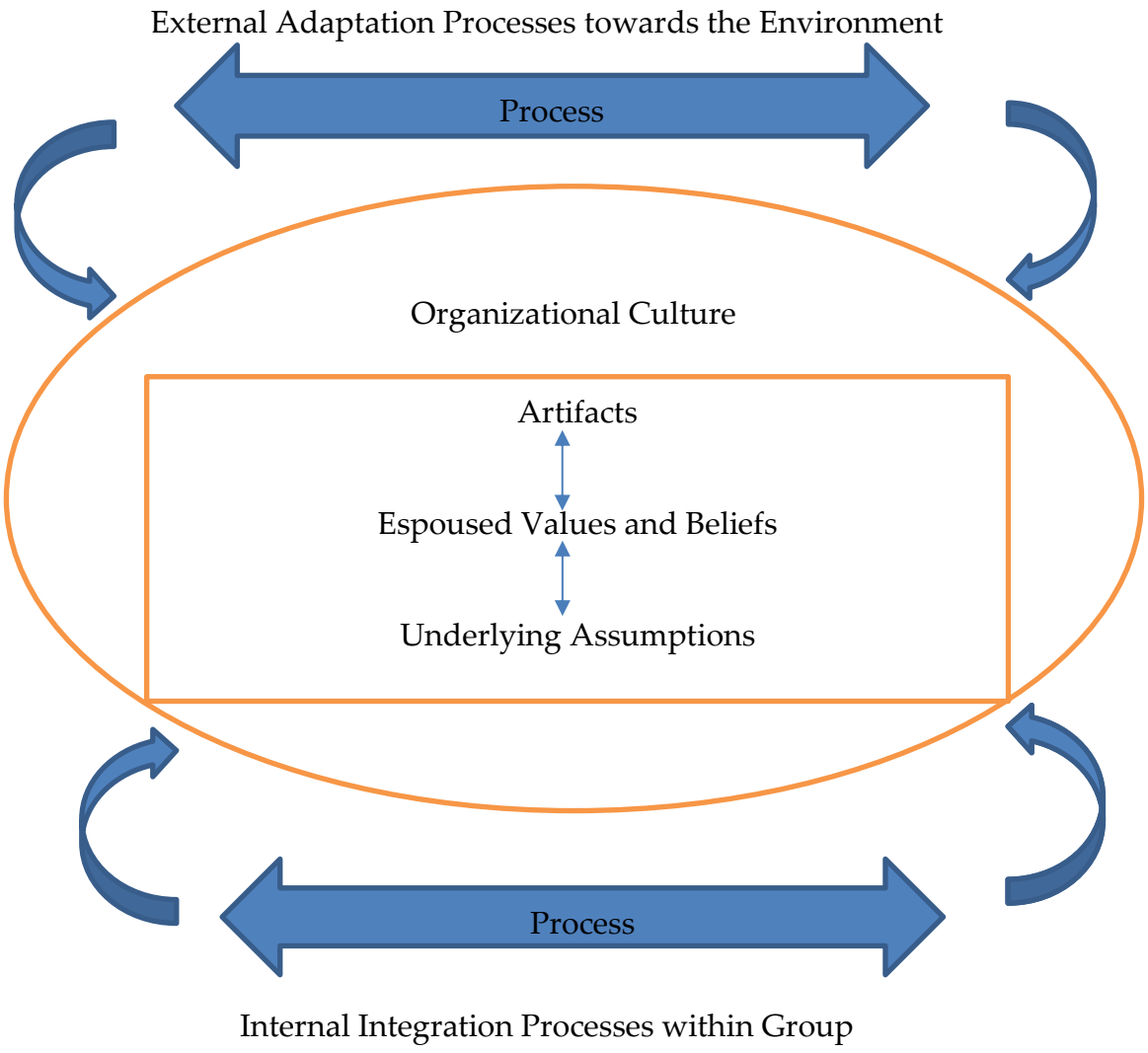
This modified scoping study follows the methodological framework outlined by Arksey and O'Malley (2005) and Levac et al., (2010). Many scoping studies are done by two or more researchers who—based on a protocol—independently review the articles under consideration for inclusion and who also collaborate on charting the data, and collating, summarizing and reporting results (Arksey & O'Malley, 2005; Levac et al., 2010; Valaitis et al., 2012). This approach reduces bias in what data are selected for inclusion and provides transparency that allows other researchers to replicate the study (Valaitis et al., 2012). In contrast, the context for this study is a project for a Masters of

Nursing degree and therefore the analysis was done individually. This runs the risk of introducing bias in the design of the study, including the selection of literature, the data extraction process, and how data are collated. To reduce potential bias I focused and narrowed the research question as suggested by Levac et al. (2010), and took particular care to include only those articles and data that fit the cultural assessment framework developed by Schein (2010) as predetermined in the study design. The scoping study framework—also called the Arksey and O'Malley framework (Levac et al., 2010)—consists of five steps: 1) identifying the research question, 2) identifying relevant studies, 3) selecting studies, 4) charting the data, and 5) collating, summarizing and reporting results. The framework also suggests a sixth optional step which is consultation (Arksey & O'Malley, 2005). This step was not included in this study due to constraints on time and resources available for this project.

During steps four and five the data were categorized according to the cultural assessment framework developed by Schein (2010). I used this framework to look for evidence of the three levels of culture (artifacts, espoused values and beliefs, and assumptions) found in the literature. Schein theorizes two important processes to consider when examining micro cultures such as the culture in emergency departments. These are the processes of external adaptation to the environment and internal integration which Schein suggests forms organizational culture (see Figure 2).

Figure 2

External Adaptation and Internal Integration and Organizational Culture



External adaptation to the environment is based on an organization's "(S)urvival, growth and adaptation in their environment" (p. 18). This process is governed by assumptions regarding an organization's mission and strategy, its goals, means, measurement, and ways that the organization implements, measures and corrects itself as it executes its strategy. One example of external adaption to the environment is how the National Health Service in the United Kingdom implemented a four hour target for discharges from emergency departments, how the different health trusts implemented this target policy, and how the departments adapted to a new reality.

The second process, internal integration, "permits daily functioning and the ability to adapt and learn" (p. 18). This process is guided by several sets of assumptions. First, assumptions related to creating or adopting language and concepts that are common with agreed upon meaning categories. Second, assumptions that determine what the boundaries are for the group and how to define who are included or excluded from the group. Third, assumptions for how trust, intimacy, friendship, and love are dealt with. Fourth, assumptions that informs the rules for how reward and punishment is structured. And finally, assumptions that make it possible to explain the unexplainable (Schein, 2010, p. 94). One example of internal integration from the literature in this study is how an emergency department developed a culture of blame (Seltzer, Gardner, Bichard, & Callison, 2011). A culture of blame reflects how the group handles trust and its assumptions for reward and punishment. This in turn impacts the

ability of the group to unlearn old assumptions that are not working well and learn new assumptions. While external adaption is important for an emergency department in meeting its mission of caring for the injured and acutely ill, internal integration is important in order to have all staff members working towards the same goals as members of a team. However, if the mission does not include caring for those who have non-urgent health concerns or if those individuals are not seen as what the team is supposed to focus on, appropriate care might not be provided for this client group.

Research Question

In their study of older adults and their experiences with hospitals Parke and Chappell (2010) found that the older adult who presented with an acute complaint received different treatment than the older adult who presented with a non-acute complaint. Based on these findings I formulated the following research question: What does the literature tell us about the elements of the micro culture in emergency departments that may impact the care provided to the older adult who presents in the emergency department with what is perceived by staff as a non-acute complaint? I used the three levels of Schein's (2010) organizational culture assessment framework—artifacts, espoused values and beliefs, and underlying assumptions found among health care providers in emergency departments—to chart the literature and respond to this question.

Identifying Relevant Studies

I consulted a health science librarian regarding the formulation of a search strategy and identification of key words. I conducted separate searches in Cumulative Index for Nursing and Allied Health (CINAHL®), Medline, Academic Search Complete, and PsychInfo based on the following search terms: emergency services, emergency departments, emergency room, organizational culture, organizational change, and culture. Only articles in English published between 1995 and 2012 were reviewed. No other filters were applied in the searches in order to capture a wide range of articles as suggested by Arksey and O'Malley (2005). A search of Summons, a compilation of library catalogues which includes gray literature such as news articles, thesis, government papers etc. (Mathews, 2004) going back to 2005 was done. In addition, the reference lists for the selected articles were reviewed for literature that met the following inclusion criteria:

- Literature addressing emergency departments in acute care settings.
- Literature describing any of the three levels of the micro culture in emergency departments and staff's experiences with the older adult.

The following exclusion criteria were established:

- Literature describing the older adult's experiences in the emergency department.
- Literature focusing on the emergency department micro culture and mental health or children and their families.

I identified a total of 217 potential articles, reviewed the abstracts, and selected 95 articles for further review.

I found only two articles that directly spoke about emergency department staff and their experiences with the older adult (Kelly, Parke, Jokinen, Stones, & Renaud, 2011; Kihlgren, Nilsson, & Sørlie, 2005) and two that reviewed existing emergency department design and practices in the context of the older adult (Adams & Gerson, 2003; Hwang & Morrison, 2007). I therefore decided to expand the scope of the study to include 14 additional articles which provided additional data on one or more of the three levels (artifacts, values and beliefs, and assumptions) of the cultural assessment framework. Eighteen articles were included in the final study.

Charting the Data

I read the articles and marked statements from study participants or comments from the author(s) that illustrated the three levels of Schein's (2010) cultural assessment framework in emergency departments. In this process I experienced difficulties distinguishing between values and beliefs staff had become attached to, and assumptions. Therefore, I had to make judgments about which statements a staff member would or could repeat as a shared belief or value, versus which statements a staff member would call an assumption. This distinction is important since in Schein's framework values and beliefs are the second layer of micro culture after artifacts. This layer is formed by how leader figures propose to solve problems or issues. As these

solutions are shown to work repeatedly, they become shared values and beliefs. However, at times the organization and/or its members do not behave according to their espoused values and beliefs. This is where an assessment of the underlying assumptions or taken-for-granted ideas that are operational within the organization or among its members becomes necessary in order to get a more complete picture of the culture. The distinction between values and beliefs and assumptions therefore becomes important for those who contemplate changing the emergency department micro culture since the process of change includes challenging and replacing the underlying assumptions.

Collating and Summarizing the Data

Statements or comments providing illustrations of the three levels (artifacts, espoused values and beliefs, and assumptions) were collated for each article. I analyzed the statements and comments within and across articles and developed key findings within each level. I went back after the initial draft was written to ensure that the authors had been represented correctly.

Findings

The findings are organized according to the three levels of Schein's (2010) organizational culture assessment framework.

Artifacts

Schein (2010) sees artifacts as the visible manifestations of organizational culture. They can be found in architecture and design of space and offices, how people dress and communicate, the published values and mission statements, and other manifestations that a researcher could observe by simply being in the environment under observation (p. 24).

Eleven articles described artifacts of the micro culture of emergency departments (Adams & Gerson, 2003; Eisenberg, Baglia, & Pynes, 2006; Fry & Stainton, 2005; Hwang & Morrison, 2007; Kelly, Parke, Jokinen, Stones, & Renaud, 2011; Kihlgren, Nilsson, & Sørlie, 2005; Moss, Walsh, Jordan, & Macdonald, (2008); Muntlin, Carlsson, & Gunningberg, 2010; Nugus & Braithwaite, 2009; Nyström, Dahlberg, & Carlson, 2003; Seltzer et al., 2011). (See Appendix A for a complete listing of all articles included in this study. See Appendix B for a summary of the data included in this scoping study.)

The picture that emerged was of the emergency department as the front door of the hospital (Eisenberg et al., 2006; Nugus & Braithwaite, 2009). Access to the emergency department could be a challenge (Eisenberg et al., 2006; Kelly et al., 2011). Most departments had a triage station, a registration desk—in one case with glass between the client and the registration clerk (Eisenberg et al., 2006)—and a waiting room (Eisenberg et al., 2006; Fry, 2011; Nugus & Braithwaite, 2009). People seeking care could not be turned away (Eisenberg et al., 2006; Fry, 2011). This was true for Australia,

Sweden, the United Kingdom, and the United States. One description was of emergency department staff as "insane ticket taker"(s) (Eisenberg et al., 2006 p. 207) admitting anyone. Clients were prioritized for care according to acuity (Nugus & Braithwaite, 2009; Nyström et al., 2003).

For those arriving by ambulance the first experience was the ambulance bay and the corridor leading into the emergency department where triage was sometimes performed (Nugus & Braithwaite, 2009). Once inside the emergency department patients were placed in cubicles separated from each other with curtains (Hwang & Morrison, 2007). The cubicles were organized according to how the care delivery or treatment process was designed (Adams & Gerson, 2003; Fry & Stainton, 2005; Hwang & Morrison, 2007; Kihlgren et al., 2005; Nyström et al., 2003; Seltzer et al., 2011). This allowed staff to monitor (Adams & Gerson, 2003) and manage the trajectory of multiple clients through the department (Hwang & Morrison, 2007; Nugus & Braithwaite, 2009). The high volume of clients created "a bunker mentality of being under siege" (Seltzer et al., 2011, p. 131), and the department was described as "a chaotic environment…ordered chaos" (p. 133). Another department was described as "a complex, high pressure, stressful working environment" (Moss et al., 2008, p. 101).

The flooring was designed for easy cleanup (Hwang & Morrison, 2007) and the lights were on 24/7 (Hwang & Morrison, 2007). Once seen by a physician, clients went for diagnostic tests and were often left in corridors waiting for tests or to be returned to

the emergency department (Eisenberg et al., 2006; Kelly et al., 2011; Nugus & Braithwaite, 2009). Staff clothing did not assist clients in determining "roles and responsibilities" (Kelly et al., 2011, p. 9) and name tags were often difficult to read (Kelly et al., 2011). A security guard was hidden from sight behind one-way glass looking into the waiting room (Eisenberg et al., 2006) and there were two doors in the triage area where the triage nurse worked—one leading to a more secure area (Eisenberg et al., 2006).

Nursing staff were mostly emergency nurses and in some areas augmented with or replaced by agency staff (Khokher et al., 2009; Moss et al., 2008). Physicians could be either directly employed by the hospital or university (for university hospitals) or attending physicians (Nugus & Braithwaite, 2009; Seltzer et al., 2011), members of a physician group contracted by the hospital (Eisenberg et al., 2006), or physicians working in other specialty areas whose rotation included shifts in the emergency department (Muntlin et al., 2010).

Espoused Values and Beliefs, and Basic Underlying Assumptions

Schein's (2010) methodology for cultural assessment relies on an anthropological approach and in his own practice he spends significant time within organizations in order to get a picture of the values and beliefs the organization or its members have become attached to. Schein describes how certain beliefs or values are introduced to the group—usually by leader figures—and as these beliefs or values are shown to work by

providing "meaning and comfort to group members" (p. 26), and therefore solves the groups problems, they become shared. Beliefs and values then can transform into underlying assumptions. Schein describes this process as "(W)hen a solution to a problem works repeatedly, it comes to be taken for granted. What was once a hypothesis, supported only by a hunch or a value, gradually comes to be treated as a reality" (p. 27).

Sixteen of the articles had representations of these elements (Adams & Gerson, 2003; Eisenberg et al., 2006; Fry, 2012; Fry & Stainton, 2005; Hwang & Morrison, 2007; Kelly et al., 2011; Kihlgren et al., 2005; Khokher, Bourgeault, & Sainsaulieu, 2009; Liu, Chang, Camargo, Weissman, Walsh, Schuur, Deal, & Singer, 2012; Moss et al., 2008; Muntlin et al., 2010; Nugus & Braithwaite, 2009; Nyström et al., 2003; Sbaih, 2001; Seltzer et al., 2011; Ummenhofer, Amsler, Sutter, Martina, Martin, & Scheidegger, 2001). I have identified five main beliefs and values from the literature reviewed along with corresponding assumptions embedded in the culture of emergency departments that could impact care of the older adult.

The first belief was that emergency departments were for urgent cases (Adams & Gerson, 2003; Hwang & Morrison, 2007; Muntlin et al., 2010; Nyström et al., 2003). Those clients that were urgent—in many organizations defined by the triage nurses (Fry, 2012; Fry & Stainton, 2005; Nugus & Braithwaite, 2009; Nyström et al., 2003; Eisenberg et al., 2006)—were appropriate for the department. Those who were not

urgent were often labeled an "inappropriate attendee" (Nyström et al., 2003, p. 761) and staff believed these attendees did not belong in the department (Nyström et al., 2003; Muntlin et al., 2010).

The underlying assumption was that the department was "not the right place" (Kihlgren et al., 2005, p 606) for the older non-urgent adult because their care was not a priority in the department (Adams & Gerson, 2003). Staff assumed that older adults went to the department in order to obtain services in the community that they had difficulty accessing from home (Kelly et al., 2011). Clients should be really sick in order to use the emergency department (Chinnis & White, 1998). Some surgeons were perceived as assuming that many of the clients were not really critically ill (Muntlin et al., 2010) and should not have come to the department but directed elsewhere (Nyström et al., 2003).

The second belief was that the older adult did not receive the care and respect they should be given. This was reflected in statements such as "'…we need to show a little more respect for our old patients…we miss out on that, not only at the ED but also in the whole of society, Old people do not count there'" (Kihlgren et al., p. 604) and "'(E)very step along the way, you see where elders lose and lose and lose'" (Kelly et al., p. 9). One underlying assumption was that the older adult was not seen "'as a special population---with special needs'" (Kelly et al., 2011, p. 9) in the context of an emergency department with not enough staff to handle the workload.

The third belief was there was not enough time. Khokher et al. (2009) observed how "interactions were strained" (p. 336) if the client's needs—and hence demand on time—were higher than normal since the department's mission was dependent upon "rapid patient turnover" (Adams & Gerson, 2003, p. 2). Kelly et al. (2011) observed that "work with seniors take more time" (p. 9). Clients who wasted time took resources away from those more deserving (Fry, 2012) and slowed down the system (Adams & Gerson, 2003) to the point where the department was no longer in good "shape" (Sbaih, 2001, p. 268). The main assumption around time was that staff needed to be available for real emergencies and staff members therefore limited their engagement with clients (Nyström et al., 2003). This included not having time to take people to the bathroom (Hwang & Morrison, 2007), tune out the sounds of the distressed or scared older adult (Kelly et al., 2011), and ignore complainers when staff became busy (Nyström et al., 2003). Since most of the clients were not critically ill they could wait (Muntlin et al., 2010). This wait was not only unavoidable; it was seen as acceptable (Chinnis & White, 1998).

The fourth belief was that having well-functioning teams were important for both clients and staff satisfaction (Eisenberg et al., 2006; Moss et al., 2005). Teamwork was also seen as important when working with older adults (Adams & Gerson, 2003) or during resuscitation (Ummenhofer et al., 2001). Every team had shared attitudes and beliefs that were "'correct'" (Nyström et al., 2003, p. 765). There was an assumption

that nurses were unified within a team (Nyström et al., 2003) and an assumption about mutual respect within the nursing group since nurses were all going through the same thing (Khokher et al., 2009). There was also an assumption that there would be conflict between teams (Nyström et al., 2003) which led to an assumption that there would be unresolved conflicts between nurses (Khokher et al., 2009) and that emergency nurses eat their young (Keough et al., 2003).

The fifth belief was that emergency nurses felt that they were competent in looking after acute situations but they did not feel as competent at providing good nursing care (Kihlgren et al., 2005). Good nursing care was linked to the ability to meet patients' needs by having "enough time to provide good nursing care…(and that) the routines…would have to allow the patients to be met in a positive way and the nurses would have to be prepared to help the older patients" (Kihlgren et al., 2005, p. 607). Emergency nurses also expressed their preference for emergency nursing rather than bedside nursing, something that became an issue when patients had to wait long in the department for a hospital bed (Liu et al., 2012). Education was typically geared towards emergency nursing topics, general nursing care issues did not get the same priority (Kihlgren et al., 2005). Staff assumed that they knew what to do in a crisis situation (Eisenberg et al., 2001, Kihlgren et al., 2005) and that emergency department staff only needed to be proficient in emergency nursing or medicine (Chinnis & White, 1998) and to get the work done by applying "common sense" (Sbaih, 2001, p. 270). Emergency

nurses also assumed that visitors to the emergency department did not need nursing care since they were in the department to be seen by a doctor (Nyström et al., 2003). The care that was provided was assumed to meet the need of the clients (Nyström et al., 2003).

A number of additional beliefs arose from the articles that were included as a result of expanding the sample. The first belief was that emergency staff often feels neither respected nor supported by management and administration (Eisenberg et al., 2001; Keough et al., 2003; Khokher et al., 2009; Moss et al., 2008). Staff assumed that managers would turn over rapidly based on past history (Keough et al., 2003; Khokher et al., 2009: Eisenberg et al., 2006) and assumed that management did not matter, staff could do what they wanted (Eisenberg et al., 2006). There was also the assumption that staff could not trust administration due to its inability to deal with issues (Seltzer et al., 2011). The second belief was that both nurses and physicians lacked mutual respect (Keough et al., 2003; Seltzer et al., 2012) which was evident in a culture of blame (Seltzer et al., 2011) and the different cultures and philosophies of the different disciplines in the emergency department (Muntlin et al., 2010; Ummenhofer et al., 2001). These additional beliefs become important when managers or administrators contemplate cultural change.

Limitations

This scoping study was based on an anthropological approach to understanding organizations and their culture (Shein, 2010). This led to difficulties when I attempted to incorporate quantitative studies measuring concepts into an anthropological framework. One example of such a study is Mallidou et al. (2011) where the authors identified nurse specialty subcultures in acute care, including emergency departments. Consequently, two quantitative studies that were identified during the literature search were not included in the scoping study. This study was done as an individual project. It therefore suffers from bias formed from my own world view, my experiences as an emergency department nurse, and my experiences with older adults in emergency departments. The study does not include the optional element of consultation.

Discussion

In this scoping study I found only two articles that directly spoke about emergency department staff and their experiences with the older adult and two articles commenting on emergency department design and operation from the perspective of improving care of the older adult. This is too small a sample to warrant conducting a systematic review. However, by expanding the sample—as was done in this study—a sufficiently large sample of literature would be available for a systematic review focusing on the micro culture in emergency departments. This systematic review could

shed light on potential barriers for optimal care of the older adult presenting with non-urgent health experiences.

This study found several values and beliefs, and assumptions held by emergency department staff that reflect Schein's (2010) understanding of how the processes of external adaptation to the environment and internal integration impacts the formation of emergency departments micro culture. Examples of the external adaptation process were evident in both the artifacts—such as in the design and organization of the emergency department—and in the beliefs about the purpose of the department, who were appropriate or inappropriate attendees, the belief about not enough time, lack of respect for the older adult and how they were not seen as a separate group with special needs within the context of a busy department, that the department was not seen as the right place for the older adult, and the underlying assumption of having to be available for emergencies when they arose. Internal integration processes were reflected in the beliefs about teams, about respect—mutually within groups in the department, between disciplines and from management and administration—and about the nursing care that was provided to the older adult.

Conclusions

What I have documented through this modified scoping study is that there are elements of the micro culture of emergency departments that have been formed through the processes of external adaptation to the environment and internal

integration. These elements, such as values and beliefs, underlying assumptions, and artifacts represented through physical design, layout, and organization of emergency departments have potential to impact the care of older adults visiting emergency departments for health experiences that are not judged as urgent by emergency staff.

The move by some health care organizations to establish separate geriatric emergency departments (George, 2011; Rosenberg, Zionts, Karounos, & Bahar, 2010) might impact external adaptation to the environment and internal integration processes and thereby create a different micro culture in these departments. One measurable outcome from the establishment of geriatric emergency departments is a reduction in the rate of revisits to the department of the older adult (George, 2011). This finding has the potential to directly impact the number of visits to emergency department by older adults currently seen in traditional emergency departments. As the number of older adults increase, initiatives such as geriatric emergency departments might no longer be an option to explore, but a must in order for the acute care system to cope.

I suggest that a systematic review of literature that can shed light on the micro culture in emergency departments is warranted for several reasons. The first is that this scoping study clearly indicates that the current micro culture in emergency departments might have barriers towards optimal care for older adults, and that change needs to be contemplated. The second is to bring individual research efforts up to the level of summary on the evidence hierarchy (LoBiondo-Woods et al., 2013) in order to support

evidence based / informed practice changes. The third is that a systematic review may provide an approach that can allow a researcher to include both qualitative and quantitative research. One possible approach toward synthesizing this knowledge could be to use a systematic review protocol for literature from mixed sources such as the protocol outlined by Hoon et al. (n.d.). This systematic review could then be compared with systematic reviews already conducted or proposed on the experiences of clients visiting emergency departments (Gordon et al., 2010; Hoon et al., n.d.) with the goal to create a combined picture of the micro culture of emergency departments and the experiences of the older adult client. This picture could be an important element in discussions regarding future research and planning for allocation of resources to improve how the health care system meets the older adult at the front door—the emergency department.

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Appendix A

Table 2

Literature Included in the Scoping Study

Author	Title	Journal	Year	Type of article	Type of research	Sample	Location
Adams & Gerson	A new model for emergency care of geriatric patients	Academic Emergency Medicine	2003	Commentary			
Chinnis & White	Challenging the dominant logic of emergency departments: Guidelines from chaos theory	The Journal of Emergency Medicine	1999	Commentary			U.S.
Eisenberg, Baglia, & Pynes	Transforming emergency medicine through narrative: Qualitative Action Research at a community hospital	Health Communication	2006	Research concluding with a narrative	Qualitative action research	6 months of observation followed by thematic analysis and creation of narrative in collaboration with hospital staff and management	U.S.
Fry	An ethnography: Understanding emergency nursing practice belief systems	International Emergency Nursing	2012	Research, thematic data analysis	Ethnographic study	10 triage nurses from four ED's	Australia
Fry & Stainton	An educational framework for triage nursing based on gatekeeping, timekeeping and decision-making processes	Accident and Emergency Nursing	2005	Research, content and thematic analysis	Ethnographic study leading to development of an educational framework for ED nurses	10 triage nurses from 4 ED's	Australia
Hwang & Morrison	The Geriatric Emergency Department	Journal of American Geriatric Society	2007	Model of care			

Kelly, Parke, Jokinen, Stones, & Renaud	Senior-friendly emergency department care: an environmental assessment	Journal of Health Services Research & Policy	2011	Research, presented as an environmental assessment	Focused ethnography using observation, interviews, survey and hospital administrative data	Seniors or proxy decision makers, staff and key community informants	Canada
Keough, Schlomer, Bollenberg	Serendipitous Findings From an Illinois ED Nursing Educational Survey Reflect a Crisis in Emergency Nursing	Journal of Emergency Nursing	2003	Report of survey	Survey	900 ED nurses in Illinois	U.S.
Kihlgren, Nilsson, & Sørlie	Caring for older patients at an emergency department - emergency nurses' reasoning	Journal of Clinical Nursing	2005	Narrative from interviews	Interviews as part of a larger observational study	10 nurses from an ED	Sweden
Khokher, Bourgeault, & Sainsaulieu	Work culture within the hospital context in Canada: professional versus unit influences	Journal of Health Organization and Management	2009	Thematic analysis	Data collected until saturation	60 health providers from four different units; ICU, Head and Neck surgery, Maternity care, and ER	Canada
Liu, Chang, Camargo, Weissman, Walsh, Schuur, Deal, & Singer	A mixed-methods study of the quality of care provided to patients boarding in the emergency department: Comparing emergency department and inpatient responsibility models	Medical Care Research and Review	2012	Secondary data analysis from existing project plus interviews with health care providers	No particular approach to analysis of qualitative data reported	1431 charts for secondary data analysis from 2 ED's with different models for how to provide care for boarded patients. 2 ED residents, 4 medical residents, and 4 ED nurses included in the qualitative section	U.S.

Nugus & Braithwaite	The dynamic interaction of quality and efficiency in the emergency department: Squaring the circle?	Social Science & Medicine	2009	Thematic analysis	Ethnographic study	Observations and field interviews from two ED's	Australia
Moss, Walsh, Jordan, & Macdonald	The impact of practice development in an emergency department: a pluralistic evaluation	Practice Development in Health Care	2008	Pluralistic evaluation with thematic and integrative analysis	Individual and focus group interviews	Focus groups and individual interviews with ED staff and other stakeholders within the hospital.	New Zealand
Muntlin, Carlsson, & Gunningberg	Barriers to change hindering quality improvement: The reality of emergency care	Journal of Emergency Nursing	2010	Content analysis	Explorative design through interviews with focus groups, based on a previous patient survey	5 focus groups with 3 physician groups from different specialties, one LPN group, and one RN group	Sweden
Nyström, Dahlberg, & Carlsson	Non-caring encounters at an emergency care unit - a life-world hermeneutic analysis of an efficiency-driven organization	International Journal of Nursing Studies	2003	Thematic analysis	Life-world hermeneutic analysis	9 emergency nurses and 9 ED patients	Sweden
Sbaih	Shaping the future: reforming routine emergency nursing work	Accident and Emergency Nursing	2001	Commentary			
Seltzer, Gardner, Bichard, & Callison	PR in the ER: Managing internal organization-public relationships in a hospital emergency department	Public Relations Review	2011	Case study		650 employees in one ED	U.S.

Ummenhofer Amsler, Sutter, Martina, Martin, & Scheidegger	Team performance in the emergency room: assessment of inter-disciplinary attitudes	Resuscitation	2001	Report of survey	Questionnaire for assessment of attitudes and judgments in resuscitation procedures followed by factorial analysis	143 emergency department staff from different professions and disciplines	Switzerland

Appendix B

Table 3

Adams. J. A., & Gerson, L. W. (2003). A new model for emergency care of geriatric patients. *Academic Emergency Medicine, 10*(3), 1-4.

Artifact	Values and Beliefs	Underlying Assumptions
Ed design for ill or injured, central nurses and physician station enables maximal visibility of care rooms	"Emergency caregivers have known for many years that older people are not optimally served in modern ED's" (p. 1)	
Rapid treatment of emergent and urgent needs	"The current model of ED care was designed for the acutely ill and injured patient, not a medically complicated, slow-moving, functionally impaired geriatric patient. " p. 2	
	"The emphasis was, and remains, on rapid treatment of emergency and urgent needs" p. 2	
	"For older patients, it is more important than ever to work as a team" p. 3	

Table 4

Chinnis, A., & White, K. R. (1998). Challenging the dominant logic of emergency departments: guidelines from chaos theory. *The Journal of Emergency Medicine, 17*(6), 1049-1054.

Artifact	Values and Beliefs	Underlying Assumptions
		Waits are unavoidable and acceptable
		The customer is captive
		It is too expensive to deliver primary or non-urgent care in the ED
		The ED is for life threatening emergencies only
		Emergency care providers must achieve proficiency in critical care only
		More nurses, fewer ancillary providers means better care.

Table 5

Eisenberg, E. M., Baglia, J., & Pynes, J. E. (2006). Transforming Emergency Medicine Through Narrative: Qualitative Action Research at a Community Hospital. *Health Communication, 19*(3), 197-208. doi: 10.1207/s15327027hc1903_2

Artifact	Values and Beliefs	Underlying Assumptions
Front door	We can do as we please and treat improvement efforts as optional since there is no consistent leadership	
"Please do not enter while other patients are being triaged. Patients are seen in the order of seriousness or injury. Your understanding is appreciated"	Long wait, may languish for hours, patient expectations re violated and bottlenecks begin.	
Security guard	Waiting room an emotional place, most staff avoid going there	
Triage area both front and back door (leading to a more secure area)	Mob psychology: if one person loses it as a result of the long wait, others often follow suit, creating a chaotic and potentially dangerous environment	
Registration clerk behind glass	Practice of jumping the line bypasses and usurps the supervisor's power and authority, it is unfair to patients, and those who	

	participate in it tend to have an atypical experience of the ED	
	Staff stress and turnover result of stressful nature of the ED	
	Mixed feelings on behalf of the client at the time of initial assessment due to the long wait – irritation and relief.	
	Wait times have to be compared to the alternative—wait for apt with GP	
	The long waiting time due to delay in results due to lack of resources in support departments and communication and collaboration issues between these departments and the ED	

Table 6

Fry, M. (2012). An ethnography: Understanding emergency nursing practice belief systems. *International Emergency Nursing, 20*(3), 120-125. doi: 10.1016/j.ienj.2011.09.002

Artifact	Values and Beliefs	Underlying Assumptions
	Respecting space and privacy	If you have time to pack a bag or put on makeup you cannot really be sick
	Clients need to take control and responsibility – if you had taken something you would have felt better; I like to empower people to do something for themselves,. (Used to differentiate between the appropriate and inappropriate (not stated) visit(or))	
	Patients should not arrive with expectations; evidenced by a "positive bag sign", client had time to pack a bag before arriving, on the other hand, bag sign not always best indicator….	
	Clients should not ask for bed, this is the role of the triage nurse	
	Expect a level playing field, particularly in settings where the ED saw both public and privately	

	funded (through insurance) clients.	
	No benefit in having a referral letter from your doctor, the triage nurse will complete their assessment anyway.	
	Do not waste time, culturally timely and appropriate ED visit. Taking resources away from sicker patients	

Table 7

Fry, M. & Stainton, C. (2005). An educational framework for triage nursing based on gatekeeping, timekeeping and decision-making processes. *Accident and Emergency Nursing, 13*, 214-219. DOI: 10.1016/j.aaen.2005.09.004

Artifact	Values and Beliefs	Underlying Assumptions
	"'Triage Nurses need to keep order and control, you need fairness and equity that's what we have to do' (Peter) " (p. 215).	
	Triage nurses balance notions of urgent and non-urgent, appropriate and inappropriate, and right and wrong within gatekeeping processes	
	Triage nurses are time keepers	
	Triage nurses are decision makers	
	Triage nurses work with physicians to optimize timekeeping and patient safety	

Table 8

Hwang, U., & Morrison, R. S. (2007). The geriatric emergency department. *Journal of the American Geriatrics Society, 55*, 1873-1876.

Artifact	Values and Beliefs	Underlying Assumptions
Space is planned with the intent of quick patient evaluation and turnover; the physical layout of a traditional ED is focused on maximal use of resources. Privacy is forsaken at the expense of improving throughput so that curtains rather than walls serve as barriers between beds in an open-spaced ED allowing for greater staff maneuverability and placement of multiple patients in shared bays during periods of crowding p. 1873.	ED unique environment where highly specialized care is delivered to the acutely ill and injured and safety net care is provided to disenfranchised and vulnerable populations. p. 1873	We do not have time to take clients to the bathroom.
Narrow, thinly mattressed stretchers		Catheters save time otherwise used to change diapers, providing bedpans p. 1873
Floors designed for easy cleanup, slip hazard		
Ground floor to provide privacy (and access)		
Light fluorescent lights might promote		

disorientation in cognitively impaired elderly not exposed to regular day/night cycles.		
Noisy, monitor alarms and chatter of staff contributing to communication problems in older adults.		

Table 9

Kelly, M. L., Parke, B., Jokinen, N., Stones, M., & Renaud, D. (2011). Senior-friendly emergency department care: an environmental assessment. *Journal of Health Services Research and Policy, 16*(1), 6-12.

Artifact	Values and Beliefs	Underlying Assumptions
Orientation and wayfinding cues and access presented challenges p 8	Every step of the way you see where elders lose and lose	Feeling distressed when unable to meet care needs end up conditioning yourself, get so used to hearing it (help help)
Name tags often not legible	Appropriateness of nursing home referrals could be dealt without transfer to the ED, on the other hand, nursing homes sometimes waiting too long	Seniors visit the Ed as a way to access community or home care services because of problems accessing such services
Clothing did not distinguish between roles and responsibilities. 9	Seniors take more time p. 9	
Often placed in hallways waiting for tests, treatment or admission	You have to wait for the next set of enzymes	
Some service providers only available Monday to Friday		

Table 10

Keough, V. A., Schlomer, R. S., & Bollenberg, B. W. (2003). Serendipitous findings from an Illinois ED nursing educational survey reflect a crisis in emergency nursing. *JEN: Journal of Emergency Nursing, 29*(1), 17.

Artifact	Values and Beliefs	Underlying Assumptions
	Nurses concerned about the core of the problem but feelings of desperation over lack of concern (from health care leaders)	No respect for skill, loyalty, or expertise of staff, staff easily replaced by agency staff
		No incentive to stay
		No commitment from staff
		Younger nurses feel they deserve more money but working less
		Nurses eating their young
		Low morale, negative attitudes

Table 11

Khokher, P., Bourgeault, I. L., & Sainsaulieu, I. (2009). Work culture within the hospital context in Canada: professional versus unit influences. *Journal Of Health Organization And Management*, *23*(3), 332-345.

Artifact	Values and Beliefs	Underlying Assumptions
	In the ER for example doctors and nurses found it quite difficult to have any type of meaningful interaction with patients because their time with them was so brief: Usually they're not there long enough to…develop any type of relationship with them…basically you're going in and treating them and.. reassessing them and hopefully sending them home or admitting them to the floor	Animosity between groups of nurses – us vs. them, particularly in ED
	Constant pressure to treat as many as possible in order to minimize patient wait time	But also source of support: We have respect for each other because we're all going through the same thing
	When the individual's condition required more time and attention, several participants admitted that their interactions were strained	

	Poor leadership and high turnover	
	ED Second class citizen within the hospital hierarchy, no support, no resources to get the job done.	

Table 12

Kihlgren, A. L., Nilsson, M., & Sørlie, V. (2005). Caring for older patients at an emergency department – emergency nurses' reasoning. *Journal of Clinical Nursing, 14*(5), 601-608. doi: 10.1111/j.1365-2702.2004.01104.x

Artifact	Values and Beliefs	Underlying Assumptions
The Ed is divided into different units	Being knowledgeable also means being able to organize one's time in order to give them such treatment by giving them good care. "When I try to calm down and organize my work, often when there is not so much to do, then I can concentrate and take an active part in the care of many people, then it is good" p. 604	
	For the older patient to feel safe and secure the nurses have to possess the knowledge and understanding needed to be able to meet each patient as an individual and treat their family members well.	
	It is important to try to understand and have an insight into the older patient's situation, as they are in a strange environment. 604	

	Important being responsible as a guarantee of good nursing care..prerequisite for having the courage to meet the patients and their relatives even when the situation is difficult.	
	Good nursing care is prevented when there is simply not enough time available: “patients are in and out so quickly, often there is no time for anything more than medical care..there is not time to sit down, some patients demand this and everything needs it” 605	

Table 13

Liu, S. W., Chang, Y., Camargo, J. C. A., Weissman, J. S., Walsh, K., Schuur, J. D., . . . Singer, S. J. (2012). A mixed-methods study of the quality of care provided to patients boarding in the emergency department: comparing emergency department and inpatient responsibility models. *Medical care research and review : MCRR, 69*(6), 679-698. doi: 10.1177/1077558712457426

Artifacts	Values and Beliefs	Underlying Assumptions
	Work in ED for a reason, did not want to do bedside nursing, to the next thing and keep things going…When you are doing something you really do not want to do in an environment where you want to be, its frustrating.	The volume and acuity some days are so intense that by necessity these (boarded) patients are being neglected
	Would be better if we did not have to take care of patients with more acute care (than the boarders)	
	ED nurse's mindset of a.b.c… which ones do I have to see now, which one can wait and how do I get them to a point where they are either admitted or can go home. Given this mindset, giving the nurse a boarder while she also has	

	to look after a person with chest pain off the street--- did not work	
	Significant amount of time are required in caring for boarded patients...helping patients feel clean and comfortable “fluffing and buffing” takes considerable time when there is continual pressure to increase ED flow, often leading to staff stress and burnout.	

Table 14

Moss, C., Walsh, K., Jordan, Z., & Macdonald, L. (2008). The impact of practice development in an emergency department: a pluralistic evaluation. *Practice Development in Health Care, 7*(2), 93-107.

Artifacts	Values and Beliefs	Underlying Assumptions
"a complex, high pressure, stressful working environment" p. 101	Dysfunctional teams impacts patient care, changed team structure improved patient care and the culture	Lack of respect from management
Use of agency staff		

Table 15

Muntlin, A., Carlsson, M., & Gunningberg, L. (2010). Barriers to change hindering quality improvement: the reality of emergency care. *JEN: Journal of Emergency Nursing, 36*(4), 317-323. doi: 10.1016/j.jen.2009.09.003

Artifacts	Values and Beliefs	Underlying Assumptions
The patient is looked upon as an object or problem	Non-urgent patients were the reason for over-crowding and long waits in the ED	Many surgeons they do not care about waiting patients because they think that several of the patients are not really critical ill and therefore they can wait.
The physicians and nurses belong to different organizational cultures	Many patients shouldn't be there and hindered their ability to do good work	Many physicians down in the ED are just there and—just hoping that their shift will be over soon, It's a long, agonizing shift.
The hospital organization hinders the optimal flow of patients and improvement of quality	Lack of collaboration between the ED and other areas of care such as radiology, lab., other wards, and primary care centers which led to limitations in the ED care process, delays and duplicate work	You get rewarded if you don't admit patients to the wards

Table 16

Nugus, P., & Braithwaite, J. (2010). The dynamic interaction of quality and efficiency in the emergency department: Squaring the circle? *Social Science & Medicine, 70*(4), 511-517. doi: 10.1016/j.socscimed.2009.11.001

Artifacts	Values and Beliefs	Underlying Assumptions
Whatever the country, ED's are known colloquially as the front door of the hospital.	ED's organized according to patient acuity and urgency—the most seriously ill patients, or those requiring most urgent attention, were given priority	Short stay units in ED seen as a place to send patients to free up resources in the ED department
They are typically configured into sub-departments or areas—including the waiting room, triage des, ambulance bay, treatment cubicles, acute section, sub-acute section and the emergency medical unit—short stay.	ED staff are universally given or assume the task of meeting high standards of care for patients in this environment (enact quality care) while optimizing throughput and reducing waiting time (produce efficiency)	They're your patients, If they're particularly sick. See me…It's not fair to make them wait
Patient proceed in various trajectories through these locations	The goal of *accomplishing multiple, rather than single, patient trajectories*, was a function of experience and position, The more senior the clinical, the more they were responsible fro groups of patients rather than providing instances of care for individuals alone.	
Sub-departments of the ED	The importance of limiting	

presented options for providing clinical treatment appropriate to the urgency and acuity of individual patients and also facilitating the flow of *multiple patients* through the ED	test ordering in the diagnostic process to save time and money.	
	Triage nurse believe in efficiency	
	Being "part of the team" meant sharing an organizational culture which enacted efficiency—"keeps it moving".	

Table 17

Nyström, M., Dahlberg, K, & Carlsson, G. (2003). Non-caring encounters at an emergency care unit—a life-world hermeneutic analysis of an efficiency-driven organization. *International Journal of Nursing Studies, 40*, 761-769. doi: 140.1016/S0020-7489(03)00053-1

Artifacts	Values and Beliefs	Underlying Assumptions
Division of labour. All nursing personnel were stationed in specific areas. In each area, a registered nurse acted as a coordinator	Nursing staff are expected to have sufficient knowledge to be able to translate short instructions into specific actions. Principles and rules are of greater significance than caring needs, individual difference, and new ideas for problem solving.	ED staff complained about frequent visits from patients who could have been treated elsewhere 767
Nursing interventions appear to be carried out according to a system similar to a conveyor belt in industry	The most stimulating events were described in terms of acute medical interventions, especially when it concerns 'saving patients' lives'.	You can't stay too long with one patient. You must always be available for acute medical situations.
	Caring for old or lonely people. Some of whom had primarily psychosocial problems, was perceived as boring.	Our patients do not need nursing care, they are just waiting for a medical examination.
	Distinct and firm goals, as well as common goals,	Complainers can wait (be neglected) when I am busy

	were reported by the nurses to be important in order for the nursing work to run smoothly and without friction. The goals concerning medical tasks at the ED met these criteria. 766	(nurse)
	Nurses are supposed to direct clients to other care providers when we are busy (doctor).	All teams believed their own opinions and attitudes to be 'correct'. 765
	Surgeons don't want us to admit all patients who come to the ECU. Some of them should not be attending an ECU at all.	Within team we (nurses are unified, but it is problematic to substitute for a nurse in another team

Table 18

Sbaih, L. C. (2001). Shaping the future: reforming routine emergency nursing work. *Accident and Emergency Nursing, 9*, 266-273.

Artifacts	Values and Beliefs	Underlying Assumptions
	When clients took more time they slowed down the flow of the department to the point where the department was out of shape	
	Nurses get their work done by applying common sense	

Table 19

Seltzer, T., Gardner, E., Bichard, S., & Callison, C. (2012). PR in the ER: Managing internal organization–public relationships in a hospital emergency department. *Public Relations Review*, *38*(1), 128-136. doi: 10.1016/j.pubrev.2011.12.002

Artifacts	Values and Beliefs	Underlying Assumptions
Door volume is so high, I think that's part of what breeds the feeling to hunker down and just get through it		Perceived prevalence of uncivil behavior among the staff—nurses in particular—that includes simple bullying, as well as more serious threats p. 132
It's a little more of a bunker mentality of being under siege more		Physicians and nurses did not trust each other
The ED as a chaotic environment, In the ED we have ordered chaos.. p. 133		Administration is unable to deal with lateral violence and bullying—leads to lack of trust
Physical layout of the pods and size of hospital create problems for both nurses and physicians trying to locate members…difficulty connecting with attending physicians spread across multiple office buildings outside the ED.		Staff did not have control leading to cynicism
Physical barriers within Ed created a silo effect where		Blaming culture lacking in trust among the various

staff does not interact with each other..established exclusive territories within the ED, such as nurses laying claim to a break room		groups p. 134

Table 20

Ummenhofer, W., Amsler, F., Sutter, P. M., Martina, B., Martin, J., & Scheidegger, D. (2001). Team performance in the emergency room: assessment of inter-disciplinary attitudes. *Resuscitation, 49*. 39-46.

Artifacts	Values and Beliefs	Underlying Assumptions
	Teams important in resuscitation situations	Different cultures and philosophies among different disciplines in the department