

PROMOTING FUNCTIONAL STATUS OF OLDER ADULTS IN THE
EMERGENCY DEPARTMENT: EXPLORING NURSES' PERCEPTIONS OF CARE

by

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ABSTRACT

Older adults presenting to the Emergency Department (ED) are at risk for functional decline. Registered Nurses (RNs) in the ED are challenged to optimize the functional status of older adults in a dynamic practice environment with conflicting priorities and system demands. This interpretive descriptive qualitative study used elements of action research and visual methods to explore ED nurses' perceptions of care on promoting the functional status of older adults in the ED. Eleven purposefully selected ED RNs completed a questionnaire and participated in up to three focus groups. Study results suggest that improving the ED nurses' ability to promote the functional status of older adults in the ED can improve the wellbeing of older adults and ease nurses' moral distress. From a cost and quality of life perspective, the vulnerability of older adults toward functional decline and the vulnerability of ED nurses toward moral distress must be recognized and addressed.

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Chapter 1: Introduction

Older adults represent a large and growing subset of emergency department (ED) users who are susceptible to functional decline (Aminzadeh & Dalziel, 2002; Roethler, Adelman & Parsons, 2011). Registered Nurses (RNs) can influence the functional status of older adults in the ED through interventions to prevent functional decline (Boltz, Resnick & Galik, 2012; King, 2006); however, the traditional episodic, acute care, disease-focused model of emergency care is often inhospitable and insufficient to meet the unique needs of the aging population. RNs who endeavour to optimize the functional status of older adults in the ED are challenged to simultaneously manage a wide variation of patient needs and expectations in a, “fast paced, technologically dependent, intervention-intensive setting” (Parke, Beath, Slater & Clarke, 2011, p. 1427).

Research literature offers assessment and management strategies that RNs can use to maintain or improve the functional status of hospitalized patients (Boltz, Capezuti, Shabbat & Hall, 2010; Boltz et al., 2012; Doran, 2003; Graf, 2006; King, 2006), but it is lacking in information pertaining to the perceptions of RNs seeking to promote the functional status of older adult patients in the ED. The purpose of this study was to explore ED RNs’ perceptions of care on promoting the functional status of older adults in the ED of St. Mary’s General Hospital (SMGH) in Kitchener, Ontario and preventing their functional decline.

1.1 Background Information

Aging demographics. In July 2014, there was an estimated 35.5 million people living in Canada, of which approximately 15.7% were older adults (aged 65 years and older) (Statistics Canada, 2014). The number of older adults living in Canada is projected to increase to between 23% and 25% of the population (9.9 to 10.9 million) by 2036, and

between 24% and 28% (11.9 to 15.0 million) by 2061 (Statistics Canada, 2010). The life expectancy for a newborn Canadian in 2009 to 2011 was 79.3 years for males and 83.6 years for females (Statistics Canada, 2013). The number of Canadians aged 80 years and older is projected to reach one in three persons by 2036, and close to two in five persons by 2061 (Statistics Canada, 2010).

The population of Ontario represented more than 38% of the entire Canadian population in 2009, and is projected to reach 40% of the Canadian population by 2036 (Statistics Canada, 2010). An estimated 13.6 million people lived in Ontario on July 1, 2014 (Statistics Canada, 2014); this population is projected to grow to almost 17.4 million by July 1, 2036 (Statistics Canada, 2010). The life expectancy in Ontario is one of the highest in Canada and among the developed countries around the world (Ontario Ministry of Finance, 2013). In 2009 to 2011, the life expectancy for a newborn male born in Ontario was 79.7 years and a newborn female was 83.9 years (Statistics Canada, 2013). In 2036, the life expectancy for a newborn male is projected to be 85.3 years and for a newborn female 87.8 years (Ontario Ministry of Finance, 2013).

The older age group is expected to be the fastest growing segment of the Ontario population. There were approximately 910,000 Ontarians aged 75 and over in 2012, and this number is projected to double to over 2.2 million in 2036. The number of Ontarians over the age of 90 was approximately 96,000 in 2012, and is projected to more than triple to 291,000 by 2036 (Ontario Ministry of Finance, 2013). Although the future number of older adults in Ontario is projected to be slightly less than that in other provinces and territories across Canada, the annual growth rate in Ontario is projected to exceed that of the Canadian population as a whole (Statistics Canada, 2010).

Health of older adults. On average, older adults are living longer and are healthier

than ever before; however, with increasing age, they are also more likely to have a greater number of chronic conditions that contribute to functional disability and an increased use of health care services. In the 2008 Canadian Survey of Experiences with Primary Health Care, approximately 76% of adults aged 65 years and older reported having at least one of 11 chronic conditions (e.g., arthritis, asthma, cancer, chronic pain, depression, diabetes, emphysema or chronic obstructive pulmonary disease, heart disease, hypertension, a mood disorder other than depression and stroke) and 24% of this population reported having three or more of these conditions (Canadian Institute for Health Information [CIHI], 2011).

The risk of functional disability and cognitive impairment increases with age and are common features of frailty. These manifestations of chronic illness are normally measured as the inability to perform activities of daily living (ADLs) and are associated with the gradual loss of independence that often affects quality of life. An estimated 20% of adults aged 65 years and older, and as many as 35% of adults aged 70 years and older, have some degree of functional disability. The prevalence of cognitive impairment ranges from 4% in adults aged 65 to 69 years to greater than 36% in adults aged 85 years and older (Black & Rush, 2002). Physical and cognitive impairment are frequently described as the principal underlying cause of ED use by the older adult population (Gruneir, Silver & Rochon, 2011).

Individuals with chronic health conditions, functional disability and/or cognitive impairment are more apt to use health care services more frequently and more intensively than those without. As their number of health problems increase, so does the intensity of services used (Black & Rush, 2002; CIHI, 2011; Health Council of Canada [HCC], 2007). In 2012, the latest available year for data broken down by age groups, 14.9% of

Canada's population were over the age of 65, yet they accounted for over 45% of health care expenditures overall (CIHI, 2014a). Proactive steps are needed to sustain the health and social systems required to support the health and functional well-being of our aging population (CIHI, 2011).

Nursing workforce. Nurses constitute the largest group of paid health care workers in all of Canada (CIHI, 2010). Between 2005 and 2014, the supply of regulated nurses in Canada (i.e., group that includes RNs, Nurse Practitioners [NPs], Licensed Practical Nurses, and Registered Psychiatric Nurses) increased at an average annual rate of 1.8%; however, in 2014, the supply of RNs (including NPs) declined by 1%. In 2014, there were 406,817 regulated nurses eligible to practice in Canada and of these 293,205 were RNs or NPs (CIHI, 2015). In 2013, there were 408,093 regulated nurses eligible to practice in Canada and of these 296,029 were RNs or NPs (CIHI, 2014b).

The anticipated need for more nurses to provide more care to more elderly patients is obvious, but it is compounded by the fact that the nursing workforce is also aging and at a faster rate than the general population (Fitzgerald, 2007). The Canadian Nurses Association (CNA) (2009) projected a shortage of nearly 60,000 full-time equivalent RNs in Canada by 2022, if the health needs of Canadians follow previous trends and no policy interventions are implemented. In 2014, approximately 50% of the RNs in Canada and 53% of the RNs employed in Ontario were between the age of 40 and 59 years, while 13.5% of the RNs in Canada and 13.4% of nurses employed in Ontario were aged 60 years and older (CIHI, 2015; College of Nurses of Ontario [CNO], 2015). The current nursing shortage, which is predicted to last beyond 2020 (Fitzgerald, 2007; CNA, 2009), and the recruitment numbers that are not meeting current or projected demands (Special

Senate Committee on Aging, 2007; CNA, 2009) are sure to have an undesirable affect on the healthcare of our aging population.

Older adults in ED. Older adults use the ED more often than individuals in other age groups and the growing number of older adults with increasingly complex health care needs is a growing concern in EDs that are already experiencing overcrowding (Gruneir et al., 2011). The majority of older adults who seek ED care tend to be more acutely ill, have complex co-morbid conditions, need more diagnostic tests, wait longer in the ED, and are admitted to hospital (Aminzadeh & Dalziel, 2002; CIHI, 2011; Flynn et al., 2010). The ED length of stay (LOS) for older adults is 19% to 58% longer than patients in other age groups (Gruneir et al., 2011). ED crowding, poor patient flow, inadequate staffing and rising acuity of older patients in the ED contribute to their prolonged ED LOS (Donatelli, Gregorowicz & Somes, 2013).

An ED visit for an older adult is seen as, “a period of extreme vulnerability that extends beyond the visit itself” (Gruneir et al., 2011, p. 146). Older adults who are discharged home are at a greater risk of functional decline (10% to 45% at three months), repeat ED visits (24% at three month, 44% at six months), and institutionalization and death (10% at three months) (Aminzadeh & Dalziel, 2002; Roethler et al., 2011). For every hour spent in the ED, older adults who are admitted to hospital have a 3% increased chance of experiencing adverse events (AEs) such as delirium, infection, pressure sores and falls, a 4% increased chance of experiencing a medication-related AE, and a 5% increased chance of experiencing multiple in-hospital AEs (Ackroyd-Stolarz, Guernsey, MacKinnon & Kovacs, 2011).

St. Mary’s General Hospital. St. Mary’s General Hospital (SMGH), a 150-bed acute care hospital in Kitchener, Ontario, is located within the jurisdiction of the

Waterloo-Wellington Local Health Integrated Network (LHIN) and serves the needs of over 750,000 residents within the Region of Waterloo and surrounding municipalities. On average, more than 130 people are seen and treated each day in the ED of SMGH, which is open 24 hours per day, seven days per week (SMGH, 2012). SMGH does not currently have best practice guidelines or protocols in place to optimize the functional status of older adults in the ED and to prevent functional decline of this population.

Between April 2011 and March 2012, more than 26% (n = 12,777) of the total ED patient visits at SMGH, and more than 64% (n = 2,536) of the total number of admissions through the ED of SMGH, involved older adults. Approximately 18% (n = 709) of the admitted patients were aged 65 to 74 years, 26% (n = 1,019) were aged 75 to 84 years, and 20% (n = 808) were aged 85 years and older. Statistics concerning these ED visits provide evidence that a correlation exists between the age of ED patients and their ED LOS. The average ED LOS was 3.6 hours for those under the age of 65, 4.5 hours for those aged 65 to 74 years, 5.1 hours for those aged 75 to 84 years, and 5.7 hours for those aged 85 and older. Of the total number of ED patients who were aged 65 years and older, 77% (n = 9,854) had an ED LOS of less than 8 hours, 18% (n = 2,244) had an ED LOS of between 8 hours and less than 16 hours, 3% (n = 399) had an ED LOS of between 16 hours and less than 24 hours, and 2% (n = 260) had an ED LOS of 24 hours or more (D. Pletz, [SMGH Manager of Decision Support and Central Bookings], personal communication, October 31, 2012).

All nurses who worked in the ED of SMGH during this study were RNs. The Canadian Nurses Association (2004) said that RN staffing can be linked to, “positive patient outcomes” and, “(i)n acute care hospitals, the positive relationship between RN care providers and patient outcomes has been attributed to RNs, who have effective skills

for in-depth assessment and surveillance of clinical changes on an ongoing basis” (p. 3). These skills are important in the ED setting where patients are often unstable and acutely ill, but are they enough to address the complex needs of older adults in the ED of SMGH when applied to nursing practice with a goal of optimizing the functional status of this population?

1.2 Study Purpose

The purpose of this study was to explore ED RNs’ perceptions of care on promoting the functional status of older adults in the ED of SMGH and preventing their functional decline. I proposed that the information generated from this study would lead to new insights and a better understanding of the strategies and interventions used by the ED nurses, and the facilitators and barriers they encountered in their quest to provide care to prevent functional decline in older adults in the ED of SMGH. I am hoping that a better understanding of this phenomenon will prompt the ED nurses and hospital administrative staff to initiate and support changes to better meet the needs of the older adult population.

1.3 Study Aims

The specific aims of this study were to:

- explore the awareness, attitudes and experiences of RNs in the ED of SMGH with respect to functional decline in the older adult population;
- identify the strategies and interventions used by RNs in the ED of SMGH to maintain and/or enhance the functional status of older adults within the ED;
- identify what RNs in the ED of SMGH perceived as being the facilitators and barriers to providing quality care to prevent functional decline in older adults in the ED; and,

- identify what RNs in the ED of SMGH perceived as being the best approaches to improving care and preventing functional decline in older adults in the ED.

1.4 Research Approach

This study employed qualitative research methods guided by elements of action research. Purposeful sampling was used to recruit 11 ED RNs who volunteered their time to participate. All participants completed a questionnaire and were asked to partake in at least two focus groups. Eight semi-structured focus groups and one semi-structured personal interview complemented by the use of visual methods were used as the primary method of data collection and formed the basis for the overall findings of the study. The focus groups were conducted over three time waves. The focus groups and personal interview were tape recorded and transcribed verbatim. Data analysis was ongoing throughout the study using interpretive description methods informed by action research methodology. Field notes, which were documented by the researcher over the course of the study, were also used during the analysis process. Approval for conducting the study was obtained from the Research Ethics Board (REB) of Trinity Western University (TWU) (Appendix A) and the Tri-Hospital Research Ethics Board (THREB) for SMGH (Appendix B).

1.5 Researcher

While conducting this study, I was a student in the Master of Science in Nursing (MSN) program at Trinity Western University and employed on a full-time basis as a Geriatric Emergency Management (GEM) nurse in the ED of SMGH. Prior to that, I worked as: a Hospital Case Manager/Transition Planner for the Waterloo-Wellington Community Care Access Centre at Grand River Hospital (GRH) in Kitchener for three years; a Clinical Resource Nurse/ Discharge Planner on the inpatient surgical unit of

GRH for three years; an ED RN at GRH for 13 years; and, an ED RN at SMGH for three years. I brought to the inquiry process, practical experience as a working professional in addition to some knowledge and understanding of the environmental context.

1.6 Definition of Key Terms

There are several key terms that require clarification of meaning. The following is not an attempt at full definitions, but rather a means of explaining my understanding of these concepts and how they were used throughout the study.

Aging and old age. *Aging* is more commonly defined as a developmental process that begins at birth and ends at death; it does not lead to disease, but it does make humans more susceptible to illness (Pankow & Solotoroff, 2007). The process of aging in humans is accompanied by a, “myriad of changes” (Smith & Cotter, 2012, p. 23) that are more pronounced after the age of 85. Many of these changes occur as a result of a reduction in physiological reserve and end in organ systems becoming, “progressively less capable of maintaining homeostasis in the face of stresses imposed by the environment, disease, or medical therapies” (Smith & Cotter, 2012, p. 23).

Age can be viewed as a dimension of behavior and structure within a species, and the aged as a population of people categorized in terms of their expected lifespan (Bengtson & Bonder, 2009). *Chronological age* refers to the specific measurement of time (i.e., months or years) since an organism was born and it follows a predictable scale. *Biological age* refers to an organism’s position along the lifespan based on the level of development or deterioration of its biological systems and organs. Organisms of the same species can develop and deteriorate at different rates, so their biological age can be significantly different than their chronological age (Pankow & Solotoroff, 2007).

Chronological age by itself may be, “an insufficiently sensitive measure of

senescence” (Chodzko-Zajko, 2001, p. 30), but healthcare related programs and policies utilize the conventional language of chronological age, so this study deferred to its usage. The terms *older adult(s)*, *elder(s)*, *elderly*, *senior(s)*, *geriatric* and *older adult patient(s)* are used interchangeably to refer to person(s) who are aged 65 years and older. Additional terms to further distinguish the older adult population are also used: *young old* (aged 65 to 74 years); *middle old* (aged 75 to 84 years); *oldest-old* or *frail-old* (aged 85 years and older) (Bonder, 2009); *nonagenarians* (aged 90 years or older); and, *centenarians* (aged 100 years or older) (Banerjee, Dehnadi & Mbamalu, 2011; Iwata, Kuzuya, Kitagawa & Iguchi, 2006).

Functional status. *Functional status* is a “multi-dimensional construct” (Doran, 2003, p. 31) comprised of cognitive (e.g., concentration and attention), behavioural (e.g., completion of ADLs), social (e.g., activities relating to roles at various stages of development) and psychological (e.g., mood) elements. Various terms are used interchangeably in the literature to refer to functional status including: function; functioning; physical function; functional capacity; functional ability; functional performance; handicap; impairment; functional assessment; health status; activities of daily living; and, quality of life. Outcomes of functional status include: physical and social functioning; mental and cognitive functioning; role functioning; continence and mobility; home functioning; and, self care. A distinction exists between functional status (i.e., the actual performance of a given activity or function) and the ability or capacity to perform an activity or function (Doran, 2003).

Functional decline. *Functional decline* refers to a decline from baseline, of an individual’s physical ability to perform ADLs and instrumental activities of daily living (IADLs). Dimensions of ADLs include: eating; bathing; dressing; toileting; hygiene;

transferring; and, ambulation. Dimensions of IADLs include: housework; finances; driving; shopping; meal preparation; reading; medication adherence; awareness of current events; hobbies; employment; and, volunteer work (Krešević, 2012; Schnitker, Martin-Khan, Beattie & Gray, 2011). Functional decline can lead to persons being unable to perform activities that ensure their independence and may diminish quality of life, as well as result in return hospital visits, increased lengths of hospitalization, and institutionalization (Black & Rush, 2002; Creditor, 1993; Graf, 2006).

Study participants. *Study participants* refer to RNs who worked in the ED of SMGH at the time the study was conducted. They were employed on a full-time, part-time or casual basis and had varying levels of education and experience. All were currently registered with the College of Nurses of Ontario at the time of the study.

Emergency nursing. *Emergency nursing* is a specialty and in this study, it refers to the practice of RNs who worked in the ED of SMGH. Emergency nursing entails components of the nursing process, which includes assessment, analysis and diagnosis, planning, implementation and evaluation (Heilicser, 2013). The practice of emergency nursing also incorporates critical care nursing, because it includes the care of critically ill patients experiencing life-threatening conditions (Canadian Association of Critical Care Nurses [CACCN], 2009).

1.7 Outline of Thesis

This thesis is presented in six chapters. In Chapter One, background information is presented, along with the purpose and aims of the study, an overview of the methods used, and the definitions of some key terms. Chapter Two focuses on the search and retrieval strategy used for the literature review and the presentation of information related to the key elements and findings of the study. Chapter Three provides a description and

analysis of the research design, methodology and procedures used in the study. Chapter Four presents a summary of the study findings. Chapter Five focuses on a discussion of the study findings and further exploration of the literature relative to what is already known. Chapter Six provides a summary of the study's main findings as well as implications for organizations and future nursing education, practice and research.

Chapter 2: Literature Review

The purpose of this qualitative research study was to explore emergency department (ED) nurses' perceptions of care on promoting the functional status of older adults in the ED of St. Mary's General Hospital (SMGH) and preventing their functional decline. This chapter opens with a discussion of the search and retrieval strategy used for the literature review of the study, followed by the presentation of information related to the key elements and findings of the study. The topics of information presented include: older adults; older adults in the ED; functional status of older adults; functional decline of older adults in the ED; nursing care of older adults; nursing care to promote the functional status of older adults; nursing care in the ED; and, nursing care of older adults in the ED. Information pertaining to the study's overall theme of vulnerability and the concept of moral distress in nursing is also reviewed.

2.1 Search Strategy

Literature was obtained from various sources and a review of the literature was ongoing throughout the study. The types of materials gathered and read included: books; book chapters; articles; reviews; and, electronic media. A limited number of sources that reflected the perspectives of registered nurses (RNs) caring for older adults in the ED were found and the majority of these sources were obtained from a review of the references cited. The literature review did not yield previous studies about ED RNs' perceptions of care as it related to functional status and functional decline of older adults in the ED, but it did produce studies and sources of relevant information pertaining to aspects of the study.

The Cumulative Index to Nursing and Allied Health Literature (CINAHL) database was used as the primary electronic database. Numerous searches of this database were

conducted using CINAHL headings and key words. CINAHL is an extremely relevant database for nurses because it includes references for almost all English-language nursing and allied health journals, book chapters, books, selected conference proceedings and nursing dissertations (Polit & Beck, 2008). For this reason it was felt to be the most relevant and comprehensive electronic data source for the literature review.

A general search was conducted at the onset of the study and a more targeted, advanced search followed throughout the remainder of the study. The titles and abstracts of the articles/studies obtained from each CINAHL search were reviewed and the full text of the articles/studies felt to be potentially relevant were read in full to further scrutinize their relevance. The reference list of all articles/studies and other resources were also reviewed for other potentially relevant sources of information.

Preliminary search. A preliminary review of numerous textbooks, journal articles and resources relevant to the topic of functional decline of older adults in the ED was conducted to gather information for the grounding of the study. This involved a review of previous Trinity Western University MSN course materials, books and articles obtained from the library and nursing colleagues, a basic search of the CINAHL database, and a review of materials gathered from the references cited. Sources that did not pertain to nursing care to promote functional status or prevent functional decline of older adults in an acute care hospital setting were excluded.

The preliminary search of CINAHL was conducted using the subject headings MH “Emergency Service”, MH “Aged”, MH “Aged, 80 and over”, MH “Aged, Hospitalized” and MH “Functional Status” and the key term “functional decline”. The Boolean heading “OR” was used to group the subject headings related to the older adult population (e.g., MH “Aged”, MH “Aged, 80 and Over” and MH “Aged, Hospitalized”), and the subject

heading and key term related to function (e.g., MH “Functional Status” and “functional decline”). The Boolean heading “AND” was used to focus the search by combining the previous searches together with the subject heading “MH “Emergency Service”. The limiter of “English language” was also used. This search yielded 40 hits and of these, 22 articles/studies were found potentially relevant and read in full. Six of the potentially relevant sources were excluded after being read in full, and another 51 potentially relevant sources were obtained from the references of these papers.

Advanced search. An ongoing review of the information sources and the use of additional CINAHL searches were carried out throughout the remainder of the study and into the writing of this document to situate the findings in the context of what was already known (Speziale & Carpenter, 2007). Additional search terms used and combined with terms from the preliminary search included: MH “Functional Assessment”; MH “Geriatric Functional Assessment”; MH “Nursing Care”; MH “Nursing Practice”; MH “Emergency Nursing”; MH “Emergency Care”; MH “Vulnerability”; MH “Attitude”; MH “Perception”; key term “vulnerable”; and, key term “moral distress”. The use of the Boolean heading “OR” was used to combine similar subjects, and the Boolean heading “AND” and the limiters of “English language” and published date of January 2004 or later, were used to narrow the searches. Numbers pertaining to the results of the advanced search have not been included, due to the ongoing changes that occurred in the CINAHL database.

2.2 Data from Literature Review

Older adults. According to two surveys, the majority of older adult Canadians have one or more chronic health conditions and those with two or more conditions are more apt to report having a disability or being in poor health. Self reported data collected in 2005

using the Canadian Community Health Survey showed that more than 75% of older adult Canadians had at least one chronic health condition, and over 50% had more than one; 36% of the individuals with one chronic health condition and 51% with two or more conditions reported moderate to severe disability (HCC, 2007). Similarly, in the 2008 Canadian Survey of Experiences with Primary Health Care, approximately 76% of older adult Canadians reported having at least one chronic condition and 24% reported having three or more chronic conditions; those with three or more conditions were less likely to report good health (CIHI, 2011).

Functional disability and cognitive impairment are common features of frailty that increase with age. Older adults with chronic health conditions, functional disability and/or cognitive impairment are more apt to use health care services more frequently and more intensively than those without. As their number of health problems increase so does the intensity of services used (Black & Rush, 2002; CIHI, 2011; HCC, 2007). In 2009, only 14% of Canada's population were over the age of 65, yet they accounted for 40% of acute hospital stays and 45% of health care expenditures overall (CIHI, 2011). In 2012, the latest available year for data broken down by age groups, the percentage of Canadians over the age of 65 years increased to 14.9% and they accounted for over 45% of health care expenditures overall (CIHI, 2014a).

Older adults in ED. Older adults are frequent users of the ED due to the consequences of aging and an increased prevalence of chronic conditions, multiple medical issues and functional impairments (Black & Rush, 2002; Gruneir et al., 2011; Salvi et al., 2007). A cross-sectional survey of 40,253 ED visits done by Li et al. (2007) revealed that in the United States and Ontario, Canada, persons aged 75 years or older had a higher rate of ED visits than persons under the age of 75.

Wilber, Blanda and Gerson (2006) conducted a prospective, cross-sectional study of 90 ED patients aged 74 years and older, in a community teaching hospital in the United States, and found that 61% were dependent in at least one ADL, 68% were dependent in at least one IADL, and only 22% were completely independent in both ADLs and IADLs. They also noted that 75% of the patients who reported recent ADL decline and 65% who reported recent IADL decline said their decline contributed to their ED visit.

Older adults who visit the ED are a heterogeneous and complex population, with every older adult being different due to the combined effects of genetics, medical problems, environment, lifestyle, sociocultural influences and lifetime exposure to health habits (Hayes, 2000; Parke & Chappell, 2010). When they present to the ED, they are often difficult to diagnose due to the atypical presentation of symptoms, altered mental status, communication problems, co-morbidity and polypharmacy (Hayes, 2000; Rogers, 2009).

Older adults have distinct emergency care needs and are more likely to utilize Emergency Medical Services (EMS) than those under the age of 65 years (Aminzadeh & Dalziel, 2002; Gruneir et al., 2011; Shah et al., 2003). In a prospective cohort study of 930 non-institutionalized older adults who presented to the ED of an urban, academic medical center in the United States, Shah et al. (2003) found that 30% used EMS, with 27% being between the ages of 65 and 85 years and 48% being 85 years or older. The major reasons for their use of EMS included: acute illness symptoms; poor health status; limited functional status; and, requests made by persons other than themselves (Shah et al., 2003).

According to the systematic reviews conducted by Aminzadeh and Dalziel (2002) and Gruneir et al. (2011), when compared to younger persons, the majority of older adults

appropriately used ED services for the diagnosis and treatment of their health problems. They were also more apt to be acutely ill, have complex co-morbid conditions, need more diagnostic tests, require hospital admission and wait longer in the ED.

Gruneir et al. (2011) reported that the ED length of stay (LOS) for older adults was 19% to 58% longer than patients in other age groups. In an article presenting a case study to heighten awareness of how ED LOS might affect the outcomes of older adults presenting to the ED with a trauma situation or medical emergency, Donatelli et al. (2013) cited ED crowding, poor patient flow, inadequate staffing, and the rising acuity of older ED patients as factors contributing to their extended ED LOS.

Ackroyd-Stolarz et al. (2011) completed a retrospective cohort study at the largest adult tertiary care facility in Atlantic Canada between 2005 and 2006, to determine whether a prolonged ED LOS was associated with an increased risk of adverse events (AEs) for 982 community-dwelling older adults who were admitted to hospital. The AEs were events that occurred in-hospital after the patients were discharged from the ED and included delirium, infection, pressure sores and falls. Seventy-five percent of the study participants experienced a prolonged ED LOS as defined by the Canadian Association of Emergency Physicians (2009) guidelines (i.e., more than six hours for emergent or urgent conditions and four hours for those with less urgent and non-urgent conditions). They determined that for every hour an older adult spent in the ED, there was a 3% increased chance that he/she would experience a single in-hospital AE, 4% increased chance that he/she would experience a medication-related in-hospital AE, and 5% increased chance that he/she would experience multiple in-hospital AEs (Ackroyd-Stolarz et al., 2011).

Older adults discharged home from the ED are at greater risk for repeat ED visits (Aminzadeh & Dalziel, 2002; McCusker, Cardin, Bellavance & Belzile, 2000), which can

contribute to overcrowded EDs and be the result of relapsing chronic medical conditions, inadequate primary care for chronic conditions, psychological and social characteristics of patients, and poor quality of care at an initial ED visit (McCusker et al., 2000).

McCusker et al. (2000) completed an observational cohort study of 1,122 older patients who visited the EDs of four Canadian hospitals and found that 43% of the older patients returned to the ED one or more times, and 7.5% made three or more visits during the following six months. Return visits made within 30 days of the initial ED visit were considered potentially avoidable with better ED care.

The global population of oldest-old adults is projected to more than triple between 2010 and 2055 (World Health Organization [WHO] & National Institute on Aging [NIA], 2011) and with that comes the need to have a better understanding of their needs. Iwata et al. (2006) analyzed 275 ED visits of nonagenarians in Japan between 2002 and 2003. Seventy-eight percent of the nonagenarians in their study had problems with disability, 43% were referred from long term care (LTC), 15% were classified as an emergency, and 65% required admission to hospital. Only 1% of this population had health-care wishes in the form of advanced directives, which was significantly less than the average of 20% to 27% for ED patients in the United States. Banerjee et al. (2011) analyzed 259 ED visits of nonagenarians in England in 2009, and had slightly different results. Fewer nonagenarians in their study were referred from LTC (5%), but the proportion of those classified as an emergency (15%) and requiring admission (60%) were similar. A similar analysis of ED visits for oldest-old adults in Canada was not found.

Functional status of older adults. Boltz et al. (2012) defined functional status as, “a key determinant of quality of life for older adults” and the promotion of function as, “a basic gerontological tenet” (p. 104). Kresevic (2012) described physical functioning as, “a

dynamic process of interaction between individuals and their environments” (p. 89); a process that is influenced by physical capacity, cognitive ability, illness, motivation and the external environment including social supports (Krešević, 2012). The ability to perform day-to-day functioning (e.g., eating, bathing, dressing, ambulating, toileting, managing medications and managing money) is considered the foundation of health for older adults (King, 2006; Krešević, 2012).

Aging is associated with functional changes such as: reduced muscle strength and aerobic capacity; vasomotor instability; diminished pulmonary ventilation; increased propensity to confusion; altered sensation of appetite and thirst; fragile skin; decreased bone density; and tendency toward urinary incontinence. When these factors are superimposed on bed rest and hospitalization, a “cascade to dependency” (Creditor, 1993, p. 219) with a deterioration in transfer ability, mobility, toileting, grooming and feeding can occur in as little as two days (Creditor, 1993; Graf, 2006).

Functional decline of older adults in ED. Physical and cognitive impairments that limit independence and functionality are frequently described as the principal underlying cause of ED use by the older adult population (Gruneir et al., 2011; Hayes, 2000). Boltz et al. (2012) and Krešević (2012), cited risk factors for functional decline in older adults who present to hospital as being: acute illness; pre-hospitalization functional loss; an ED visit or hospitalization within the previous 12 months; presence of two or more co-morbidities; impaired cognitive ability and depression; pain; polypharmacy and medication side effects; malnutrition and nutritional problems; history and fear of falling; prolonged bed rest; decreased mobility; and, changes in environment or routines.

Conforti, Basic and Rowland (2004) conducted a study of 469 elderly ED patients in Australia to evaluate the effect of recent functional decline, measured in the ED, on

hospital LOS. They suggested that it was important to recognize older adults with recent functional decline, because they were more likely to have impaired physiological reserves and difficulty adapting to the effects of an acute illness, making them especially vulnerable to dependency. They proposed that barriers to conducting a geriatric assessment in the ED to alleviate the risk of functional decline in older adults included: short ED LOS; limited staff resources; high turnover of staff; lack of staff experienced to the special needs of older patients; and, inadequate continuity of care between the ED and community services.

Sirois et al. (2013) conducted a prospective multicenter study in the ED of three Canadian teaching hospitals between 2009 and 2011, to determine the cumulative incidence of functional decline and to identify the predictors of functional decline in independent older adults, three and six months after they sought ED treatment for a minor injury. They found that 14.9% of the population had functional decline at three months, and 17.3% had functional decline at six months, with the decline occurring most often in four ADLs: bathing; dressing; transferring; and, walking. The factors predictive of functional decline were: occasional use of a walking aid; need for help with instrumental activities of daily living (IADLs) before the injury; daily use of five or more medications; and, the ED physician's assessment of risk of functional decline. Other factors that were strongly associated with functional decline included: being 85 years of age and older; presenting with five or more co morbidities; and having a fall in the three months prior to the ED visit.

The development of functional decline in older adults following an ED visit was also noted in a systematic literature review conducted by Schnitker et al. (2011), to identify the range of negative outcomes and AEs in older people attending EDs. In their

review of ten papers, they found that short-term functional decline (≤ 3 weeks) was experienced in 10% to 52% of the older ED patients, and that three months after an ED visit, 6% declined in their ability to perform basic activities of daily living (ADLs) and 20% declined in their ability to perform IADLs.

Runciman, Currie, Nicol, Green and McKay (1996) conducted a randomized controlled study in Scotland with 424 ED patients, aged 75 year or older. Patients in their intervention group (n = 232) received a follow up home visit by a health visitor, most within 24 hours of being discharged from the ED. Prior to their ED visits, 26% of the intervention group were dependent in ADLs and 61% were dependent in IADLs. At the time of the follow up visit, 51% were dependent in ADLs and 83% dependent in IADLs. Four weeks later, most patients had returned to their pre-ED visit functional levels.

Nursing care of older adults. The attitudes, knowledge and beliefs of nurses and the characteristics of their practice environment are among the factors that can influence the quality of nursing care provided to older adults (Cheek & Gibson, 2003; Francis & Lahaie, 2012; Parke & Chappell, 2010). Liu, Norman, and While (2013) conducted a systematic search of eight databases covering English and Chinese language publications to explore RNs' and student nurses' attitudes towards older adults. In their review of 25 articles, they found that RNs had a slight decrease in positive attitudes towards older people since 2000. They also found that gender, age and education were inconsistent predictors of the nurses' attitudes toward older people, but that gerontology education and preference to work with older people were associated with positive attitudes toward the older population.

Wells (2004) conducted a paper-based survey with 727 health professionals in Australia, to compare nurses' attitudes toward aging and older adults with that of other

health professionals. Twenty-eight percent of the surveys were completed by nurses, 40% by physicians, and the remaining by other health professionals and aged care service providers. When compared to other health care professionals, nurses were found to have less accurate knowledge and higher anxiety about aging and were more likely to believe that working with older adults was associated with low self esteem. The nurses' level of reward in working with older adults was higher than the physicians, but similar to that of the other healthcare professionals.

Boltz et al. (2008) conducted a retrospective, descriptive cross-sectional study of data from a previous study (i.e., responses of 9,802 direct-care RNs from 75 acute-care hospital in the United States) to test the relationship between nurses' perceptions of a geriatric nurse practice environment and perceptions of geriatric nursing knowledge and delivery of geriatric care. They found that nurse characteristics of age, race or ethnicity, years of professional experience and level of academic education, and nurse staffing levels did not show a significant relationship with geriatric nursing knowledge. They did, however, find a significant relationship between positive geriatric care delivery and a positive geriatric nurse practice environment. Resource availability, capacity for collaboration and institutional values were perceived to influence the care of hospitalized older adults.

Cheek and Gibson (2003) conducted an exploratory qualitative study using 24 interviews, four focus groups and a nominal group of individuals from outside of their study site, to investigate issues impacting RNs' ability to care for older adults in a publically funded teaching hospital in Australia. It was perceived that: (a) many nurses and other health professionals lacked the necessary knowledge and skills to manage the complex needs of older people in the ED; (b) aspects of the ED environment including

the physical layout, patient mix, noise level, pace of activities, rigidity of routines and interactions with numerous personnel were obstacles to managing older adults' needs; and, (c) poor communication and fragmented care within various sectors of the healthcare system hindered continuity of care. They recognized the presence of tension in RNs who believed they had too little time to promote the independence of older adults, or who were unable to consistently meet the expectations of older patients, their relatives, other staff and/or management personnel.

Nursing care to promote functional status of older adults. Various nursing interventions can have an impact on the functional status of older adults in an acute care setting. Assessment of function in older adults is especially important because it can facilitate their diagnosis and the direction of care required (Bissett, Cusick & Lannin, 2013; Hayes, 2000; Salvi et al., 2007). Strategies recommended to maintain the functional status of hospitalized older adults include: completing a functional assessment of patients upon admission and at least once daily during their hospital stay; ensuring the use of eye glasses and hearing aids; having assistive devices available; ensuring adequate food and fluid intake; encouraging and assisting patients out of bed and into chairs especially for meals; offering toileting every two hours while patients are awake; providing patients with the opportunity to ambulate three times per day to the point of mild fatigue; and, doing range-of-motion exercises to prevent joint stiffness with patients who are unable to ambulate (Boltz et al., 2012; Doran, 2003; King, 2006).

Doherty-King and Bowers (2013) conducted a secondary analysis of data obtained from 25 RNs who worked on a medical or surgical unit of two urban hospitals in the United States, to explore the RNs' sense of responsibility for ambulating hospitalized patients. They found that the RNs were in one of two groups: those who felt that

ambulating patients was their responsibility or those who felt that it was the responsibility of others. Those who claimed responsibility focused on the need for patient independence and psychosocial wellbeing and described ways to overcome the barriers to ambulation. Those who attributed the responsibility to others focused on the potential for injury to self or patients. Being aware of the consequences associated with immobility had little effect on the RNs' practice, as it was their sense of personal responsibility that affected their actions. Unit level expectation was also found to be a powerful influence on encouraging the RNs toward change to ambulate the patients.

Nursing care in ED. The practice of ED nursing requires, “the acquisition and application of a specialized body of knowledge and skills, accountability and responsibility, communication, autonomy, and collaborative relationships with others” (Patrick, 2010, p. 4). RNs in the ED may assume the same roles (e.g., assessment, analysis and diagnosis, planning, implementation and evaluation) (Heilicser, 2013) as RNs practicing in other hospital settings; however, their practice environment is quite different. They must manage the care of an unpredictable number of individuals with unknown severity, urgency and diagnosis (Patrick, 2010) in, “fast paced, technologically dependent, intervention-intensive settings with shifting priorities and very wide variations in patients' needs and expectations” (Parke et al., 2011, p. 1427). ED settings are also culturally diverse and often plagued with limited resources (Patrick, 2010).

Nairn, Whotton, Marshal, Roberts and Swann (2004) conducted a systematic literature review on the patient experience in EDs and found, “evidence that the softer, caring aspects of care are under threat from an emphasis on efficiency where patients sometimes feel as though they are part of an industrial conveyer belt” (p. 162). Similar results were obtained by Wiman and Wikblad (2004) who completed a study to explore

caring and uncaring encounters between slightly injured ED patients and ED nurses on a trauma team in Sweden. They analyzed videotapes of five caring episodes involving 10 nurses and found 61 aspects of *uncaring* versus 36 aspects of *caring*. Care that was perceived to be uncaring involved care that was incompetent and indifferent, lacked trust, and entailed mutual avoidance between the patient and the nurse. They determined that the predominance of care of, “doing tasks and taking action on behalf of people” (Wiman & Wikblad, 2004, p. 428), which they termed *instrumental behaviour*, suggested that aspects of psychological care needed by ED patients was being missed by the ED nurses.

Nursing care of older adults in ED. In their descriptive overview of literature pertaining to the nursing care of older ED patients, Moons, Arnauts and Delooz (2003) said:

An accurate assessment of physical, mental, and social functioning, improved communication with patients and their families, improved co-operation with primary health care, and clear discharge guidelines will be at the forefront of efforts to optimise nursing care for this vulnerable group of patients (p. 119).

Hayes (2000) suggested that an appropriate ED assessment for older adults should involve, “accurate triage and identification of potential physical, psychological, and sociocultural problems” (p. 434).

Kelley, Parke, Jokinen, Stones and Renaud (2011) conducted a focused ethnography study in a hospital in Ontario, Canada to assess how the ED environment impacted the care of older adults aged 75 years and older. Using data from interviews with older adults or their proxy decision-makers, staff and community informants, on-site observations, a staff survey and hospital administrative data, they found that the expectations of seniors were often unmet and that ED staff experienced moral anguish

when recognizing these unmet needs. They proposed that better communication and coordination were needed between the ED and other components of the health care system.

Roethler et al. (2011) conducted a quantitative study in a large teaching hospital in the United States using surveys from 32 ED nurses and found that the ED nurses were unaware of their lack of familiarity and understanding of the needs of geriatric patients. Incongruence existed between the nurses' perceptions of knowledge and their knowledge about geriatric care. More than 80% of the nurses rated themselves as "good" or "very good" in their capability of providing geriatric emergency care but the majority gave themselves lower ratings when it came to diagnosing delirium (76%), providing end-of-life decision-making information (74.2%) and assessing polypharmacy (73.3%).

Fry, Gallagher, Chenoweth and Stein-Parbury (2014) conducted a study to explore the experiences and expectations of ED nurses with family and carers accompanying older adults to the ED of a university hospital in Australia. They conducted four focus groups with 27 nurses and found time was the most important theme. The nurses used time to judge the value of family/carers; family/carers were perceived as being helpful and supportive when they saved the nurses time and obstructive and demanding when they cost the nurses time.

Capezuti and Hamers (2013) said, "it is the nurse's perception of her own role that helps drive her ability and commitment to care provision that is directed by the individual's values, preferences, traditions, and strengths of older persons and their families" (p. 1154). This was also suggested by a comprehensive observational study conducted by Kihlgren, Nilsson and Sorlie (2005) to better understand what constitutes good nursing care for older patients in the ED. Kihlgren et al. (2005) interviewed 10 ED

nurses from a hospital in Sweden and the nurses in their study felt that being aware and understanding of older patients' situations was not enough. They felt that they needed to take responsibility for providing good nursing care and that the prioritization of tasks and routines was a threat to providing this care. The nurses were said to be, "working in a state of tension between an idealistic and realistic situation" (p. 607).

Olofsson, Carlström, and Bäck-Pettersson (2012) conducted open-ended interviews with 14 chronically ill Swedish ED patients, between the ages of 71 years and 90 years, to explore their ED experiences. Patients in their study indicated that their triage experiences were generally positive because the care that they received was prompt, competent, personal and established a respectful relationship, but beyond the triage encounter, they sensed inattention, indifference, lack of interest and poor communication, which left them feeling frustrated, isolated and alone.

Nikki and Lepistö, and Paavilainen (2012) found negative feelings of isolation and disappointment when they conducted nine interviews with family members of elderly ED patients in one Finnish ED. Family members in their study wanted to be active participants in the care of the elderly patients, but were often left feeling separated and like outsiders.

Meyer, Bridges and Spilsbury (1999) conducted an action research study to explore the organization of care for older people in the ED of a publically-funded hospital in the United Kingdom. They conducted 11 periods of observation tracking of individual older patients throughout the ED and had informal interviews with the patients, their caregivers and ED staff including nurses. They convened multidisciplinary workshops and conducted three focus groups and 11 one-on-one interviews with hospital administration, ED management and nursing staff to gather data on the gaps of care and the process and

outcome of change. They found a mismatch between the realities of the patients' needs and the nurses' perceptions of their roles, and an indication that older people might be low on the list of priorities of care for nurses as well as the organization as a whole. The overriding theme that emerged from their study was that more could be done for older patients in the ED.

Parke and Chapelle (2010) conducted a critical ethnographic study of three data sets from a hospital in Canada. Their data sets included a 12 week observation period in three areas of the hospital including the ED, and semi-structured interviews with eight older adults, three spouses and 14 hospital employees. In their study, they presented four older adult-hospital environment dimensions of fit (e.g., physical design, social climate, policies and procedures, and care systems and processes) and identified two groups of older hospital patients- those who were appropriate and 'fit' and those who were different or less appropriate and 'did not fit' within these dimensions. In their discussion of study findings, they said:

The issue is actually a combination of three factors interacting simultaneously- vulnerability, a high demand environment, and an inflexible system of care delivery. The lack of fit rests in the relationship between being an old and different patient in the context of a fast-paced acute intervention setting. Further, this study shows the incongruence between these patients' needs, and the demands of acute care environment result in troublesome work for hospital employees (p. 122).

Research literature shows that ED nurses providing care to older adults in the ED is a multifaceted issue with the potential for improvement. Unfulfilled needs and/or expectations of the older adults and their families/caregivers can influence and be

influenced by characteristics of the ED nurses, their practice environment and the health care system as a whole.

Vulnerability. The concept of vulnerability is complex and difficult to define. Purdy (2004) said being vulnerable includes, “being susceptible, likely to, liable to, at risk for, and/or having a chance of” (p. 28). Malone (2000), who conducted an interpretive ethnographic study using narratives of 30 ED nurses caring for patients who frequently visit the ED of two inner-city hospitals in the United States, said that vulnerability can be perceived as a factor of the relationships between personal resources and environmental supports or as a common, constant condition of all living beings. Results of her study suggest that a relationship of vulnerability exists between older ED patients and the nurses who care for them:

If an aim of nursing practice is compassionate engagement with patients, vulnerability cannot be conceptualized in terms of patient susceptibility alone ...

Vulnerability is an ever-present aspect of being human, and recognition of mutual vulnerability is a way to preserve on a societal level the value of caring for others (p. 10).

Spiers (2000) provided a way of looking at the concept of vulnerability from a nursing perspective based on a differentiation between the concepts of risk and experience. She stated that the *etic* or external evaluation of vulnerability was based on demographic characteristics, which are generally assumed to increase social dependence, and that the *emic* view of vulnerability was based on challenges experienced by the person, which places vulnerability in a psycho-social-cultural context. She added that vulnerability implies the potential for harm, but it could also be experienced as the potential for growth in, “a mutual rather than unilateral experience of health care

encounters” (Spiers, 2000, p. 720).

Moral distress in nursing. Moral distress in nursing has been described as, “painful feelings and/or the psychological disequilibrium that occurs when nurses are conscious of the morally appropriate action a situation requires, but cannot carry out that action because of institutionalized obstacles” (Corley, 2002, p. 636-637). It can manifest as frustration, anger, guilt, anxiety, loss of self-worth, resentment, powerlessness and helplessness and is associated with burnout, decreased job satisfaction and resignations (Corley, 2002; Fernandez-Parson, Rodriguez and Goyal, 2013; Zuzelo, 2007).

In their review of research literature on the topic of moral distress in nursing, Burston and Tuckett (2012) stated that the experience of moral distress in nursing is grounded in: (a) individual factors (e.g., character traits/personal qualities, world view, experience and nature of professional relationships); (b) site specific factors (e.g., resources, staffing, dimensions of care and organizational structures); and (c) broader external influences (e.g., economic factors at a more macro level, organizational policy and procedures and requirements of nursing practice standards, the law and third-party expectations).

Maben, Adams, Peccei, Murrells and Robert (2012) conducted a mixed methods case study in England using a patient survey, 18 staff interviews and 18 patient and caregiver interviews to examine the links between the staff’s experience of work and the older peoples’ experience of hospital care. They determined that there were times when staff felt obligated to make compromises in the care and dignity of patients so that their physical needs could be met quickly and safely. Most nurses in their study expressed feelings of frustration, guilt and low morale because of their perceived inability to offer good patient care to patients, especially to those who did not have urgent care needs.

Langeland and Sorlie (2011) conducted interviews with nurses to explore their experiences of ethical challenges in an ED in Norway. Narratives from the five RNs who were interviewed revealed their own vulnerabilities when relating to the suffering of their patients. Study results revealed that the nurses were in conflict with the system world and the life world- the dilemma of following the rules of the system and rationality, at the same time as having to abide by the true nature of care. The nurses felt it necessary to have tremendous capacity to cater to the needs of everyone simultaneously and found it difficult providing satisfactory care under those circumstances.

Fernandez-Parsons et al. (2013) conducted a quantitative, cross-sectional descriptive study using a questionnaire to assess the frequency, intensity and type of moral distress experienced by 51 ED nurses in a community hospital in the American state of California. The situation with the highest level of moral distress was found to be working with nurses or other health providers who were not as competent as the patient care required. Their study also showed that due to moral distress, 6.6% of the ED nurses left a previous position, 20% considered leaving a position and 13.3% were currently considering leaving their position.

2.3 Summary

This chapter presented the search and retrieval strategy used for the literature review and information pertaining to the key elements and findings of the study. The literature review was ongoing throughout the study and CINAHL was used as the primary electronic database to complement information gathered from other sources. Subject headings and key terms related to the key elements and findings of the study (e.g., older adults, ED, functional status, functional decline, nursing care, vulnerability and moral distress) were used along with the Boolean headings of “OR” and “AND” and the limiters

of “English language” and published date of January 2004 or later. There was no indication in the literature review to suggest that a study had ever been conducted to explore ED RNs’ perceptions of care on promoting the functional status of older adults in the ED and preventing functional decline within this population.

Research literature shows that older adults are more likely to have chronic health conditions, complex medical conditions, atypical presentation of symptoms and functional and cognitive impairments. These conditions contribute to their need to access EMS and ED services and add to the many challenges faced by ED nurses who strive to provide quality nursing care to patients of varying age and acuity in an unpredictable practice environment. Inadequate primary care and transitions of care were also found to contribute to the older adults’ need to seek ED services.

Research literature shows that older adults are more likely to have longer ED lengths of stay, return ED visits and be admitted to hospital than patients of other age groups. Issues contributing to their ED presentation have also been identified as risk factors for their development of functional decline especially when combined with prolonged bedrest, limited mobility, change in routines and loss of independence in the ED setting.

The concepts of functional status, vulnerability and moral distress, as well as the needs of older adults and the roles and responsibilities of ED nurses are dynamic and complex. Research literature suggests that nursing interventions can influence the functional status outcomes of older adults in the ED and be influenced by the characteristics and expectations of the older adults and their family/caregivers, the ED nurses and the ED nurses’ practice environment.

ED nurses who have a positive attitude toward older adults in the ED, adequate

knowledge and understanding of the older adults' needs, and a sense of responsibility toward the care that they provide, are more likely to meet the needs of the older adults in the ED and be satisfied with the nursing care that they provide. Incongruence between the needs and expectations of older adults in the ED and the demands of the ED's acute care, task-driven environment with a time-based focus on patient flow, can contribute to the vulnerability of older adults toward functional decline and of ED nurses toward moral distress. Vulnerability implies the potential for harm but it can also provide an impetus for change and the potential for growth.

The following chapter will describe the research methodology used in the study. Topics that will be discussed include: research design; sampling technique; recruitment process; data collection; data analyses; ethical considerations; and, measures of validity and reliability.

Chapter 3: Method

The purpose of this study was to explore emergency department (ED) nurses' perceptions of care on promoting the functional status of older adults in the ED of St. Mary's General Hospital (SMGH) and preventing their functional decline. This chapter describes the research methodology used in the study including the: research design; sampling technique; recruitment process; data collection; data analyses; ethical considerations; and, measures of validity and reliability.

3.1 Research Design

A qualitative design was used for this study. Qualitative research is grounded in human and social sciences and is used to answer questions, "concerned with human responses in a particular situation and context and the meanings that humans bring to those situations" (Powers, 2011, p. 435). The qualitative data used in this study included data gathered from eight focus groups, one personal interview, and field notes that were documented over the course of the study. A self-reported paper-based questionnaire was used to gather demographic and nursing practice information from each participant because the use of a questionnaire was the most convenient way to obtain this information.

The qualitative research methodology used in this study was based on interpretive description (ID) and elements of action research (AR). Interpretive description, an eclectic, inductive analytic qualitative approach rooted in nursing and the traditional qualitative methods of ethnography, grounded theory and phenomenology, is used to examine clinical phenomenon for recognition of patterns and themes among subjective perspectives while accounting for variations among the individuals (Hunt, 2009). Interpretive description provides a framework through which a variety of data collection

and analytic strategies can be used to create a product with, “empirical integrity and disciplinary utility” (Thorne, 2008, p. 18). What is known to the researcher through clinical interpretation or formal research is used in ID as the, “foundational forestructure to a new inquiry” (Thorne, Reimer Kirkham & MacDonald-Emes, 1997, p. 173).

Action research is a method of inquiry that uses collaboration between the researcher and participants to develop knowledge as well as raise consciousness and empower participants, with the goal of identifying and solving practical problems (Holter & Schwartz-Barcott, 1993; Polit & Beck, 2008; Reed, 2005). Action research is used to encourage members of a community, “to investigate their own social condition, to recognize political or environmental constraints operating on it, and to work collectively to improve it” (Melrose, 2001, p. 160). I combined ID methodology with elements of AR to produce rich and detailed data and create an impetus for change to better meet the needs of older adults in the ED.

There is research literature to suggest that various nursing interventions can have an impact on the functional status of older adults in an acute care setting (Boltz et al., 2010; Boltz et al., 2012; Doran, 2003; Graf, 2006; King, 2006), but I found very little concerning the perceptions of registered nurses (RNs) promoting the functional status of older adults in an ED setting. A qualitative approach that is committed to exploring the unique perceptions and experiences of ED RNs from their reality was therefore needed to further explore the practice of nursing as it related to this phenomenon. My intent was to examine and more fully understand the perceptions of RNs in the ED of SMGH to collaboratively determine and support the need for change, and to use what was learned to further nursing knowledge and research in this regard.

3.2 Research Sample

Sampling. This study utilized a combination of purposeful and convenience sampling. Purposeful sampling is the technique used to recruit specific individuals who have experience in a particular setting for the purpose of obtaining a greater understanding of a particular phenomenon (Thorne, 2008). Convenience sampling involves the selection of individuals who are available and willing to participate in a study (Hesse-Biber & Leavy, 2011). The purpose of this study was to explore ED RNs' perceptions of care on promoting the functional status of older adults in the ED of SMGH, so the participants had to be RNs who provided nursing care to older adults in the ED of SMGH. The majority of RNs in the ED of SMGH were required to do shift work and as such their availability and willingness to participate in at least two focus groups also had to be considered.

Recruitment. Recruitment took place over a 23-day period and involved the distribution of one hard copy invitation and three electronic invitations, as well as a printed poster advertisement. Only RNs who were employed in the ED of SMGH in March 2013 ($n = 60$) were invited to participate. An invitation (Appendix C) was placed in all ED RNs' internal SMGH ED mail files and an electronic version of the invitation (Appendix D) was sent to them through Medical Information Technology, Inc. (MEDITECH™), the information system used for staff communication at SMGH. Included in the electronic invitation was a proposed list of dates and times for five sets of two focus groups to be conducted at one of two locations (i.e., SMGH or Wilfrid Laurier University [WLU]), from which preferences could be chosen. An advertisement poster (Appendix E) was affixed to the bulletin board in the ED staff break room and another in their washroom. Written on the poster was a note directing individuals to look at their

MEDITECH™ email invitation for more information and the list of focus group options. All interested RNs were asked to self-identify themselves to the principal investigator in person or by e-mail or telephone.

Two additional electronic invitations were sent to the ED RNs following the initial invitation. The first of these invitations was sent nine days after the initial invitation and included a revised list of proposed focus group times and a deadline response date of 10 days from the date of that invitation (Appendix F); the second was sent eight days later and provided a reduced list of focus group dates and a one week extension of the previous deadline response date (Appendix G).

All RNs who expressed interest in participating in the study were given a participant information letter that clearly outlined information about the study goals, type of data being collected, estimated time commitment, list of potential risks and benefits from participating, pledge of confidentiality, voluntary consent, right to withdraw or withhold information at any time, and my contact information (Appendix H). I reviewed the information letter with all prospective participants and provided them with an opportunity to ask questions.

Participants. The study sample included 11 female RNs who had current registration with the College of Nurses of Ontario and worked in the ED of SMGH in March 2013 (Table 1). Nineteen percent of the participants were between the age of 30 and 39 years, 45% were between the age of 40 and 49 years and 36% were over the age of 50 years. All of the participants had at least six years of nursing experience and 64% of them had over 20 years of nursing experience. Fifty-five percent of the participants had up to 10 years of experience as a RN in the ED of SMGH, and the remaining had more than 10 years of experience. Sixty-four percent of the participants held a diploma in

nursing, and the remaining had a university education, with half holding a baccalaureate degree and half holding a master's degree. Four of the participants had achieved certification with the Canadian Nurses' Association (CNA): three in Gerontological Nursing and one in Critical Care Nursing.

Table 1

Participant Characteristics

Variable	n
Age (years)	
30 – 39	2
40 – 49	5
50 – 59	1
≥ 60	3
Experience as RN (years)	
6 - 10	1
11 - 20	3
21 - 30	4
30 +	3
Experience as RN in ED of SMGH (years)	
0 - 10	6
11 - 20	3
21 - 30	2
Nursing education	
Diploma	7
Baccalaureate	2
Master's degree	2
Geriatric education	
CNA certification in gerontology nursing	3

All of the participants attended at least two focus groups with the exception of one participant who voluntarily withdrew from the study after attending her first focus group session due to conflicting commitments. Fortunately, she consented to allow her data to be used in the study. Five participants attended three focus groups and one participant attended two focus groups and a personal interview which was conducted to accommodate her availability.

Compensation. Participants were on unpaid time for the focus groups and the interview. To show appreciation for their involvement, all participants were provided with food and beverages during the sessions. As a means of compensation, each participant received a \$10.00 Tim Hortons™ gift card and the opportunity to be entered into a draw for a \$50.00 Chapters™ gift card. Participants who attended the final focus group (i.e., validation session) had their names entered into an additional draw for a \$10.00 Chapters™ gift card.

3.3 Data Collection

The data collection strategies used in this study to solicit information and construct an understanding of what constituted data (Thorne, 2008) included: a participant demographic questionnaire; eight semi-structured focus groups and one semi-structured personal interview that incorporated visual methods; and, the researcher's detailed descriptive and reflective field notes.

Each participant was required to sign an informed consent form, of which they were given a copy (Appendix I), prior to completing the demographic questionnaire and participating in their first focus group or interview. This form was similar to the information letter, but had an additional section for signatures on the last page. Signing of the informed consent, ensured that the participants were voluntarily participating in the study and could withdraw from the study at anytime without repercussion; also that the data collected during the study would be kept confidential and in anonymous form for a period of two years following the completion of the study.

Participant questionnaire. Questionnaires can be used to provide supportive and/or corroborative data in a qualitative study (Bloomeberg & Volpe, 2012). In this study, a self-reported paper-based questionnaire (Appendix J) was used to collect

demographic and nursing practice information from each of the study participants; it was the only quantitative data examined in the study. The questionnaire was completed by all participants before the beginning of their first focus group or interview. The questionnaire requested information about the participants' age, gender, years of experience as a RN, years of experience as a RN in the ED of SMGH, nursing education and education specific to geriatric nursing, because it was felt that these variables could impact the perspectives of the participants in the study. For example, it was anticipated that age and level of RN experience might influence the participants' qualitative responses. Participant contact information was also requested, but only to be used in the event that a focus group or interview needed to be rescheduled or a debriefing letter and/or study summary needed to be mailed. Information from the questionnaire was used to complement the qualitative data obtained from the focus groups, personal interview and field notes.

Interviews. Eight semi-structured focus group interviews and one semi-structured personal interview (Table 2) complemented by the use of visual methods were used as the primary data collection strategy for this study. Semi-structured interviews are used when researchers want to ensure that certain topics are covered (Polit & Beck, 2008). Focus groups have the potential to provide, "high-quality data in a social context where people can consider their own views in the context of the view of others" (Patton, 2002, p. 386). All participants were asked to participate in two focus groups, but a personal interview was conducted to accommodate the availability of one participant. Visual methods are a unique qualitative approach to data generation and when combined with participant narratives, can provide ways to empower and encourage participants to define a problem of interest and elicit a greater understanding of the subject being discussed (Keller, Fleury, Perez, Ainsworth & Vaughan, 2008). The focus groups were conducted in a

private meeting room at SMGH and the personal interview was conducted at the participant's residence. The duration of the focus groups and personal interview ranged from 34 minutes to 102 minutes; all were digitally audio-recorded and moderated by the principal investigator.

Table 2

Interview Characteristics

Session	Number of Participants	Length of Session (minutes)
Wave 1		
Group 1	3	102
Group 2	2	76
Personal interview	1	55
Group 3	5	95
Wave 2		
Group 1	3	93
Group 2	2	78
Group 3a	2	87
Group 3b	3	78
Wave 3	6	34

Note. All but the personal interview were focus groups. Wave 2, Group 2 focus group involved one participant from Wave 1, Group 2 and the personal interview participant; the other Wave 1, Group 2 participant withdrew. Wave 1, Group 3 participants were divided into two groups (i.e., 'a' and 'b') in Wave 2.

The interviews were divided into three time waves (i.e., Wave 1, Wave 2 and Wave 3). All participants were asked to attend a Wave 1 and a Wave 2 focus group and given the option to attend the Wave 3 focus group. Three focus groups and one personal interview were conducted in Wave 1, four focus groups were conducted in Wave 2 and one focus group was conducted in Wave 3.

The participants were organized into one of three groups (i.e., Group 1, Group 2 or Group 3) based on their interview schedule. Group 1 and Group 2 each consisted of

three participants and Group 3 consisted of five participants. The composition of participants in Group 1 was the same for the focus groups in Wave 1 and Wave 2, but it differed in Wave 1 and Wave 2 for Group 2 and Group 3 due to participant availability. For Group 2, Wave 1 consisted of one focus group with two participants and one personal interview, and Wave 2 consisted of one focus group with two participants because a member of this group had withdrawn after participating in Wave 1. For Group 3, Wave 1 consisted of one focus group with five participants and Wave 2 consisted of one focus group with two participants (i.e., Group 3a) and another focus group with three participants (i.e., Group 3b).

Wave 1. All participants but the personal interview participant attended a Wave 1 focus group. The Wave 1 focus groups and personal interview began with a review of the processes for the interviews and led to a discussion prompted by questions from an interview guide (Appendix K). A written guide of questions prepared in advance of the interviews offers participants a good opportunity to provide rich, detailed data about the study topic (Polit & Beck, 2008). At the end of the Wave 1 focus groups and personal interview: (1) participants were asked to bring to Wave 2, a picture, object or symbol that represented an item that helped or hindered their ability to provide best practice care to prevent functional decline of older adults in the ED of SMGH; (2) a verbal formative evaluation was conducted (Appendix L); and, (3) the meeting times and anticipated attendance for the Wave 2 focus groups were confirmed.

Wave 2. All participants with the exception of the individual, who voluntarily withdrew from the study, attended a Wave 2 focus group. The Wave 2 focus groups had a two-fold purpose: first was to confirm and clarify information gathered from the Wave 1 focus groups and interview; and, second was to stimulate new data using visual methods.

At the beginning of the Wave 2 focus groups, a written handout summarizing the tentative themes produced by the analyses of the Wave 1 focus groups and interview were presented to the participants of each respective group (i.e., Group 1 summary [Appendix M] was given to Group 1 participants, Group 2 summary [Appendix N] was given to Group 2 participants, and Group 3 summary [Appendix O] was given to Group 3 participants). Following a discussion of the respective group summaries, participants who brought a visual item were asked to present them and discuss their significance. When time allowed, there was further discussion of the questions from the interview guide. At the end of the Wave 2 focus groups, a brief review and evaluation of the focus groups were conducted to determine whether the participants felt that the study aims had been met. A script of the informal review and evaluation can be found in Appendix P. A verbal invitation to attend the Wave 3 focus group was also extended to all participants, and those who expressed interest were notified of the date.

Wave 3. Not all participants were expected or required to take part in the Wave 3 focus group; this resulted in three participants from Group 1 and three participants from Group 3 attending. The goal of this final focus group was to provide final clarification of the data and validation of the emerging themes. At the beginning of this focus group, all participants were presented with a handout (Appendix Q), which was a collaborative summary of the tentative themes produced by the analyses of the data from all previous interviews. A brief presentation of the emerging themes in the handout was followed by a discussion of their validity. At the end of the discussion, draws were held for the \$50.00 and \$10.00 Chapters™ gift cards. The names of all participants were entered into the draw for the \$50.00 gift card, and the names of the participants who attended the Wave 3 focus group were entered into the draw for the \$10.00 gift card. Upon leaving the Wave 3

focus group, all participants in attendance were given a debriefing letter (Appendix R) and a \$10.00 Tim Hortons™ gift card. I personally delivered the debriefing letter and Tim Hortons™ gift card to the remaining five participants who did not participate in the last focus group within two weeks of the session.

Field notes. Descriptive and reflective field notes were documented from the onset of the study, during and after the focus groups and interview as well as during the analysis process to validate important points and facilitate emphasis on emerging themes (Speziale & Carpenter, 2007). Descriptive notes are used to provide objective information concerning context, actions, dialogue and details about observed conversations and events. Reflective notes are analytic notes regarding the researchers' thoughts and feelings and are used to help make sense of what is going on (Polit & Beck, 2008).

3.4 Data Analyses

Data collection and the process of constant comparative analysis were conducted concurrently throughout the study, beginning with the recruitment of participants and continuing throughout the interviews (i.e., focus groups and personal interview) and the waves of clarification and validation. This involved the practice of repeatedly reading, reviewing and cross-examining interview transcripts and field notes from many angles. Data was reviewed and summarized from the perspective of each participant, each interview, each time wave (i.e., Wave 1, Wave 2 and Wave 3) and each participant group (e.g., Group 1, Group 2 and Group 3); similarities and differences in data from and between the participants, interviews, time waves and participant groups were noted. Comments or themes that were detailed, shared by many participants and/or were expressed with increased emotion were given extra consideration. Narratives pertaining to personal clinical scenarios were also highlighted and considered during the analysis

process.

Verbatim transcription of interview audiotapes is crucial to data analysis in qualitative research (Polit & Beck, 2008). Due to time constraints, two research assistants were employed to assist with the verbatim transcription of four focus groups after signing a confidentiality agreement (Appendix S). I re-read their transcripts and edited them accordingly, to ensure that they were accurate and complete. After developing a greater appreciation for the costs involved and the increased benefits of being personally immersed in the data, I transcribed the audiotapes of the personal interview and the final four focus groups.

An interpretive description researcher is expected to comprehend data, synthesize meanings, theorize relationships and re-contextualize data into findings (Thorne, Reimer Kirkham & O'Flynn-Magee, 2004). As recommended by Thorne et al. (2004), I repeatedly immersed myself in the transcripts of the focus groups and personal interview before beginning to code, classify or create linkages. By asking broad questions such as, "what is happening here?", and, "what am I learning about this?" (Thorne et al., 1997, p. 174), I was able to capture the overall picture of the data and develop a sense of the common patterns and themes that were then used later in the analytic process to further develop my interpretation and understanding of the data (Hunt, 2009).

The transcripts and field notes from the Wave 1 focus groups and personal interview were read repeatedly to identify broad patterns and themes. The patterns and themes for the interviews of each group (i.e., Group 1, Group 2, and Group 3) were summarized under the headings of the interview guide questions and presented to the participants as a handout during the Wave 2 focus groups of their group for confirmation and clarification. A similar analysis was completed using the transcripts and field notes

from the Wave 2 focus groups to determine whether there had been a change in the existing patterns or tentative themes. A combined summary of the emerging themes from the data of all Wave 1 and Wave 2 interviews was presented to participants in the Wave 3 focus group for final clarification and validation, to ensure that there had not been any serious misinterpretations or omissions of critical information. Data from the eight focus groups and personal interview were then amalgamated and analyzed as one.

The conceptualization of the conjoined data began with the coding of interview transcripts and grouping of prevalent topics under the categories of the study aims. This included: (a) awareness and attitudes of the ED RNs with respect to functional decline in the older adult population; (b) strategies and interventions used by the ED RNs to optimize the functional status of older adults in the ED; (c) facilitators to providing care to prevent functional decline of older adults in the ED; (d) barriers to providing care to prevent functional decline of older adults in the ED; and, (e) best approaches to improving care and preventing functional decline in older adults in the ED. Upon further review and reflection of the data that was summed up on a coding summary chart (Appendix T), the topics were repeatedly regrouped under six subthemes and the overarching theme of vulnerability emerged. The conceptualization of the findings is discussed in greater detail in Chapter 4.

3.5 Ethical Considerations

Prior to the recruitment of participants and the collection of any data, ethics approval was obtained from the Trinity Western University Research Ethics Board (TWU REB) and the Tri-Hospital Research Ethics Board (THREB). THREB is responsible for granting approval for research conducted at SMGH.

A number of steps were taken to ensure the anonymity of study participants, even

though confidentiality could not be guaranteed because the study involved focus groups where participants were known to each other (Patton, 2002). A request for privacy and confidentiality was written in the information letter, consent form and debriefing letter and a verbal request for privacy and confidentiality was made at the beginning of each focus group. The research assistants who were employed to transcribe audiotapes were also asked to sign a confidentiality agreement. All participants were given the opportunity to attend focus groups away from SMGH. During the collection and analyses of the data, participants were coded as EDRN1, EDRN2, etc.; actual names were not used in any of the transcribed reports or in any of the quotes. All information gathered throughout the study, including the participants' contact information, demographic questionnaires, signed consent forms, audiotapes, hard copies of the transcripts, and electronic data stored on a password encrypted USB drive, are being kept in a locked cabinet in a locked office. All paper based files and electronic files will be kept for a period of no more than two years. At that time, I will shred the paper- based files and wipe the USB drive.

This study utilized elements of action research (e.g., collaborative participation of the researcher and participants toward the potential promotion of change) and the researcher was an 'insider', who worked with the participants in the practice setting, so the issue of power had to be considered (Löfman, Pelkonen & Pietilä, 2004; Speziale & Carpenter, 2007). At the beginning of the focus groups and the personal interview, participants were informed that there were no right or wrong answers. Whenever possible, the participants were allowed to direct and control the discussions that took place. Throughout the process of data collection and analyses, the researcher ensured that the focus was placed on the 'voice' and the needs of the participants.

3.6 Validity and Reliability

In qualitative research, issues of validity and reliability refer to the rigor or trustworthiness of results (Merriam, 2009). Validity is the degree to which suppositions made in a study are correct and well-substantiated. Reliability is the degree to which study results are consistent or dependable (Polit & Beck, 2008). Lincoln and Guba (as cited in Polit and Beck, 2008) offer four criteria for trustworthiness: credibility; confirmability; dependability; and, transferability. The strategies used to help establish the trustworthiness of this study are presented with a focus on these four criteria.

Credibility refers to how the research findings compare to reality from the standpoint of the researcher, participants and reader (Bloomberg & Volpe, 2012; Merriam, 2009) and triangulation is a technique that can be used to achieve credibility (Cohen & Crabtree, 2006). Triangulation refers to the collection of data from the same or different sources by multiple methods to establish a trend (Melrose, 2001). I used data from the focus groups, personal interview, visual items and field notes to validate my conclusions during the analysis process (data triangulation). The focus groups involved different participants and a varying number of participants per session and this helped to validate data on the phenomenon from multiple perspectives (person triangulation) (Polit & Beck, 2008).

Triangulation and respondent validation were used as safeguard methods to address my subjectivity and strengthen the trustworthiness of the study. Respondent validation is a strategy that can help ensure credibility as well as confirmability. Confirmability implies that the study findings reflect the voices of the participants and the conditions of the research (Merriam, 2009; Polit & Beck, 2008). Confirmability was sought by summarizing findings from the Wave 1 focus groups and personal interview and

presenting them to participants for clarification and confirmation during the Wave 2 focus groups, then summarizing findings from the Wave 1 and Wave 2 interviews and presenting them to participants for validation during the Wave 3 focus group.

Dependability typically refers to reliability or the extent by which study findings can be replicated; however, for qualitative research it relates more to the consistency between the study results and the data collected. Triangulation, which was already discussed, is one strategy that can be used to help ensure dependability (Merriam, 2009). Another strategy that can and was used in this study was the maintenance of notes with details on how the data were collected, how the themes were derived and how the decisions were made over the course of the study.

Transferability refers to the extent by which study findings can be transferred or applied to other groups or settings (Merriam, 2009; Polit & Beck, 2008). Results of this study are unique to SMGH; however, individuals interested in the phenomenon might see transferability as a realistic possibility should they be involved with similar participants and in similar settings.

3.7 Summary

This chapter provided a detailed description of the methodology used in this study and included information on: the research design; sampling technique; recruitment process; data collection; data analyses; ethical considerations; and, criteria of trustworthiness. Qualitative research methodology, quantitative and qualitative data, and a qualitative approach known as interpretative description along with elements of action research, were used in the study. Volunteer participants were recruited using purposeful and convenience sampling techniques. Data collection strategies included: a participant questionnaire, eight focus groups and one personal interview complemented by visual

items; and, field notes. Data collection and concurrent data analyses was ongoing throughout the study and involved the process of constant comparative analysis. Ethical issues including the need to protect the anonymity of all participants were addressed. Strategies used to establish the trustworthiness of the study, namely the issues of credibility, confirmability, dependability and transferability were also discussed.

The next chapter will provide a discussion of the study's findings, which includes the presentation of the study's overarching theme of vulnerability and the subthemes or influential variables of: ED nurses; older adults in the ED; the ED nurses' practice setting; the ED nurses' roles and responsibilities; the family/caregiver(s) of older adults in the ED; and, the community links of older adults in the ED.

Chapter 4: Findings

The purpose of this study was to explore emergency department (ED) nurses' perceptions of care on promoting the functional status of older adults in the ED of St. Mary's General Hospital (SMGH) and preventing their functional decline. Eleven Registered Nurses (RNs) who worked in the ED of SMGH participated in the study. Study findings were produced by the analysis of data gathered from a participant questionnaire, eight semi-structured focus groups and a semi-structured personal interview, visual items shared by the participants during the interviews and the researchers' field notes that were documented over the course of the study.

This chapter opens with the presentation of the study's overarching theme of vulnerability, followed by the presentation of findings relevant to the subthemes or influential variables of: ED nurses; older adults in the ED; the ED nurses' practice setting; the ED nurses' roles and responsibilities; the family/caregiver(s) of older adults in the ED; and, the community links of older adults in the ED.

4.1 Overarching Theme: Vulnerability

Vulnerability emerged as the overarching theme of the study: (1) older adults in the ED are vulnerable to functional decline; and, (2) ED nurses, dissatisfied with the care that they are able to provide to promote the functional status of older adults in the ED, are vulnerable to moral distress. The participants perceived that characteristics of the ED environment did more to promote functional decline than it did to promote the functional status of older adults. They identified the ED environment as a barrier to the ED nurses' ability to fully practice the art of nursing, contributing to their vulnerability to moral distress.

The concept of vulnerability became linked to the ED nurses' perception of care

provided and its association with the *functional status of older adults in the ED* and the *ED nurses' satisfaction of care*. Several interrelated variables found to influence the nursing care provided and received include: the ED nurses themselves; the older adults who present to the ED; the ED nurses' practice setting; the ED nurses' roles and responsibilities; the family/caregivers of the older adults in the ED; and the community links of the older adults who present to the ED (Figure 1).

Figure 1. Influential Variables in the ED Practice Setting

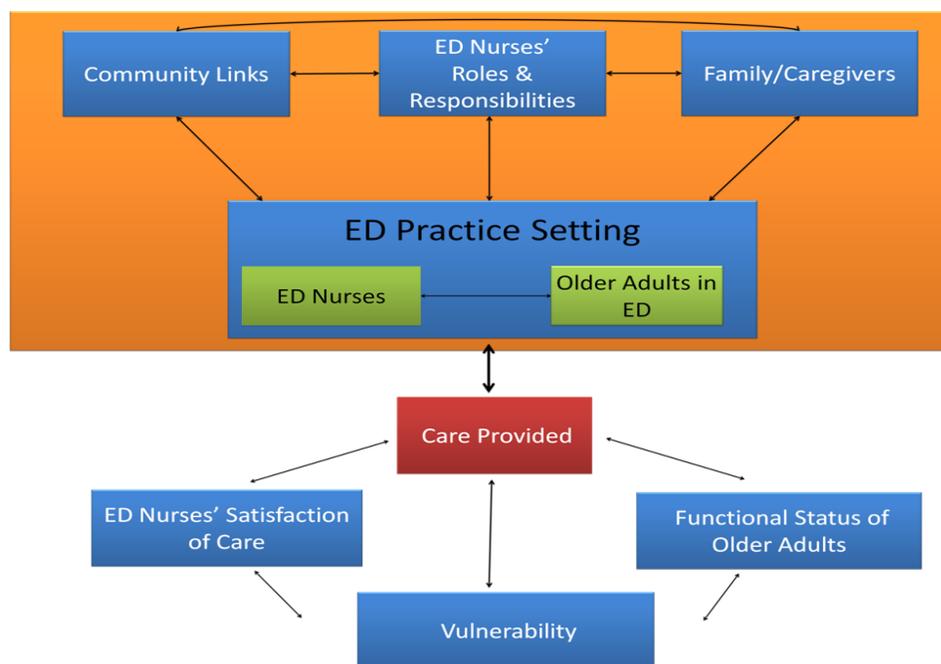


Figure 1. The diagram demonstrates the influential variables contributing to the vulnerability of older adults and nurses in the emergency department.

4.2 Influential Variables

Through the coding of data and the ongoing process of constant comparative analysis, various topics were identified and groupings were made. Data was initially sorted and organized under the groupings of: advocacy; ageism; assessment; care in the past; community; communication; competing priorities; computers and technology; documentation; ED environment; ED nurse; end-of-life; falls; family; functional decline;

functional status; nursing care; older adult; organizational support; and, resources. From this, the data was regrouped under the headings of ED RNs, ED RN roles, older adults, ED physical environment, social culture, and human resources. Upon further review and reflection of the topics, the concept of six influential variables emerged: ED nurses; older adults in the ED; ED practice setting; ED nurses' roles and responsibilities; family/caregivers of older adults in the ED; and, community links of older adults in the ED.

ED nurses. The age, experience and education of ED nurses were perceived to influence the attitudes they had toward older adults in the ED and the nursing care that they provided to the older adults and their family/caregivers.

Age. Three participants believed that with age, the attitudes ED nurses had toward older adults could change. One participant said, "I've always been more interested in older people, but I think as you get older ... you think more of your own feelings ... and you can empathize with them a bit more." Another participant felt that both age and personal experience could affect ED nurses' attitudes, "in our profession, you change with your own age ... older people may annoy you until your parents ... are aging or your family member."

An outlier to this influential modifier was expressed disagreement as to whether the age of ED nurses might affect the care that they provided to older adults. One participant, who believed that younger nurses were not as good or confident in their practice said, "A good young nurse will not have the confidence! It's the ones ... that are young with the confidence ... that scares me most." Another participant who felt that the care provided was not dependent on a nurse's age said, "I've seen some younger nurses give some awfully good emotional and physical care ... I think you're more aware as an older person ... but I don't think ... that their care is jeopardized just because, they're

younger.”

Experience. Three participants believed that ED nurses with experience were more comfortable and confident in their care of older adults. One participant expressed, “expert nurses ... they’ve got experience ... They may be in an area and it might twig them—oh my goodness ... I’m worried about this—and [they] have the confidence and experience ... to [act].” A different participant suggested that ED nurses who had experience were, “more fluid and dynamic in [their] thinking.” Another participant alleged that an experienced nurse would be, “more comfortable” dealing with family/caregivers of older ED patients.

Education. One participant described ED nurses as, “highly educated and trained people,” who, “come from a wide, diverse background,” and this was supported by data gathered from the participants’ questionnaire; however, five participants admitted to having limited knowledge concerning the older adult population and expressed the need for additional education to enhance their care. One participant said that it would be “beneficial” if ED nurses were educated and re-educated, “for the demographics that we serve” and that there was a need to know, “what is our role when we have elderly people.” She admitted that she had not given much thought to the topic of functional decline of older adults in the ED before she became involved in the study and since then had come to believe that, “we need to be educated about what to look for.” Another participant shared that she witnessed several occasions when ED nurses were offered educational opportunities to learn more about the treatment and care of older adults, but did not engage; “a couple of times ... I’ve gone to huddle and I had a student who tried to do a couple of things ... they just ... fluffed her off.”

Older adults in ED. All participants perceived that older adults in the ED were complex heterogeneous individuals and that the concept of functional status was, “as complex as the patients themselves.” They recognized that there were several aspects of older adults’ functional status including physical, cognitive, mental and emotional. One participant described the functional status of older adults as, “being dynamic ... somebody might be functional one day and then you see them in Emerg and they’re completely ...not looking, how they tell you they were two days ago.”

Various words were used throughout the focus groups and personal interview to describe older adults and most of these words and phrases implied an element of functional inability or decline: *weak; frail; not as vibrant as younger patients; time consuming; unhappy; unkempt; distressed;* and, *in need of more help.* Two participants perceived that there was a difference between an “older adult” and an “elderly person;” one of them said:

I see an older adult as a more healthy, functioning older person. I see an elderly person as not functioning as well and being in more, under more ... physical and cognitive decline ... they might, could be 80, they could be 90, but if they’re walking, talking ... I’ll see them as an older adult.

Six participants remarked that the functional ability and capacity of older adults were more significant than their chronological age. One of the participants said, “We’ve all had a 90 year old who can do a cartwheel into the bed ... and then we’ve had a 50 year old ... who you have no idea how they ... get up in the morning ... or get themselves dressed.”

Four participants believed that the appearance and functional abilities of many older adults changed as soon as they presented to the ED. One of the participants said:

I find personally ... as soon as they ... come in by the ambulance ... they go into a stretcher, and then suddenly they can't do things that they normally do for themselves ... walking to the bathroom, or sitting at the bedside, and ... I don't know, because they're not feeling well? Or whether they feel that they ... are not allowed to ... or whether it's just, the environment that does it? Somehow their functional status decreases.

Another participant suggested that this could be the result of chronic health conditions, "I find ... some people have chronic health issues, multiple chronic health issues and they're used to being, cared for, even if they're capable of doing more ... are gonna assume that you're gonna do everything for them."

Seven participants perceived that older adults with cognitive deficits were an extra challenge for ED nurses. One participant said, "the physical function ... you can see it ... but, I find the mental one, even though we've seen it forever and ever and ever ... they still pull the wool over my eyes." Another participant expressed feelings of frustration related to this challenge:

It can be a lot more work to deal with a confused patient ... and sometimes you can reorient them, sometimes you can't ... it can be frustrating. It can be frustrating because ... it is so labour intensive and you ... can be so consumed with that patient ... you really can't do the job ... you're tied up with that one patient so much ... you're concerned about that patient, 'cause your biggest fear is that patient is gonna, crawl out of bed and fall ... it can wear you down.

ED practice setting. All participants perceived that aspects of the ED practice setting had a negative impact on the functional status of older adults and the fulfilment and satisfaction of care provided by ED nurses to support the older adults' functional

abilities; this included the setting's physical environment and social climate. Three participants presented pictures to emphasize their concerns about the ED practice setting: one picture was of an ED treatment room, three pictures were of equipment items not readily available in the ED, and two pictures were of items that were routinely used in the ED.

Physical environment. Eight participants identified physical design and all participants identified lack of appropriate equipment as barriers to optimizing the functional and associated cognitive status of older adults in the ED. One participant said, "the longer [older adults are] in the Emerg department, we're going to see more functional decline because we're a department with no windows, little rooms." Another participant shared a picture of an ED treatment room and the following description:

A completely, abysmal, boring wall ... with no windows ... for our patients who are spending ... a long period of time with us, they lose track of time which isn't helpful ... in their orientation ... in knowing what's going on ... They can't see what's happening outside. They don't know if it's day or night ... it's not uncommon for a patient to say, 'I've been here for seven hours' and they've really only been there for two.

The equipment perceived to be necessary included clocks to keep the older adults orientated and lower beds, bedside tables, geriatric chairs, chairs with arms, commodes, wheelchairs and gait aids such as walkers and canes to keep them active and mobile. One participant said:

A patient who comes in from a retirement home ... and is held in the department ... ideally, this person should be sitting up in a chair for every meal, and walking twice

a day. Let's say this person requires an assistive device—they're limited in our department. We don't always have geriatric chairs to sit a patient up. You're not going to sit them in our chairs ... sometimes that's inappropriate for those patients, 'cause they're not safe.

Another participant shared her concerns regarding the ED stretchers, "trying to get this frail elderly person to even stand at the bedside, or ... trying to get them in and out of bed is a frustration 'cause all the beds ... they're not low enough." A different participant spoke about the benefits of having bedside tables:

If our patients had bedside tables, they would be more willing to sit up in a chair to eat. They would sit on the side of the bed because they have something to lean on ... nurses would feel safer about leaving a bedside down and them sitting there if they had something in front of them ... I think they would have fluids in front of them ... they would drink more ... their general condition would be better.

One participant provided pictures of three pieces of equipment not readily available in the ED and described how each item might benefit older adults in the ED: (1) a long foot stool ("a lot of our patients need to have a wide base when they stand down off the stretchers 'cause our stretchers are too high"); (2) a slider sheet ("we don't use them enough to get used to them because by the time you think about it, you're half way through helping them and it's way over there somewhere in the unit"); and, (3) a four-wheeled walker with attached cardiac monitor and oxygen tank ("this is a sturdy walker with a monitor and an oxygen holder so you can walk the patient and put it at the proper level so their gait isn't compromised ... our walkers are really outdated—they're almost dangerous").

Two participants jointly presented pictures of a cardiac monitor and a call bell. Both

items, which are routinely used in the ED were perceived as important and necessary pieces of equipment, but also as barriers to promoting the functional status of older adults in the ED. One participant said of the cardiac monitor:

We ... tie all these wires to them ... and in addition to us putting all these things all over them, that makes them feel constricted in the bed ... it's beeping, it's loud ... I've also had elderly patients or seniors in the middle of the night ... who are frustrated because the person next to them is beeping and it's keeping them up, which as you know, for everybody, makes you feel not so good in the morning.

The other participant added:

We render them immobile, and if we had those, those telemetry packs that they have up on the cardiology floors ... you are free to walk around, right? But here ... it's just understood—you're stuck here—so they submit to the environment of submission.

Feelings of frustration were also evident in one of the participant's description of call bells:

Our call bells drive me crazy. We can no longer put them on the side rail ... so you pin them to the pillow. Either A, you go in there in the middle of the night, and they're wrapped around their neck 15 times, 'cause they've pulled and pulled and pulled at them ... or B, they think they have no call bell ... and then you hear ... tap, tap, tap ... on the side of the bed, because they can't find it.

Three participants perceived a discrepancy between the availability of equipment in the ED as compared to that on the inpatient units. One participant gave the example of a, "unique commode system" that was borrowed from an inpatient unit, "there's all kind of things that are not like ... our primitive bedside commodes. There's all kinds of ... things

that are on the floors.”

Social climate. All participants proposed the need to improve the social climate of the ED to better meet the needs of the older adults and the ED nurses. Facets of the social climate requiring improvement included: human resources; interpersonal relations; model of care with time-based focus on flow; and, organizational support.

Six participants acknowledged that an increased presence of specialized staff (e.g., geriatric nurses and home care case managers) in the ED had the potential to better meet the needs of older adults, but along with other participants, they also felt that improvements could be made to the human resources in the ED. Six participants believed that ED RN staffing levels were inadequate; one of them said, “it’s staffed appropriately for normal Emerg patients but when you have a high elderly population in your Emerg, for any of the type of care that you need to do ... you often need two nurses.” Two of the six participants also believed that volunteers were poorly utilized, as suggested by another participant, “I think we’re not using, that skill ... some of them are, like, retired nurses and ... they could be in spending time ... visiting with patients.” Three participants declared that there was a disparate presence of allied health staff, such as occupational therapists, physiotherapists and social workers, in the ED when compared to inpatient units, and one of the participants provided an example of what was lacking in the ED, “you have physio on the [other] floor[s] often ... you have aides sometimes helping you put these people up in chairs.”

Six participants shared experiences of ageism to show that older adults were not always given equal treatment or opportunities and that when compared to ED patients of younger age, assumptions were being made that they did not need or want the same level of care. One participant described a newspaper as an item, which could be used to help

keep patients oriented, then admitted that she herself was less likely to give one to an older adult ED patient. Three participants noted that frail older adults were more likely to be placed in an ED area where there were fewer nurses and less acute care, one stating that, “from my perspective ... the frail people are always in sub-acute, and the ones that are not frail are always in acute care.” Another participant expressed feelings of frustration using an example of ageism by a physician as proof that older adults were being devalued based on age, which would be considered negligence if the person were a young adult:

You can have a very vibrant, otherwise healthy, never spent any time in the hospital, 90-year-old coming in, having their first heart attack, and you have the physician—‘Well, what would you want me to do about it? ... they’re 90, I’m not going to take them to the cath lab!’ ... maybe they could be just as easily fixed as a 40 year old! Now, a 90 year old who’s having their 25th heart attack and has CHF and all kinds of other things—that’s a different scenario—but ... I think a lot of times they paint them with the same brush ... You’re not giving them the option to make that decision. It’s being taken away before they’re even ... asked!

The perception that RNs practiced in the ED as members of a family or team, “who depend on each other” came across during the focus groups and personal interview and in the language used (i.e., all participants used the word we rather than I during parts of their discussions); however, the perception of being the member of a team did not extend beyond the ED for all participants. One participant said that she was resistant to join hospital committees because, “Emerg has a different set of priorities than the floor. And I feel sometimes we get overshadowed, because the medical floors are just ... the larger piece, and we have different ideas.”

Seven participants perceived that in the ED, too much emphasis was placed on patient flow and that this focus limited their level of autonomous practice and ability to meet the needs of older adults in the ED. Four participants proposed that the need to focus on patient flow prevented them from practicing the, “art of nursing” and providing patient-focused care. One participant said:

I think nurses have had some of their autonomy removed in an effort to streamline. We’ve over streamlined everything ‘cause we’ve had to. Everything is coming down to minutes and seconds in time ... And they’ve taken the autonomy away ... which is *sucking* [emphasis added] the life out of everybody ... If I wanted to look into numbers, I would have gone into banking ... I’m not in this job about numbers or times ... that’s banking ... this is nursing.

Another participant said:

Process is what is emphasized ... that’s the message that comes down from on top ... so that’s what becomes our focus ... that’s what guides our behaviour ... Process and doing it more efficient, will result in more dollars, and so patient care is not seen as ... most important.

Six participants spoke of feeling unsupported and unappreciated by the organization as a whole. One participant implied that better organizational support was needed for education of front-line staff, “I think the educators here have more of a corporate education role. They roll out big hospital projects ... versus saying the front- line clinical point of care.” Another participant said, “it’s interesting that we sat here and ... talked mostly of the negative things ... we’re not used to hearing the positives,” to which a different participant added, “When we do get feedback ... it’s negative feedback, which is very demeaning.”

ED nurses' roles and responsibilities. All participants spoke about the numerous roles and responsibilities that they had as ED nurses and seven participants provided evidence of moral distress when sharing experiences of being unable to provide the care that they felt was necessary to promote the functional status of older adults in the ED. The roles and responsibilities perceived to be contributing most to their distress were assessment, documentation and priorities of care.

Assessment. Assessment was perceived by one participant as, "part of our nursing responsibility" and by another participant as a necessary role, "to figure out, is there a disease process going on, or ... a decline in what way, they've been, prior to coming to hospital." It was also perceived as a challenge to all participants because older adults frequently presented to the ED with "vague, non-specific complaints," "general weakness" and, "failure to cope." One participant said, "there's an expectation that ... you have this magic wand, that you know everything about them, and that's not necessarily the case." The inconsistent availability of background information, the unpredictability of the older adults' functional and cognitive abilities, and an emphasis on patient flow were identified as factors contributing to ED nurses' challenge to complete a good assessment.

Two participants spoke about the assessments done in triage. One of them said, "I think we do ... a good job of our initial triage ... We're told to keep to that limit—three to five minutes—so you've got to be good at getting the information that you want." The other participant had a different perspective:

If we had the time to listen to them, we would glean more information about their baseline ... Many times, you have to cut them short ... so you, you're sort of limiting the picture that you can get at triage ... 'cause you have to stop them in their tracks ... in order to move them from A to B.

There was consensus among the participants that it was essential to have good background information about the functional status of older adults including whether they needed assistance with ADLs and/or IADLs or had recent changes to their functional and/or cognitive status. One participant said that background information was important because often, “the reason they present to Emerg is not really the reason that brought them in.” Another participant said that it could help with determining their discharge needs, “if you can uncover that there’s other, kinda coping issues and they lack motivation because they’re depressed, those things are gonna affect how they’re gonna be discharged because you can’t send them back home without proper resources.”

During one focus group, two participants expressed a sudden awareness that the questions asked during their assessments focused on the deficits rather than the abilities of older adults. One of them said:

We look at their list of deficits. We’re not saying their positives. We’re not saying, ‘Oh, look, they can get up and walk. They got into the gown.’ We’re asking, ‘What can’t you do? ... Tell me all the things wrong with your health ... Show me all our pills’ ... We’re right from the get-go ... looking at a list of deficits.

Six participants expressed concerns regarding the inconsistency of information received from supportive care facilities (e.g., retirement and nursing homes) and emergency medical services (EMS) when older adults presented to the ED. One participant said: Depends on ... which facility they come from, as to how much information you get. And even if you call, and try to get more information ... it’s a hit and miss ... There’s sometimes not a lot ... they don’t send a really good history in ... And then the EMS, when you try to get, a good report from them—again—it depends on how much the EMS asked. Sometimes they ask more, sometimes they don’t.

Seven participants suggested that it was desirable to have family or caregivers who could provide corroborative information when they were faced with having to assess older adults with cognitive impairment. One participant shared a personal example of frustration, which involved a scenario with a family member who was not helpful:

We had a patient a few weeks ago, who came in ... by the EMS ... she had an obviously broken wrist ... the husband was with her, and apparently he said ... they'd been to the lab and they were walking out of the lab ... and, she stepped down ... and, she fell ... So, I'm saying to him, 'Well, what is she like normally with her mobility? ... if she's only taking a step off the sidewalk, does she have issues with her mobility?' ... She was totally confused ... He really couldn't give me a good history ... And if you think of trying to figure out what *might* [emphasis added] have happened ... it's any number of scenarios ... anything could have gone on ... But trying to get him to, give me a history of, 'What happened today?' ... he wasn't a reliable historian. And EMS is only going to recount what he told 'em ... he was so vague, that it was so frustrating ... it required *a lot more investigation* [emphasis added]!

Seven participants indicated that their assessments were often challenged by an emphasis on time and patient flow. One participant said:

It's very time consuming to get everything, to get all the facts and figures ... and or, all the information you need to deal with this particular situation, without pushing them ... back in the community, for them only to come back again.

Another participant agreed:

Emerg is designed for rescue but it also becomes a safety net for seniors ... even though we are funded as an Emerg, we're penalized for taking good care of them ...

the new Sinha Report says they want seniors in and out of Emerg within four hours ... How are we going to unpack what's going on medically, if we've only got four hours? ... that's hard to do because they never present with one issue.

Nursing documentation. All participants perceived that nursing documentation was a necessary but challenging obligation that was plagued with inconsistency, in both frequency and quality of documentation. One participant said, "some nurses are good at charting and some nurses don't do very much." Another admitted:

We're not always so good at documenting ... all the stuff that we tell each other ... I *know* [emphasis added] that I've given a five minute report on a social going on of a patient ... Have I got five minutes worth of reading in the chart? Probably not. Three participants spoke about how computer documentation took away their ability to provide patient-focused care. One participant said:

We're supposed to do computer charting now ... that means I go someplace where there's no patient, and I stare at a screen, and I have to put in the right things ... I'm not even talking to the patient like this. I'm not even developing a rapport, or a trust thing. They're looking at me, looking at the screen ... typing all this in madly, to get to the next person.

Another participant said, "documentation ... that's what the focus is now *not* [emphasis added] the patient care. It's the, the documentation and all these ... dotting the I's and crossing the T's." Yet another participant expressed the same idea but in a different way, "I feel like we're deep in the forest, and we're missing the trees ... and part of it is our system of documentation."

One participant suggested that a shift in attitude was needed in documentation to address the aging population, "we're really focusing Emerg and we're not recognizing ...

that maybe, there's been a shift, and it's ... people with more chronic issues." Another participant agreed with her, but also with five other participants who expressed the need for a standardized assessment/documentation tool to provide greater consistency in documentation:

If elderly, the elderly population is going to be a reality ... then we need to address it in our charting. There needs to be a tool ... that's consistent ... whether people use it or not, at least it's there for the people who want to use it.

Priorities of care. All participants identified that the ultimate challenge to ED nurses was to provide an array of nursing care to a diverse patient and family/caregiver population in an ever-changing chaotic environment of competing priorities and system demands. They were aware of their need to promote the functional status of older adults in the ED and expressed feelings of frustration, guilt, and concern regarding their perceptions of care that did not meet this need. They were aware that to optimize the functional status of older adults, they needed to empower them and put them in control whenever possible, but as noted by several participants, it was not something that was consistently done. One participant said that, "from the minute they walk in ... we take so much away from them ... they have to conform to OUR plan." Another participant said:

We don't support what they can do ... It takes more time to get them off the stretcher and walk them to the bathroom, than it does to give them a bedpan ... it sounds like a horrible excuse but, it's very real ... even setting them up with their lunch tray. It's faster to open everything up ... instead of finding out what they can do ... that's your turmoil ... as a nurse ... you carry that guilt with you ... all the time.

Yet another participant expressed similar feelings:

I've, noticed that people sometimes will put the patient in a wheelchair ... because it's faster ... if they can't, can't walk because they're ill that's one thing ... but if it's faster—we're taking away their dignity. So now we've already embarrassed them or, taken something away before we're even out of the waiting room ... When they're in the back ... putting them on a bedpan because ... bathroom's all the way around the corner, or someone's in the bathroom—that's number 2! ... we're removing, some of their ability that they had ... two hours ago when they were at their own house ... then, we feed our patients in bed ... We have a table that goes across ... We don't even get them up! ... So, some days I go home and I think—I just left that 85 year old lady in bed for 12 hours! ... And, you feel *horrible* [emphasis added] ... We take away, in a 12 hour shift, more things than they probably lost in months!

Four participants expressed feelings of frustration as they spoke about their obligation to care for both admitted and emergency patients simultaneously. One participant described it as a, “dichotomy of trying to be a good bedside nurse and trying to be an Emerg nurse, who's trained and skilled to, to pounce on you ... if you're having a cardiac arrest.” She went on to say, “We are the *best* [emphasis added] at resuscitating somebody, or dealing with an urgent life threatening problem ... not so good at looking after an 85 year old, fall with a broken hip.” Another participant provided a similar perspective:

It's like, a war of two worlds ... You've got... the way an admission ought to be looked after, and then you've got the reality that we have to look after our Emerg patients ... so at the end of the day, you feel conflicted ... Was I a good Emerg nurse today or was I good, a good admission nurse? ... It's really, really, really hard to do

both.

The negative impact of maintaining isolation precautions was presented by seven participants. One of the participants said:

You can see them mentally decline, when they're in a room, especially if they're isolated ... you can see by day two that there's, there's often a difference in their mentation, their awareness—they're truly isolated in every sense of the word.

Another participant added:

Just the very fact that they're isolated, deters nurses or anybody from going in there—I'm sorry to say ... you have to put a gown on ... you have to put your gloves on. If they're ringing ... you're more liable to go off and do something else first because you know it's going to take time ... whereas if they weren't in isolation, you could buzz in and say, 'Hi, how are you? ... Do you need anything?' and then come out again.

Four participants provided examples of palliative and of end-of-life care being a barrier in an environment with a, "get them in, get them fixed, get them out" focus; however, one participant presented an end-of-life care scenario in response to the request to share an example of when all things aligned and she was able to provide an older adult and/or family member with the nursing care that she felt they required:

I had a lady ... she was mid 70's ... actively dying. At home the husband couldn't deal with it any longer so he sent her up here ... I worked two days, two nights. I had her for three of my shifts. On my third shift, I moved her to acute care bed nine ... She didn't need the monitor but it just reassured him, so I thought that's easy to please ... put her back on the monitor ... We didn't think she'd live through the night, so I went and got a second stretcher and made a double bed ... he held her as

she passed away ... [the palliative physician] came up on my next rotation, some five or six days later ... gave me a great big hug and thanked me ... I was happy ... it meant something to [the husband] and he remembered it ... for all the days you're frustrated, I'll never forget that.

Family/caregivers. All participants indicated that issues with family/caregivers had in some way, affected their care of older adults in the ED. Seven participants shared experiences of family/caregivers being helpful and supportive of their care of the older adults, while eight participants shared experiences of family/caregivers being unsupportive and barriers to care. Four participants suggested that many family members were unaware and unsupportive of the actual needs and expectations of their older adult family members, and to this point, one participant said:

We come to them quite often and say ... 'If we don't find a medical reason for your parent to be here, and they're discharged home, what kind of aids do you need, to go home? How can we help you at home?' And they don't, like, they're very uncomfortable that—'What do you mean if there's nothing wrong? Look at them. There's something wrong! ... And how can you say that they're not gonna be, like they were before ... that I'm gonna have to take them home like this?'

Another participant shared a similar example:

Grandma might know, 'I'm gonna die. I'm, I'm 90 years old. I know statistically, I don't have that many more years left under my belt' ... most of us can all know that ... when you reach 90 ... your time is limited, but the family often can't see that. They can't see ... the tree for the forest ... so when you say, 'Well, you know, things aren't going to get better, they're going to get worse over time, because she has fill-in-the-blank of disease process' ... they're shocked [emphasis added]! ... And they

don't wanna talk about DNR status.

Community links. Community links refer to the individual(s) and organization(s) in the community to which older adults in the ED are connected. Participants identified primary care/family physicians and supportive care facilities (e.g., retirement and nursing homes) as the links through which the health care needs of older adults could be improved.

Primary care physicians. One participant suggested that the majority of older adults had a primary care physician who they saw on a regular basis; however, six participants believed that if the older adults were better supported by their primary care physician, fewer would need to seek ED services especially for chronic and end-of-life care. One participant said, "a lot of times, they do have family doctors but they're not getting their needs met, so they're looking ... to the department to ... get it done." Another participant linked this lack of support to the limitation of time and communication between the older adults and their primary care physician:

Do their family doctors give them that time? ... if ... they're a senior who likes to chat a little, and isn't really good giving direct, it's to-the-point answers ... I think sometimes they get kinda brushed aside ... or if they have a language barrier, I think a lot of times, the docs just don't get what they're saying, and they don't have ... half an hour to sit there and try ta, work through it ... I'm not sure that ... they even take that time, to have those good conversations with them.

Another participant spoke of how the lack of communication and end-of-life planning between the primary care physicians and older adults contributes to her frustration when having to address the unmet needs of older adults when they present to the ED:

I, often am frustrated if ... I see co-morbidities—about 10 of them on a patient—and they've come in, and the family doctor has *never* [emphasis added] chatted with them ... Like, we *never* [emphasis added] talk about death, like death doesn't have to be, the awful thing ... death is inevitable ... I know they come into us, in the *acute* [emphasis added] phase ... and they can't breathe, and they just want you to get rid of that phase ... but I just feel no one has really talked to them about their condition ... this *is* [emphasis added] grade 4 ventricle ... this *is* [emphasis added] end stage, COPD and at the end of it, will be death.

Two participants suggested that many family physicians were too quick to prescribe medications for older adults; especially to address their psychosocial needs and that this too contributes to the vulnerability of older adults toward functional decline. One of the participants proposed that the reason for this was that, “the issues of the older adults ... could be ... more complex with their health issues and then mental health issues, perhaps ... family doctors are not sure how to ... deal with it, besides just pharmacology.”

Supportive care facilities. Four participants felt that more care should be provided to older adults who live in supportive care facilities such as retirement homes and nursing homes, to avoid what they believed were unnecessary ED visits, especially when the concerns that prompted their ED visits involved chronic issues. One participant said it was “traumatic” to bring them to the ED only to sit on a stretcher for hours; she also stated:

One of my first questions ... especially if they're coming from a ... nursing home ... not, ‘Why are they bringing them here?’ but, ‘What could be done to keep them in their own setting?’ ... it just seems sometimes that it's, it's so unnecessary, to uproot some of these older people and bring them into the emergency department.

Another participant suggested advanced care planning at the facilities might help:

We see *a lot* [emphasis added] of people from retirement homes who are declining ... Where they're having more falls and they just can't function in a retirement home anymore ... Why do they come here to have that assessed? Why could that not be assessed *there* [emphasis added], where they live? And have the family involvement and the physicians there saying, 'You know, you're father's no longer ... able to manage here ... he's going to have to go into a place with more care, or we'll have to get more care here.'

Two participants who suggested that more should be done for older adults who reside in supportive care facilities also admitted that they were unaware of what medical and nursing services were available in these facilities. One of the participant asked, "Are there measures that they can take in the community to accommodate those residents?"

4.3 Summary

Results of this study suggest that: (1) older adults in the ED are vulnerable to functional decline; and, (2) ED nurses who are dissatisfied with the care that they are able to provide to promote the functional status of older adults in the ED are vulnerable to moral distress. The vulnerability of older adults to functional decline and ED nurses to moral distress was linked to features of six interrelated influential variables: ED nurses; older adults in ED; ED nurses' practice setting; ED nurses roles and responsibilities; family/caregivers of older adults in ED; and, community links to older adults in ED.

All participants recognized the complexity and heterogeneity of older adults and the concept of functional status. There was also consensus among them that: (1) aspects of the ED practice setting negatively affects the functional status of older adults in the ED and the ED nurses' sense of satisfaction in the care that they are able to provide to

promote the functional status of the older adults; (2) there was a need to improve the social climate of the ED practice environment; (3) the constant challenge of providing care to a wide range of patients in an ever changing environment made it more difficult for them to meet their needs and expectations as well as the needs and expectations of the older adults and their family/caregivers; (4) it was essential to have good background information for all older adults who present to the ED; (5) assessment and documentation are essential nursing roles that are often inconsistently done; and, (6) issues with family/caregivers can have a positive or negative influence on their care of older adults in the ED.

More than half of the participants indicated that: (1) the functional ability and capacity of older adults was more important than their chronological age; (2) older adults with cognitive deficits were an extra challenge; (3) the ED physical design, lack of equipment and isolation precautions contributed to functional decline in older adults; (4) there is too much emphasis on patient flow, at the expense of the autonomy of older adults and the ED nurses; (5) they felt unsupported and unappreciated by the organization as a whole; and, (6) there was an inconsistent amount of information provided by supportive care facilities and EMS.

Participants provided what they perceived were opportunities for improvement. This included: (1) education pertaining to the assessment and care needs of the older adults; (2) increased RN staffing and better utilization of volunteers; (3) use of tools for greater consistency of assessments and documentation; and, (4) advocacy for improved care of older adults in the community.

This chapter provided an overview of the study's most prevalent findings. The next chapter will focus on the discussion and interpretation of the study's results relative

to what is already known in the research literature.

Chapter Five: Discussion

The purpose of this study was to explore emergency department (ED) nurses' perceptions of care on promoting the functional status of older adults in the ED of St. Mary's General Hospital (SMGH) and preventing their functional decline. The qualitative research methodology of interpretive description guided by elements of action research was used to construct data and conceptualize findings of the study. Data was gathered from: a participant questionnaire; eight semi-structured focus groups and one semi-structured personal interview during which participants were invited to present visual items; and, field notes that were documented by the researcher over the course of the study. Eleven registered nurses (RNs) who provided care to older adults in the ED of SMGH were participants of the study.

The discussion of findings using an interpretive description approach provides an opportunity for the re-examination and reinterpretation of the findings and a chance to understand them in a different way (Thorne, 2008). This chapter presents a discussion of the study findings within the context of what is already known and provides interpretive insights into expected and unexpected results.

5.1 Overarching Theme: Vulnerability

I anticipated that the study findings would lead to a greater understanding of the strategies and interventions used and the facilitators and barriers encountered by ED RNs providing care to promote the functional status of older adults in the ED of SMGH, and from that would come the recognition of improvement opportunities and a willingness to facilitate change to better meet this goal. What emerged were the perceptions that older adults in the ED were vulnerable to functional decline and ED nurses who were dissatisfied with the care that they were able to provide to promote the

functional status of older adults were vulnerable to moral distress; with that, came the recognition that changes need to be made.

Older adults are commonly referred to as a vulnerable population (Martin-Khan, Burkett, Schnitker, Jones & Gray, 2013), so it was plausible that they might be perceived as being vulnerable to functional decline in the ED; however, I did not consider that ED nurses providing care to promote the functional status of older adults in the ED, might also be a vulnerable population. I was surprised that many of the experiences shared by the participants involved feelings of frustration, anger, guilt, embarrassment, resentment, suffering and shame; feelings that are related to, “the pain and psychological disequilibrium of moral distress” (Corley, 2002, p. 642). I also did not expect the participants to share stories of palliative and end-of-life care in a study that focused on care to promote the functional status of older adults or to have participants use these experiences as examples of care with which they felt satisfied.

Research literature provides evidence that nurses are often challenged to provide holistic care to vulnerable populations in stressful clinical environments such as the ED where lack of time, power and control predisposes them to moral distress, yet little attention has been paid to the vulnerabilities of the nurses (Davenport & Hall, 2011). While older adults seeking ED care are at high risk for functional decline (Aminzadeh & Dalziel, 2002), the recognition of the vulnerability of ED nurses to moral distress as well as the vulnerability of older adults to functional decline in the ED should be used as fuel to facilitate change to better meet the needs of both.

5.2 Influential Variables

The nursing care provided by ED nurses to promote the functional status of older adults in the ED of SMGH was linked to six interrelated influential variables (i.e., ED

nurses, older adults in the ED, ED practice setting, ED nurses' roles and responsibilities, family/caregivers of older adults in the ED, and community links of older adults in the ED). It was also linked to the study's overall theme of vulnerability relative to its association with the functional status of older adults and the ED nurses' satisfaction of care.

ED nurses. Participants of this study differed in opinion as to whether age, experience and/or education of ED nurses influenced their attitudes and the care that they provided to older adults and their families/caregivers. Similarly, Liu et al. (2013) found that age and education were inconsistent predictors of nurses' attitudes and quality of care, while Courtney, Tong and Walsh (1999) suggested that knowledge deficits and negative attitudes could negatively influence RNs' practice and older adults' quality of care.

Boltz et al. (2008) found that nurses' age, experience and professional education were unlikely to influence their basic geriatric knowledge and that might be why many of the study participants perceived the need for additional education to better meet the needs of older adult in the ED. Most participants were over the age of 40 years, had over 10 years of nursing experience and college education. Their awareness of the need for geriatric education speaks to the ideas that providing care to older adults in an acute care setting requires specialized knowledge and skills (Cheek & Gibson, 2003), and that the nurses over the age of 40 years likely graduated from programs that did not include formal gerontological education (Gillis, MacDonald & MacIsaac, 2008).

If the majority of participants perceived the need for additional education specific to geriatrics, why did one of them experience limited interest on behalf of ED nurses when learning opportunities were made available? It might be explained by findings in the

study by Roethler et al. (2011), who discovered that ED nurses were unaware of their lack of familiarity and understanding of the geriatric patients. It might also be explained by the nurses' decision to disengage because of moral distress (Burston & Tuckett, 2012).

Browning (2013) identified a positive correlation between moral distress intensity and age, and a positive correlation between psychological empowerment and age, years of experience and end-of life care education. Research literature suggests that nurses who experience moral distress may express it in their workplace by choosing not to examine a problem or take actions to improve it (Burston & Tuckett, 2012), and that nurses with knowledge and experience, are more likely to identify situations that persuade them to "push the boundaries" (Corley, Minick, Elswick & Jacobs, 2005, p. 388) and make changes to better meet the needs of their patients; they are also more likely to manage moral distress (Corley, 2002).

Older adults in ED. Participants of this study recognized the complexity and heterogeneity of older adults and their functional abilities, and spoke of how these issues challenged them and the nursing care that they were able to provide to promote the functional status of older adults in the ED. They identified frailty and diminished functional and cognitive abilities as more important than chronological age when considering older adults' susceptibility to functional decline, and evidence of this was also found in the research literature (Jett, 2008; Quinlan et al., 2011; Stoukides, Holzer, Ritzau, & Burbank, 2006).

Participants of this study spoke about the differences between physical and cognitive functioning and how it was more challenging and frustrating to assess and provide care for older adults with cognitive impairment especially when they had limited background information and no one to provide collateral information. This relates to

cognitive impairment being described as, “an important and common concern for ED practitioners” (Parke et al., 2011, p. 1430) for which effective interventions must be sought if we are to adequately meet the needs of cognitively impaired older adults who are unable to make their own decisions or function independently in the ED.

Participants of this study perceived that many older adults came to the ED unnecessarily; however, there was inconsistent information in the literature to support this claim. The systematic reviews conducted by Aminzadeh and Dalziel (2002) and Gruneir et al. (2011) indicated that the majority of older adults appropriately used the ED for the diagnosis and treatment of healthcare issues as compared to persons of younger age, while Carter, Datti and Winters (2006) found that 20.3% of 48 million older adult ED visits involved conditions that could have been managed in the community by primary care physicians (PCPs). The participants’ view that older adults came to the ED unnecessarily might be akin to the “lack of fit” between the older adults and the ED environment that was proposed by Parke and Chapelle (2010) or it might be that the older adults to which the participants referred, presented to the ED because they had limited access to their PCP (D’Avolio, Strumpf, Feldman, Mitchell & Rebholz, 2013; Gruneir et al., 2010).

Participants of this study suggested that the functional abilities of many older adults changed when they came to the ED, in that they suddenly couldn’t do things that they normally did for themselves. This appears to validate the idea of physical function being, “a dynamic process of interaction between individuals and their environment” (Krešević, 2012, p. 89), but of utmost importance and concern, it might also confirm the idea that the ED environment is a barrier to the older adults’ functional independence (Boltz et al., 2010).

Older adults who are seen and treated in the ED have needs that extend beyond their ED visits (Cadogan, Phillips, & Ziminski, 2014). Poor communication and fragmented care within the various sectors of the health care system can contribute to their need to seek ED services and hinder the continuity and functional and clinical outcomes of their care (Cheek & Gibson, 2003; D'Avolio et al., 2013; Harris, Kidd & Snowdon, 2008). Since older adults who are admitted to hospital or discharged home from the ED have higher rates of adverse effects such as functional decline, it is necessary to have a better understanding of the transitional care and the supports that they require, so that they can be properly addressed.

ED practice setting. There is evidence in the research literature that suggests that the characteristics of a practice environment can influence nursing practice (Cheek & Gibson, 2003; Francis & Lahaie, 2012; Parke & Chappell, 2010). In their position statement, the Canadian Nurses' Association (CNA) (2001) said that the quality of a nursing practice environment, "has a direct correlation with job satisfaction, work production, recruitment and retention, the quality of care, and ultimately, client outcomes" (p. 3). Consistent with findings in a study by Meyer et al. (1999), participants of this study believed that more could be done to meet the functional needs of older adults in the ED. They perceived that aspects of their ED practice setting did more to promote functional decline of older adults than to promote their functional status, which suggests the need for change to improve the quality of this environment.

It is noteworthy that the study participants' response to the invitation asking them to share pictures, objects or symbols of items that helped or hindered their ability to provide best practice care to prevent functional decline of older adults in the ED, resulted in the presentation of pictures pertaining to the ED practice setting. One picture was of an ED

treatment area and five pictures were of various types of equipment, so one might assume that the need for change should begin with addressing the physical environment, but the question is, would this be enough to make a difference to the care? As noted by Kihlgren et al. (2005), being aware and understanding of the older adults' situations is not enough, it is nurses taking responsibility for providing good care that makes the difference.

Participants of this study said that they were challenged to provide quality nursing care to promote the functional status of older adults in the ED due to the following barriers: poor physical design; lack of physical resources (e.g., mobility aids, low beds, geriatric chairs, commodes, bedside tables, bedside stools and clocks in treatment rooms); isolation rooms; lack of human resources (e.g., nurse staffing, allied health and support staff); cardiac monitors; and, a time-based focus on tasks and patient flow. These issues relate to the site specific contributing factors of moral distress identified by Burston and Tuckett (2012), which include: availability of resources; staffing levels; the nature of care being provided; and the general organization structures or, "world of work" (p. 316).

Stichler (2009) said that hospital environments can, "promote healing or exacerbate illness for patients, families, and providers as they respond to the relationships, social supports, organizational culture, and physical design of the healthcare environment" (p. 176). Similarly, Kelley et al. (2011) said that aspects of the ED's physical environment, social climate, hospital policies and procedures, and health care system could affect the vulnerabilities of older adults and ED nurses. As suggested by participants in this study and in the study by Kelley et al. (2011), the needs of older adults are often unmet and when recognizing these unmet needs, ED staff experience moral distress. Kelley et al. (2011) suggested that the need for change to the ED physical environment and, "realignment of resources, introduction of new care protocols, staff

education, and creation of strategic linkages with the health care community” (p. 10) were needed to better meet the needs of the older adults in the ED.

Participants of this study also identified ageism and lack of organizational support as environmental issues that negatively influenced their practice. These findings relate to those of Meyer et al. (1999), who found that the care needs of older adults may be low on the list of priorities of care for nurses and organizations, and that in the absence of organizational support, ED nurses felt disempowered and blamed the organization for their inability to give good care. They suggested that while organizational support may be an essential motivating influence to the care of older adults, individual nurses could do more to improve the older adults’ ED experiences.

Findings of this study suggest that to address the needs of the ED nurses, organizational strategies are needed to better meet the needs of older adults in the ED. The Regional Geriatric Programs (RGPs) of Ontario developed the Senior Friendly Hospital (SFH) Framework as a guide for health care design to maximize health outcomes for frail seniors and the health care system. The five components of their framework (i.e., physical environment, organizational support, processes of care, emotional and behavioural environment, and ethics in clinical care and research) (Wong, Ryan & Liu, 2011) relate to the areas of concern expressed by the participants of this study.

ED nurses’ roles and responsibilities. Participants of this study revealed a general awareness of the strategies and interventions required to promote the functional status of older adult in the ED, but indicated that they were often unable to implement these actions in their practice. Demands placed on them by patients, family/caregivers, colleagues, physicians, the organization and the health care system contributed to their

feelings of powerlessness and their perceived inability to provide the care they felt was needed.

Loss of control in the nursing profession is closely linked to burnout, and burnout to poor job satisfaction (Gillespie & Melby, 2003); it also contributes to experiences of moral distress (Langeland & Sorlie, 2011). In a survey of 43,329 nurses from 711 hospitals in England, Scotland, Canada and the United States of America, Aiken et al., (2001) found that 30% of the respondents were dissatisfied with their jobs, and many nurses reported spending much of their time performing tasks or functions that did not utilize their professional training. They also found that between 13% and 47% of the nurse respondents from Canada reported leaving necessary tasks undone.

As in the current study, Kihlgren et al. (2005) found that ED nurses believed that good nursing care for older adults in the ED involved being knowledgeable, responsible and understanding of the older adults' situations and that which prevented the provision of good care was prioritizing routines, medical care and practical skills. Participants of this study expressed feelings of frustration and dissatisfaction of care when having to perform tasks that prevented them from practicing the art of nursing but they conveyed feelings of satisfaction in their descriptions of palliative and end-of-life care. I believe their feelings of satisfaction were related to their sense of empowerment and their ability to practice the art of nursing.

It has been suggested that nurses feel the need to have tremendous capacity to cater to the needs of everyone simultaneously but also find it difficult providing satisfactory care under those circumstances (Langeland & Sorlie, 2011). When nurses are dissatisfied with the nursing care that they feel is needed, they may seek to relieve their feelings of dissatisfaction by finding personal satisfaction in caring for patients for whom they feel

they are, “able to ‘make a difference’” (Maben et al., 2012, p. 84). I propose that this was the reason the participants referred to their experiences of end-of-life care as examples of care with which they were satisfied. The participants expressed the desire to practice the *art of nursing* and this meant engaging with patients in a meaningful way (Maben et al., 2012). As noted by Duffy (2009), “*doing*, even if one completes all tasks, is never enough if *being* (caring) is not at the core of the actions” (p. 79).

Johnson (as cited in Chin & Kramer, 2008) identified five conceptual meanings for the art of nursing and participants of this study shared examples of each. The five meanings included the ability to: “(1) grasp meaning in patient encounters; (2) establish a meaningful connection with the person being cared for; (3) skillfully perform nursing activities; (4) rationally determine an appropriate course of nursing action; and, (5) morally conduct one’s nursing practice” (p. 156-159). By relating these meanings to the participants’ experiences, it was easier to understand the reasoning behind their classification of satisfied and dissatisfied nursing care.

Lack of time and insufficient staff were perceived as barriers to the study participants’ ability to consistently provide patient-centered care and promote the autonomy of older adults in the ED. The participants admitted that ED nurses would do things for older ED patients such as feeding them in bed or using a bedpan instead of ambulating them to the bathroom, because it took less time, and they expressed feelings of guilt and shame for doing so. The perceived lack of time was linked to poor staffing and the many roles and responsibilities that they had, and to the view that the needs of the emergency or acute care patients had to be addressed before those of the chronic or admitted patients. Other researchers have also noted lack of time and staffing, as issues of concern when caring for the older adult population (Boltz, Parke, Shuluk, Capezuti &

Galvin, 2013; Gillis et al., 2008; King, 2006).

Family/caregivers. Participants in this study perceived that the family/caregivers of older adults in the ED were both facilitators and barriers to the nursing care that they provided to promote the functional status of older adults in the ED, and their views were similar to those of participants in the study by Fry et al. (2014). Participants in both studies perceived that family/caregivers were helpful when they provided information that was needed to facilitate the care of older adults in the ED and obstructive or demanding when they were unable to help with their care or interfered with their rights and expectations. Time was seen as an evaluating factor in the study by Fry et al. (2014), in that family/caregivers were perceived as helpful when they saved the nurses time. This was not specifically noted by participants in this study, but it might be assumed based on their revelation of not having enough time to provide quality care. Ultimately, this suggests that the ED nurses' relationships with family/caregivers could be negatively affected by an ED environment with a focus on flow, contributing to their moral distress.

It has been suggested that an ED visit is a critical opportunity to provide family/caregivers of older adults with support (Boltz et al., 2013) and that by working in partnership with them, hospital nurses might enhance the well being of older adults and the quality of the nursing care that they provide to this population (Capezuti & Hamers, 2013; Lowson et al., 2012; Nikki et al., 2012). Participants of this study recognized the influence that family/caregivers might have on their nursing care to promote the functional status of older adults in the ED, but they also felt that there were times when the family/caregivers had unrealistic expectations, especially when it came to end-of-life. This might be related to a reciprocal lack of appreciation and understanding between the ED nurses and the family/caregivers as it pertains to the specific roles and responsibilities

that each feels they must assume.

Lowson et al. (2012) described family/caregivers as “conductors” (p. 1199) to the care of older adults when they were at home, but as “second fiddle” (p. 1201) to the care of older adults while they were in hospital. Nikki et al. (2012) found that family members wanted to be involved in the care of elderly patients in the ED but were often separated from them and made to feel like outsiders. By developing ways for ED nurses to work collaboratively with older adults and their family/caregivers and recognizing the continuity of care which the family/caregivers can provide to help promote the functional status of older adults in the ED, the wellbeing of family/caregivers as well as the older adults and the nursing staff has the potential to be improved (Lowson et al., 2012).

Community links. Participants of this study identified primary care physicians (PCPs) and supportive care facilities (e.g., retirement homes and nursing homes) as the primary community links to influence the nursing care that they provided to promote the functional status of older adult in the ED. They perceived that both could do more to meet the needs of the older adults especially at end-of-life.

The participants’ assumptions that the majority of older adults had a PCP and that the needs of older adults were not being adequately met by their PCPs are consistent with the research literature findings that suggested that older adults are more likely than younger ED patients to have a PCP (CIHI, 2011) and more likely to have attempted to contact them before seeking ED care (Aminzadeh & Dalziel, 2002; D’Avolio et al., 2013; Gruneir et al., 2010). Research literature also suggested that although there were older adults who preferred to receive primary care services in the ED (Ionescu-Ittu et al., 2007), the majority of older adults were satisfied with their PCPs and preferred to see their PCPs for acute and nonacute episodic illness; it was usually the inability to obtain a timely PCP

appointment (D'Avolio et al., 2013) that contributed to their need to access ED services.

Results of the study by Carter et al. (2006) suggested that older adults living in facilities with skilled nursing care were more likely to be sent to the ED for management of co morbid conditions and to receive cardiopulmonary resuscitation (CPR) at end-of-life than those who did not live in these facilities. This supports the suggestion put forth by the participants of this study that more could be done to meet the needs of older adults who reside in supportive care or assisted living facilities.

Participants in this study and in the study by Cheek and Gibson (2003) suggested that communication between the hospital and supportive care facilities is often poor. As noted by the study participants, ED nurses require a good understanding of the baseline functional status of older adults just as staff at the supportive care facilities require information about the older adults' care needs when they return to these facilities after being treated in the ED. Without this information, ED nurses are challenged to adequately plan, manage and meet the functional needs of older adults in the ED (Boltz et al., 2013).

5.3 Summary

This chapter provided an interpretation of study findings pertaining to the experiences of ED nurses providing nursing care to promote the functional status of older adults in the ED. The overarching theme of vulnerability associated with the interrelated influential variables of ED nurses, older adults in the ED, ED practice setting, ED nurses' roles and responsibilities, family/caregivers of older adults in the ED, and community links of older adults in the ED were discussed within the context of what was already known. My interpretation of expected and unexpected results was also presented in this chapter. From the emergence of information pertaining to the influential variables and the overarching theme of vulnerability (i.e., vulnerability of older adults to functional decline

and vulnerability of ED nurses to moral distress) came the recognition that changes were needed.

Nurses have a pivotal role in providing care to optimize the functional status of older adults in the ED. Similar to findings in research literature, participants of this study perceived that the age, experience and education level of ED nurses were inconsistent predictors of the ED nurses' attitudes toward older adults and the quality of care that they provided to older adults in the ED. Participants acknowledged that the care of older adults in the ED required special knowledge and skills, but they also suggested that this understanding did not exist in all levels of the organization. Research literature suggests that knowledge and experience might be factors that can persuade ED nurses to push for change and enable them to better manage moral distress, but it also suggests that organizational support is necessary for the implementation and sustainability of any change.

The participants' perception, that the functional and cognitive abilities of older adults was more important than their chronological age, is noted in the research literature, especially in that which speaks to the concept of frailty. Support for the study participants' belief that the cognitive status of older adults is an important concern for which increased supports are needed, can also be found in the literature; however, there are different factors to consider when deciding whether research findings support the participants' view that many older adults present to the ED unnecessarily. Some studies suggest that the majority of older adults access ED services appropriately, while others suggest that better support and care by PCPs could reduce the need for a lot of older adults' ED visits. Questionable ED visits does not appear to be an issue for study participants when it pertains to older adults with acute medical issues; it appears more

directed to older adults who present to the ED from supportive care facilities or with chronic issues that could be managed in the community by their primary care physician.

Results of this study and that of others in the literature suggest that the physical environment, social climate and processes of care in the ED practice setting are significant factors that influence the vulnerability of older adults in ED toward functional decline and of ED nurses toward moral distress. Changes are needed to all of these factors if we are to meet the needs of both.

Participants of this study showed an awareness of what they should be doing to optimize the functional status of older adults in the ED, similar to the strategies recommended in the research literature. They identified loss of control over their ability to practice the art of nursing, lack of time, and insufficient nursing staff among the barriers to providing care to promote the functional status of older adults and this contributed to their moral distress.

Findings of this study suggest that the ED nurses' ability to provide quality nursing care to optimize the functional status of older adults in the ED can affect their wellbeing as well as the functional wellbeing of the older adults in the ED. Identifying barriers to the provision of nursing care to promote the functional status of older adults in the ED is an important first step toward making changes that could benefit them both. The next chapter will provide a discussion of the study's limitations, recommendations, and suggestions for future research.

Chapter 6: Limitations, Recommendations and Conclusions

The purpose of this study was to generate knowledge about emergency department (ED) nurses' perceptions of care to promote functional status and prevent functional decline of older adults in the ED of St. Mary's General Hospital (SMGH). The qualitative research methodology of interpretive description guided by elements of action research was used to construct data and conceptualize the findings of the study. Data was gathered from: (1) a participant questionnaire; (2) eight semi-structured focus groups and one semi-structured personal interview during which participants were invited to present visual items; and, (3) the researcher's field notes that were documented over the course of the study. Eleven registered nurses (RNs) who cared for older adults in the ED of SMGH were participants in the study. This chapter opens with a discussion of the limitations of the study, followed by recommendations, suggestions for future research, and concluding remarks that will summarize the research.

6.1 Limitations

This study has limited generalizability because it was only conducted at one site. The Cumulative Index to Nursing and Allied Health Literature (CINAHL) is an extremely relevant database for nurses, but a more exhaustive search of other databases could have been used for a more complete literature review. There were only 11 study participants; all were female and all but one were experienced RNs with more than 10 years of experience. The request for participants to commit to at least two 90-minute focus groups may have been a limiting factor for other potential participants, contributing to the small sample size and limited variability of the participants' level of experience. Having a larger sample size inclusive of nurses with less experience may have improved the validity and variability of the study, but it was more important to study information-rich

cases capable of illuminating the topic under study than to produce, “empirical generalizations” (Patton, 2002, p. 230). Time lines set for the recruitment of participants and the scheduling of the interviews may also have resulted in the exclusion of other ED nurses with different perspectives related to the topic of the study. The time frame between the first-wave and second-wave interviews differed for each group and that could have influenced the results. Only participants from Group 1 and Group 3 attended the third-wave, validation focus group session. Data saturation was achieved, but study findings were limited to the perspectives shared by the participants, most within a group setting. The majority of participants in this study were older, more experienced nurses and two of them functioned in a broader scope of nursing practice than front-line ED nurses. Three of the participants as well as the principal investigator had education specific to geriatrics and this may have influenced the discussions and responses of the participants who had limited education of and experience with geriatric patients.

6.2 Recommendations

Shanley et al. (2008) said, “nurses need to use their clinical and administrative experiences and influence to acknowledge problems with care of the older person in the ED, and to help identify and implement alternative approaches that aim to overcome these problems (p. 154). They suggested that the traditional model of ED care which focuses on rapid triage, treatment and throughput does not adequately meet their needs and the results of this study support this.

The recognition of vulnerability as the overarching theme of this study to explore ED nurses’ perception of care to promote the functional status of older adults in the ED was an unexpected but important finding that needs to be exposed for the benefit of older adults in the ED as well as for the ED nurses who care for them. Vulnerability typically

implies the potential for harm, but it can also be viewed as an opportunity for growth (Spiers, 2000) and a motivating factor toward resilience, optimism and empowerment (Davenport & Hall, 2011).

Research literature provides evidence of hospitalized older adults being vulnerable to functional decline as well as evidence-based interventions and strategies to help prevent this (Boltz et al., 2010; Boltz et al., 2012; Conforti et al., 2004; Creditor, 1993; Gillis et al., 2008; Graf, 2006; King, 2006). Unfortunately, it offers limited information about ED nurses' experiences on providing care to promote the functional status of older adults in the ED and preventing functional decline in this population; current information is therefore required.

The functional well being of older adult ED patients is reliant on the ED nurses' ability to provide quality care and the quality of the nurses' care may suffer when they experience moral distress. Unaddressed moral distress can hamper the nurses' ability to provide optimal patient care as well as attain job satisfaction (Burston & Tuckett, 2012; Corley, 2002; Fernandez-Parsons et al., 2013; Rushton, 2006). The recognition of ED nurses being vulnerable to moral distress when they are dissatisfied with the care that they are able to provide to promote the functional status of older adults in the ED should therefore be used as an impetus for change.

The American College of Emergency Physicians (ACEP), the American Geriatric Society (AGS), Emergency Nurses Association (ENA) and the Society for Academic Emergency Medicine (SAEM) (2013) developed Geriatric Emergency Department Guidelines to improve the care of older adults in the ED. They suggested that if these guidelines, which focus on education, staffing, equipment, follow up care, policies and procedures, and quality improvement (QI) measures were implemented collectively,

improvements to patient care, staff satisfaction and customer service would occur.

The following recommendations are being made based on the results of a small-scale, one-site, qualitative study and are by no means complete. They are grouped by the categories of the guidelines by ACEP et al. (2013) and supported by research findings.

Education. Lack of geriatric education can negatively affect quality of care and affect ED nurses' vulnerability to moral distress (Boltz et al., 2008; Browning, 2013; Kelley et al., 2011). Recommendations pertaining to education include:

1. Involve ED nurses in the development and implementation of an education program to increase the ED nurses' awareness of the older adults' needs as it relates to the assessment of their physical and cognitive capabilities (Boltz et al., 2012), and the optimization of their functional status, functional impairments and functional disorders (ACEP et al., 2013; Aminzadeh & Dalziel, 2002; Kelley et al., 2011).
2. Educate older adults and their families/caregivers about the physiological and psychological benefits of ambulating older adults in the ED and on ways to prevent sensory deprivation and promote their functional abilities and self-care in this setting (Gillis et al., 2008).
3. Educate ED nurses on the availability and utilization of community resources that can help maintain or enhance the functional status of older adults after they are discharged from the ED (ACEP et al., 2013).
4. Engage ED nurses in ethics education for improved understanding and recognition of moral distress and strategies that can be used to counter the consequences of moral distress as it pertains to their inability to promote the functional status of older adults in the ED (Burston & Tuckett, 2012).

Staffing. ED nurses experience great responsibility (Langeland & Sorlie, 2011), but they are part of a team of care providers who can assist with promoting the functional status of older adults in the ED. Recommendations for consideration pertaining to staffing include:

1. Promote a more effective team approach in the ED where team members both offer and accept help in an attempt to balance workload to promote the functional status of older adults in the ED (Hohenhause, 2013).
2. Enhance availability and use of nurses who specialize in geriatrics to assist ED nurses in assessing and caring for older adults in the ED (ACEP et al., 2013).
3. Investigate and implement innovative ways to better utilize volunteers and other staff members to help optimize the functional status of older adults in the ED (ACEP et al., 2013).

ED environment. The ED environment can directly impact the function and physical activity of older adults (ACEP et al., 2013; Boltz et al., 2012). The quality of the ED environment can affect the ED nurses' quality of care, work production and job satisfaction (Canadian Nurses' Association [CNA], 2001). Recommendations for consideration pertaining to the ED environment include:

1. Invite ED nurses in collaboration with other ED staff to identify and implement ways to make the ED environment more "elder friendly" (ACEP et al., 2013; Rogers, 2009; Wong et al., 2011).
2. Increase availability of lower stretchers, appropriate gait aids and seating to encourage self care and mobilization and decrease older adults' periods of bed rest while in the ED (Conforti et al., 2004).

Follow up and transition of care. An older adult's ED visit may be, "a 'red flag' event heralding functional decline and the potential need for added health resources" (ACEP et al., 2013, p. 14). Processes should be in place to facilitate effective transition to the community and follow up as required to help minimize return ED visits (ACEP et al., 2013). Recommendations for consideration pertaining to transition of care and follow up include:

1. Involve ED nurses in the development and implementation of standardized documentation for older adults transferred to and from primary care professionals and assisted care facilities to ensure sufficient transfer of information regarding their functional status and reason(s) for ED visit (Banerjee et al., 2011).
2. Involve ED nurses in the development and implementation of processes to facilitate safe and effective transitions of older adults discharged from the ED to the community to help minimize return ED visits (ACEP et al., 2013; D'Avolio et al., 2013; Cadogan et al., 2014).

Policies and procedures. Functional decline is often undetected, inadequately addressed and poorly documented (Aminzadeh & Dalziel, 2002) and this can contribute to ED nurses' feelings of frustration and moral distress (Zuzelo, 2007). Recommendations for consideration pertaining to policies and procedures include:

1. Screen all older adults in the ED for high-risk features such as recent functional decline and risk of falls using screening tool that is simple, quick and easy to use (ACEP et al., 2013, Banerjee et al., 2011; Bissett et al., 2013).
2. Involve ED nurses in the development and implementation of strategies to increase collaboration between ED nurses and family/caregivers of older adult in the ED to help improve the quality and continuity of care for older adults in the

ED (Lowson et al., 2012).

Quality improvement. Staff education and awareness regarding functional status of older adults in the ED could be enhanced through a QI program, which could contribute to greater staff satisfaction (ACEP et al., 2013). Recommendations for consideration pertaining to QI include:

1. Involve ED nurses in the development of a QI program regarding care issues of older adults in the ED (ACEP et al., 2013).
2. Collect and monitor data to recognize areas of improvement and concerns related to care to promote the functional status of older adults in the ED (ACEP et al., 2013).
3. Involve ED nurses in the design and scheduling of forums to provide them with regular opportunities to share their concerns with other members of the organization (Burston & Tuckett, 2012).

6.3 Suggestions for Future Research

Further research to explore the ED nurses' perception of nursing care to promote the functional status of older adults in the ED may add to a greater understanding of the ED nurses' experiences and their vulnerability to moral distress. There is minimal information in the research literature pertaining to this phenomenon and results of this study; therefore, the following suggestions are being proposed:

1. Research to further explore ED nurses' perceptions of care related to promoting the functional status of older adults in the ED at multiple sites and to compare findings with results of this study.
2. Research to explore the perceptions of nursing care to promote the functional status of older adults in the ED from the older adults' and the families'/caregivers'

perspectives.

3. Research to explore factors that influence transfer of older adults to the ED by primary care physicians and assisted care facilities especially for end-of-life care.
4. Research to explore ED nurses' perceptions of moral distress and how it might affect the nursing care that they provide to promote the functional status of older adults in the ED.
5. Research to explore ED nurses' perceptions of interventions to reduce moral distress as it pertains to their ability to provide care to promote the functional status of older adults in the ED.

6.4 Conclusions

I embarked on this research journey because in my practice, I observed many instances of ageism and poor or inadequate nursing care to promote the functional status of older adults in the ED. I assumed that with sufficient education and a better understanding of the needs of older adults, ED nurses might be prompted to change their practice. I also knew, however, that to change their practice, self-motivation was necessary and this meant allowing the ED nurses to be actively involved in the learning and change process. For this reason, I decided to conduct a qualitative study where they would have an opportunity to share their thoughts and experiences with others.

The ED nurses who participated in this study: (1) shared their awareness, attitudes and experiences with respect to functional decline of older adults; (2) identified strategies and interventions used to maintain and/or enhance the functional status of older adults within the ED; (3) identified facilitators and barriers to providing quality care to prevent functional decline of older adults in the ED; and, (4) identified approaches to improving care and preventing functional decline of older adults in the ED. The overarching theme

of vulnerability emerged from the analysis of the study data: vulnerability of older adults in the ED being at an increased risk of functional decline and vulnerability of ED nurses being at risk of moral distress.

Results of this study suggest that the ED nurses' ability to provide care to promote the functional status of older adults in the ED can affect their wellbeing as well as the wellbeing of the older adults; also that an ED environment that meets the needs of older adults will also support the needs of the ED nurses who care for them. From a cost and quality of life perspective, the vulnerability of older adults toward functional decline and the vulnerability of ED nurses to moral distress, especially when preventable, must be addressed.

The recognition of vulnerability as the overarching theme was an unexpected but important finding that needs to be exposed for the benefit of older adults in the ED as well as for the ED nurses who care for them. The functional wellbeing of older adults in the ED is reliant on the ED nurses and their ability to provide quality care and their quality of care suffers when they experience moral distress. Unaddressed moral distress can hamper the nurses' ability to provide optimal patient care as well as attain job satisfaction (Burston & Tuckett, 2012; Corley, 2002; Fernandez-Parsons et al., 2013; Rushton, 2006). Nurse dissatisfaction of care can lead to moral distress. Moral distress can lead to nurses leaving their practice environment or worse, the nursing profession. Organizational and health care system support is needed to turn nurses' moral distress into an impetus for change. In the case of this study, solutions such as equipment may be an easy fix, but changing all aspects of the ED environment that predispose ED nurses to moral distress is not.

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Appendix A: Certificate of Approval from Trinity Western University



TRINITY WESTERN UNIVERSITY
Research Ethics Board (REB)
CERTIFICATE OF APPROVAL

Principal Investigator: Mary P. Ostrowski
 Department: School of Nursing
 Supervisor (if student research): Faith Richardson
 Co-Investigators: None

Title: Promoting Functional Status of Older Adults in the Emergency Department:
 Exploring Emergency Department Nurses' Perceptions of Care Related to
 Functional Decline

REB File No.: 12G19
 Start Date: December 30, 2012
 End Date: July 30, 2013
 Approval Date: December 26, 2012

Certification

This is to certify that Trinity Western University Research Ethics Board (REB) has examined the research proposal and concludes that, in all respects, the proposed research meets appropriate standards of ethics as outlined by the "Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans".


 Sue Funk, B.A. for Phillip Wiebe, Ph.D.
 REB Coordinator REB Chair

This Certificate of Approval is valid for one year and may be renewed.
The REB must be notified of all changes in protocol, procedures or consent forms.
A final project form must be submitted upon completion.

Appendix B: Certificate of Approval from Tri-Hospital Research Ethics Board



TRI-HOSPITAL RESEARCH ETHICS BOARD (THREB)

(A shared service for Cambridge Memorial Hospital, Grand River Hospital and St. Mary's General Hospital)

Grand River Hospital, Rm. K503, Kaufman Building, 835 King Street West, Kitchener, Ontario, N2G 1G3

Tel: (519) 749-4300 ext. 5367 Fax: (519) 749- 4274

<p>Tri-Hospital Research Ethics Board Membership</p> <p>Michael Coughlin, PhD Chair, Tri-Hospital Research Ethics Board</p> <p>Janet Campbell MLT, ART (Hem), CCRP. Clinical Trials Manager</p> <p>Edmond Chouinard, MD Oncologist</p> <p>Lydia Chudleigh B.A.Sc. MBA VP Quality Performance Management</p> <p>Susan Gregoroff RN, BHSA, MHA, V P, Clinical Programs & Chief Nursing Executive</p> <p>Tina Mah, BScOT, MBA VP, Planning & Performance Management</p> <p>Paul Motz, BSc Community Member</p> <p>Amy Stahlke, B.A. LLB, Community</p>	<p>January 28, 2013</p> <p style="text-align: right;">CERTIFICATE OF APPROVAL THREB #2013-0504</p> <p>Mary Ostrowski 10 Simpson Avenue, Kitchener, ON. N2A 1L3</p> <p>Dear Mary Ostrowski, THREB# 2013-0504: MSN Thesis Proposal: Promoting Functional Status of Older Adults in the Emergency Department: Exploring Emergency Department Nurses' Perceptions of Care Related to Functional Decline. SMGH</p> <hr/> <p>Study Identification Number: THREB # 2013-0504</p> <ol style="list-style-type: none"> 1. THREB Application for Review received January 09, 2013 2. Administrative approval received SMGH January 09, 2013 3. Recruitment – Hard Copy Invitation received January 09, 2013 4. Recruitment – Email Invitation received January 09, 2013 5. Volunteers Needed for Research Project – Advertisement received January 09, 2013 6. Participant Information Letter Dated: January 7, 2013 7. Participant Consent Form Dated: January 7, 2012 8. Participant Demographic Questionnaire received January 09, 2013 9. First Wave Focus Group Interview Guide received January 09, 2013 10. Dear Participant Letter received January 09, 2013 <p>Initial Approval Date: January 28, 2013 Anniversary for Renewal: January 28, 2014</p> <hr/> <p>Thank you for your application requesting approval of the above research study. The Chair of the Tri-Hospital Research Ethics Board (THREB) has reviewed your request by Delegated Review and have approved it as submitted. You have final THREB approval to begin the study.</p> <p>The study is to be reviewed in one year, before the next “Anniversary Date.”</p> <p>Approval is granted to conduct the research project in accordance with the above protocol. Requirements for ongoing approval include:</p> <ol style="list-style-type: none"> a. Annual progress reports for review and continued approval of the study by THREB; b. Submission of any changes in the protocol, informed consent documents, information sheets, questionnaires, recruitment posters or other study materials; c. Timely reporting of all local serious adverse events; d. A final report submitted within three months of study completion. <p>NOTE: The above Study Identification Number THREB # 2013-0504 has been assigned to your project. Please use this number on all future correspondence.</p> <p>If there is a contract or data sharing agreement, the study may not commence until those documents have been finalized.</p> <p style="text-align: center;">Please call me if you have any questions. Sincerely ,</p>
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Member

Vikram Venkatesh,
BSc, MD,
Radiologist

Noela Vorsteveld,
B.Sc.Pharm.
Manager,
Pharmacy

The Tri-Hospital
Research Ethics
Board operates in
compliance with
the Tri-Council
Policy Statement:
Ethical Conduct
for Research
Involving Humans
and the ICH Good
Clinical Practice
Guidelines and
Division 5 Health
Canada Food and
Drug Regulations.

Michael D. Coughlin, Ph.D.
Chair, Tri-Hospital Research Ethics Board
Cc. D. Chavez

Appendix D: Electronic Invitation

Subject: Re: Invitation to participate in a research project

Dear Registered Nurse of St Mary's General Hospital (SMGH) Emergency Department (ED),

I would like to invite you to participate in a research project that I am conducting entitled: PROMOTING FUNCTIONAL STATUS OF OLDER ADULTS IN THE EMERGENCY DEPARTMENT: EXPLORING EMERGENCY DEPARTMENT NURSES' PERCEPTIONS OF CARE RELATED TO FUNCTIONAL DECLINE.

I am conducting this research as part of the requirements for completing the Master of Science in Nursing (MSN) program at Trinity Western University (TWU) in Langley, BC.

The purpose of this study is to explore ED nurses' perceptions of practice on promoting the functional status of older adults in the ED of SMGH and preventing functional decline within this population. As a participant, you will be asked to take part in two audio-recorded focus group interviews with up to six participants per session. Each of these interviews are expected to be approximately 90 minutes long and will involve discussion prompted by questions that are based on the aims of the study. You will also have the opportunity to attend a third focus group session that will be held to validate data gathered from all of the previous interviews. The third session is not required of every participant and will be approximately 30 minutes long. You will have the choice to attend sessions in a private room at SMGH or at Wilfrid Laurier University (WLU).

Group session options, from which you will be asked to choose your first and second choice:

Group 1: Thursday March 14 0930h-1130h and Friday March 22 0930h-1130h at WLU

Group 2: Monday March 18 1930h-2130h and Monday March 25 from 1930h-2130h at SMGH

Group 3: Saturday March 23 1000h-1200h and Tuesday April 2 2000h-2200h at SMGH

Group 4: Wednesday March 27 0930h-1130h and Wednesday April 10 0930h-1130h at WLU

Group 5: Thursday March 28 1330h-1530h and Tuesday Apr 9 1330h-1530h at WLU

If you are interested, you will be provided with a handout that contains more information about the study. I will meet with you to review this information and allow you the opportunity to ask questions before expecting you to decide whether to participate. Should you decide to participate, you will be asked to sign a consent form and complete a short demographic questionnaire, both of which will take approximately 15 minutes to complete. At the conclusion of the focus group interviews, you will receive compensation in the form of a \$10.00 Tim Hortons™ gift card as well as the opportunity to enter a draw for a \$50.00 Chapters™ gift card as a token of appreciation for your time. Individuals who attend the third wave session will also be eligible to have their names entered into draw for a \$10.00 Chapters™ gift card.

This research project has been reviewed and approved by the Research Ethics Board of TWU (File #12G19) and the Tri-Hospital Research Ethics Board (THREB #2012-0504). Your support and consideration of becoming a potential participant would be greatly appreciated.

For more information about the study or to become a volunteer participant, please see me in person, contact me via e-mail through SMGH MEDITECH™ or at
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX.

Thank you for considering becoming a part of this nursing study,

Mary Ostrowski RN BScN GNC(C)
Principal Investigator
MSN Student, Trinity Western University

Appendix E: Advertisement Poster



Mary Ostrowski, RN, BScN, GNC(C)
Master of Science in Nursing Program
Trinity Western University

Volunteers Needed for Research Project

Registered Nurses from the Emergency Department (ED) of
St. Mary's General Hospital (SMGH) are needed
as volunteer participants in a study entitled:

***“Promoting Functional Status of Older Adults in the Emergency Department:
Exploring Emergency Department Nurses’
Perceptions of Care Related to Functional Decline”***

The purpose of this study is to explore ED nurses’ perceptions of practice on promoting the functional status of older adults in the ED of SMGH and preventing functional decline within this population. As a participant you will be asked to take part in two focus group interviews, with up to six participants per session. These interview sessions will be approximately 90 minutes long. A few participants will also be invited to attend a third group session which will be about 30 minutes long. You will have the choice to attend the sessions at SMGH or Wilfrid Laurier University. All participants will receive compensation in the form of a \$10.00 Tim Hortons™ gift card and the opportunity to enter a draw for a \$50.00 Chapters™ gift card as a token of appreciation. Participants who attend the third session will also have their names entered into a draw for a \$10.00 Chapters gift card.

For more information about this study or to volunteer, please contact:

Mary Ostrowski, RN, BScN, GNC(C)

via MEDITECH™ e-mail or

XXXXXXXXXXXX

Food and beverages will be provided during the sessions!!

This study has been reviewed and approved by the Research Ethics Board of Trinity Western University (File #12G19) and the Tri-Hospital Research Ethics Board (THREB #2012-0504).

Appendix F: Follow-up Electronic Invitation #1

Subject: Re: Request for participation in my research project

Dear ER RNs

I am sending this Email as a follow up to the Email I sent on March 3, asking for volunteers to participate in two focus group sessions for my research project. I would very much appreciate hearing from anyone who might be interested by March 22.

It is preferred that you attend two sessions with the same group (i.e., Group 1 or 2 or 3 etc) however if that is not possible, you may choose to attend the first wave with one group and the second with another. I have made changes to the dates for Group 1 since my last Email.

PLEASE REMEMBER THAT YOU ARE ONLY BEING ASKED TO ATTEND ONE FIRST AND ONE SECOND WAVE SESSION AND THESE SESSIONS ARE EXPECTED TO BE 90 MINUTES LONG.

List of current options include:

Group 1- held at Wilfrid Laurier University (WLU)- Fri Mar 22 and Fri Apr 22 at 0930-1100h

Group 2- held at SMGH- Mon Mar 18 and Mon Mar 25 at 1930-2100h

Group 3- held at SMGH- Sat Mar 23 at 1000-1130h and Tues Apr 2 at 2000-2130h

Group 4- held at WLU- Wed Mar 27 and Wed Apr 10 at 0930h-1100h

Group 5- held at WLU- Thurs Mar 28 and Tues Apr 9 at 1330-1500h

Thanks again for your consideration,
Mary Ostrowski

Appendix G: Follow-up Electronic Invitation #2

Subject: Re: Research study

I am still looking for anyone who might like to participate in my research study and I have extended the deadline for responses to March 26.

You are welcome to join ED RNs who have already expressed interest in participating in one of the follow groups:

- Group 1 - 1st session- Saturday March 23 1000h-1130h at SMGH
 - 2nd session- Tuesday April 9 1330h-1500h at WLU or SMGH*

- Group 2 - 1st session- Thursday March 28 1330h-1500h at WLU or SMGH
 - 2nd session- Tuesday April 9 1330h-1500h at WLU or SMGH*

- Group 3 - 1st session- Friday April 5 1200h-1330h at SMGH
 - 2nd session- Tuesday April 16 1200h-1330h at SMGH

If you are interested in participating but these times/dates do not work for you, please let me know and we can try to arrange an alternate time(s).

Thanks again for your consideration,
Mary Ostrowski

Appendix H: Participant Information Letter



Participant Information Letter
For Research Study

**Promoting Functional Status of Older Adults in the Emergency Department:
Exploring Emergency Department Nurses' Perceptions of Care Related to
Functional Decline**

Principal Investigator: Mary Ostrowski, RN, BScN, GNC(C)
Master of Science in Nursing (MSN) Student
School of Nursing
Trinity Western University
7600 Glover Road, Langley, BC V2Y 1Y1

This research is related to Mary Ostrowski MSN thesis.

Faculty Advisor for study: Faith Richardson, DNP, RN
School of Nursing
Trinity Western University
7600 Glover Road, Langley, BC V2Y 1Y1

Purpose:

Functional decline has been described as a devastating, yet avoidable consequence for older adults who receive hospital care. Literature suggests that nurses with adequate knowledge, skills, resources and supports to provide quality care can have an impact on improving the functional status outcomes of older adults through interventions to prevent functional decline, such as delirium detection, mobilization, incontinence management, restraint reductions and fall prevention.

The purpose of this study is to explore emergency department (ED) nurses' perceptions of practice on promoting the functional status of older adults in the ED of St Mary's General Hospital (SMGH). In particular, I would like to:

- learn more about the thoughts, attitudes and experiences of SMGH ED nurses with respect to functional decline in the older adult population;
 - identify what helps or hinders SMGH ED nurses' ability to give care that reduces the risk for functional decline in older adults in the ED of SMGH;
- and

- identify what SMGH ED nurses perceive as being the best approaches to improving care and preventing functional decline in older adults in the ED of SMGH.

It is anticipated that ED nurses who participate in this study will learn more about their practice and how it relates to providing quality care to prevent functional decline in older adults in the ED of SMGH, as well as identify and possibly foster additional interventions and strategies to promote the functional status of this population.

You are being asked to participate in this study because of your experience as a Registered Nurse working with older adults in the ED of SMGH.

Procedures:

In this study, participants will be asked to complete a demographic questionnaire (anticipated to take 15 minutes to complete) and participate in two 90 minute focus group interviews, with up to six participants per session. These interviews will focus on the topic of ED nursing practice and its relationship to preventing functional decline in older adults in the ED. A small number of interested participants will also be asked to take part in a third, 30 minute focus group interview being held to validate information gathered from the previous interviews. Each of the three waves of focus group interviews will be held a minimum of two weeks apart.

Participants will have the choice to attend the focus group interviews in a private room at SMGH or Wilfrid Laurier University (WLU) for the purpose of confidentiality and convenience.

Each focus group session will be moderated by the principal investigator and conducted as a semi-structured interview to allow participants to share their experiences as they relate to providing nursing care to reduce the risk of functional decline in older adults in the ED of SMGH. A series of questions pertaining to the study topic will be presented to participants during the sessions to prompt discussion. Throughout the interviews, the principal investigator will seek to clarify and summarize the information presented by the participants. A research assistant will take notes and write on a flip chart during the sessions.

The interviews will be audiotaped and any participant may request that the recording be turned off at any time during the interviews.

All audiotapes will be transcribed verbatim by a transcriptionist. After the audiotapes have been transcribed, participants will be provided with an opportunity to review the transcripts and provide comments on the content of the interviews. The first and second wave sessions will focus on clarification of data and the third session will focus on validation of data produced from analyses of data gathered from the previous sessions. Participants will be given more than one opportunity to confirm that the data summaries reflect their views, feelings, and experiences, or that they do not reflect these experiences.

All participants will be provided with a written summary of study findings and invited to attend a brief presentation of these findings. Invitations to attend this presentation will also be extended to others who may be interested in learning more about the study and its findings. Study results may also be published in a research journal.

Potential Risks and Discomforts:

It is not anticipated that the questionnaire and interview activities will cause harm to participants. The risks associated with participation in this study are no greater than those faced by the participants on a daily basis.

Participants may feel some lower back and/or leg discomfort with sitting for a prolonged period of time during the focus group interviews. Participants who need to stand and/or walk around the room during the interviews will be permitted to do so. The researcher will provide participants with refreshments and a stretch break to reduce the amount of sitting time during the interviews.

Participants are being asked to participate in group based interviews with fellow SMGH ED nurses. The face-to-face contact with other participants, the principal investigator and a research assistant means that other individuals in the group will know that they are in the study, so there is a potential risk for loss of privacy. All participants will be reminded at the start of each interview that what transpires during the interviews shall remain confidential and that the information conveyed during the interviews is not to be discussed outside the interview room. If at any time, any participant feels the need to excuse themselves from the group, they are welcome to do so. If any participant has concerns about the group sessions, they may contact the principal investigator or faculty advisor directly. Participating individually may be considered on an as needed basis.

All participants will be briefed on group expectations regarding appropriate behavior and confidentiality prior to each focus group interview. Participants may experience boredom, revelation of personal information and regret over the revelation of personal information within a group setting. Recollection of nursing practice experiences may also provoke increased emotion. The principal investigator will sensitively support and encourage expression of all experiences and if necessary or upon request, provide an additional rest break or end the interview.

Although facilitation can occasionally require the principal investigator to direct questions to specific participants to promote participation, participants will not be forced or coerced to answer questions. Participants will be made aware of their right not to answer questions and to withdraw from the study at any time.

Potential Benefits to Participants and/or to Society:

Through the opportunity of speaking with other ED nurses about their practice experiences, participants will have the opportunity to develop a greater awareness as to whether or not they have the necessary knowledge, skills, resources and supports required to prevent functional decline in older adults in the ED of SMGH. Participants can apply the experience of being involved in a nursing research study as a continuing competence activity for the College of Nurses of Ontario Quality Assurance (QA) Program. The

potential benefit to society and the nursing profession is a better understanding of what helps or hinders ED nurses' ability to provide quality care to prevent functional decline and promote the functional status of older adults in the ED.

Confidentiality:

Any information that is obtained in connection with this study and that can be identified with participant(s) will remain confidential and will be disclosed only with permission from the participant(s). The names and contact information of all participants will be kept in a locked filing cabinet separate from other information including the remaining information from the demographic questionnaires, audiotapes, transcriptions, and notes taken by the principal investigator and research assistant. Data from the demographic questionnaires, audiotapes, transcribed interviews and notes will be assigned an identification code and kept in a separate locked file drawer. A code-identity cross-reference list will also be kept in a separate locked file drawer.

Transcription will take place in a research office at WLU. The interviews will be coded numerically and no personal identifiers will be used during transcription. Participants will each be assigned a code (e.g., EDRN1, EDRN2) that will be used to identify them in the transcribed reports. Participants will be coded numerically so that the transcriptionist can identify who is speaking, but not associate these individuals to their name. No actual participant names will appear on any transcribed reports or in any quotes. In the event that a participant recounts a personal example of their experiences, any reference to other individuals (e.g., names, dates and times) will be replaced in the transcripts with XX (e.g., EDRN1 indicated that XX was in the ED on XX and was not assisted with ambulation for toileting due to...).

No identifying information will be entered on computer files. Transcriptions will be stored on the principal investigator's encrypted and password protected laptop computer and backup USB data sticks. Any data stored on the USB drives will be stripped of personal identifiers, encrypted and password protected. Hard copies of the transcriptions will be stored in a locked cabinet in a locked office.

Participants will not be identified by name in any reports, publications or presentations of the completed study.

All information gathered throughout the study will be kept in a secure area (i.e., locked cabinet in a locked office) for a period of no more than two (2) years after the study is completed. Audiotapes of the interviews will be erased at the completion of the study. The remaining data will be kept in a confidential manner for two years before being destroyed: paper documents will be shredded and electronic data on the USB drive and the principal investigator's computer will be deleted.

Renumeration/ Compensation:

All individuals who participate in the focus group interviews will receive compensation in the form of a \$10.00 Tim Hortons™ gift card and the opportunity to enter a draw for a \$50.00 Chapters™ gift card as a token of appreciation. Individuals who attend the third wave session will also be eligible to have their names entered into a draw for a \$10.00

Chapters™ gift card. Participants will be provided with light refreshments and snacks during the interviews.

Contact for Information about the Study:

If you have any questions at any time or desire additional information with respect to this study, you may contact Mary Ostrowski (principal investigator) or Faith Richardson (faculty advisor) using the contact information provided on the first page of this document.

Contact for Concerns about the Rights of Research Subjects:

This study has been reviewed and approved by the Research Ethics Board at Trinity Western University (File #12G19) and the Tri-Hospital Research Ethics Board (THREB #2012-0504). If you have any concerns about your treatment or rights as a research participant, you may contact Ms. Sue Funk in the Office of Research, Trinity Western University at 604-513-2142 or sue.funk@twu.ca or the Chair of the Tri-Hospital Research Ethics Board, Dr. Michael Coughlin at 519-749-4300 ext. 5367.

Consent:

Your participation in this study is entirely voluntary and you may decline to participate without penalty. If you decide to participate, you may refuse to participate in any or all parts of the study or withdraw from the study at any time without any consequences or explanation. If you withdraw from the study before attending the first focus group interview, your data will not be used in the study. If you withdraw after attending the first focus group interview, your study data will be included in the study, unless you request that it not be used, in which case it will be removed from the study.

I would like to thank you for reviewing the enclosed information. Should you have any questions, require additional information or want to participate in this study, please contact me directly using the contact information found on the first page of this document.

Thank you for considering becoming part of this nursing study.

Sincerely,

Mary Ostrowski, RN, BScN, GNC(C)
Principal Investigator
MSN Student, Trinity Western University

Appendix I: Participant Consent Form



Participant Consent Form
For Research Study

**Promoting Functional Status of Older Adults in the Emergency Department:
Exploring Emergency Department Nurses' Perceptions of Care Related to
Functional Decline**

Principal Investigator: Mary Ostrowski, RN, BScN, GNC(C)
Master of Science in Nursing (MSN) Student
School of Nursing
Trinity Western University
7600 Glover Road, Langley, BC V2Y 1Y1

This research is related to Mary Ostrowski MSN thesis.

Faculty Advisor for study: Faith Richardson, DNP, RN
School of Nursing
Trinity Western University
7600 Glover Road, Langley, BC V2Y 1Y1

Purpose:

Functional decline has been described as a devastating, yet avoidable consequence for older adults who receive hospital care. Literature suggests that nurses with adequate knowledge, skills, resources and supports to provide quality care can have an impact on improving the functional status outcomes of older adults through interventions to prevent functional decline, such as delirium detection, mobilization, incontinence management, restraint reductions and fall prevention.

The purpose of this study is to explore emergency department (ED) nurses' perceptions of practice on promoting the functional status of older adults in the ED of St Mary's General Hospital (SMGH). In particular, I would like to:

- learn more about the thoughts, attitudes and experiences of SMGH ED nurses with respect to functional decline in the older adult population;
 - identify what helps or hinders SMGH ED nurses' ability to give care that reduces the risk for functional decline in older adults in the ED of SMGH;
- and

- identify what SMGH ED nurses perceive as being the best approaches to improving care and preventing functional decline in older adults in the ED of SMGH.

It is anticipated that ED nurses who participate in this study will learn more about their practice and how it relates to providing quality care to prevent functional decline in older adults in the ED of SMGH, as well as identify and possibly foster additional interventions and strategies to promote the functional status of this population.

You are being asked to participate in this study because of your experience as a Registered Nurse working with older adults in the ED of SMGH.

Procedures:

In this study, participants will be asked to complete a demographic questionnaire (anticipated to take 15 minutes to complete) and participate in two 90 minute focus group interviews, with up to six participants per session. These interviews will focus on the topic of ED nursing practice and its relationship to preventing functional decline in older adults in the ED. A small number of interested participants will also be asked to take part in a third, 30 minute focus group interview being held to validate information gathered from the previous interviews. Each of the three waves of focus group interviews will be held a minimum of two weeks apart.

Participants will have the choice to attend the focus group interviews in a private room at SMGH or Wilfrid Laurier University (WLU) for the purpose of confidentiality and convenience.

Each focus group session will be moderated by the principal investigator and conducted as a semi-structured interview to allow participants to share their experiences as they relate to providing nursing care to reduce the risk of functional decline in older adults in the ED of SMGH. A series of questions pertaining to the study topic will be presented to participants during the sessions to prompt discussion. Throughout the interviews, the principal investigator will seek to clarify and summarize the information presented by the participants. A research assistant will take notes and write on a flip chart during the sessions.

The interviews will be audiotaped and any participant may request that the recording be turned off at any time during the interviews.

All audiotapes will be transcribed verbatim by a transcriptionist. After the audiotapes have been transcribed, participants will be provided with an opportunity to review the transcripts and provide comments on the content of the interviews. The first and second wave sessions will focus on clarification of data and the third session will focus on validation of data produced from analyses of data gathered from the previous sessions. Participants will be given more than one opportunity to confirm that the data summaries reflect their views, feelings, and experiences, or that they do not reflect these experiences.

All participants will be provided with a written summary of study findings and invited to attend a brief presentation of these findings. Invitations to attend this presentation will also be extended to others who may be interested in learning more about the study and its findings. Study results may also be published in a research journal.

Potential Risks and Discomforts:

It is not anticipated that the questionnaire and interview activities will cause harm to participants. The risks associated with participation in this study are no greater than those faced by the participants on a daily basis.

Participants may feel some lower back and/or leg discomfort with sitting for a prolonged period of time during the focus group interviews. Participants who need to stand and/or walk around the room during the interviews will be permitted to do so. The researcher will provide participants with refreshments and a stretch break to reduce the amount of sitting time during the interviews.

Participants are being asked to participate in group based interviews with fellow SMGH ED nurses. The face-to-face contact with other participants, the principal investigator and a research assistant means that other individuals in the group will know that they are in the study, so there is a potential risk for loss of privacy. All participants will be reminded at the start of each interview that what transpires during the interviews shall remain confidential and that the information conveyed during the interviews is not to be discussed outside the interview room. If at any time, any participant feels the need to excuse themselves from the group, they are welcome to do so. If any participant has concerns about the group sessions, they may contact the principal investigator or faculty advisor directly. Participating individually may be considered on an as needed basis.

All participants will be briefed on group expectations regarding appropriate behavior and confidentiality prior to each focus group interview. Participants may experience boredom, revelation of personal information and regret over the revelation of personal information within a group setting. Recollection of nursing practice experiences may also provoke increased emotion. The principal investigator will sensitively support and encourage expression of all experiences and if necessary or upon request, provide an additional rest break or end the interview.

Although facilitation can occasionally require the principal investigator to direct questions to specific participants to promote participation, participants will not be forced or coerced to answer questions. Participants will be made aware of their right not to answer questions and to withdraw from the study at any time.

Potential Benefits to Participants and/or to Society:

Through the opportunity of speaking with other ED nurses about their practice experiences, participants will have the opportunity to develop a greater awareness as to whether or not they have the necessary knowledge, skills, resources and supports required to prevent functional decline in older adults in the ED of SMGH. Participants can apply the experience of being involved in a nursing research study as a continuing competence activity for the College of Nurses of Ontario Quality Assurance (QA) Program. The

potential benefit to society and the nursing profession is a better understanding of what helps or hinders ED nurses' ability to provide quality care to prevent functional decline and promote the functional status of older adults in the ED.

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No identifying information will be entered on computer files. Transcriptions will be stored on the principal investigator's encrypted and password protected laptop computer and backup USB data sticks. Any data stored on the USB drives will be stripped of personal identifiers, encrypted and password protected. Hard copies of the transcriptions will be stored in a locked cabinet in a locked office.

Participants will not be identified by name in any reports, publications or presentations of the completed study.

All information gathered throughout the study will be kept in a secure area (i.e., locked cabinet in a locked office) for a period of no more than two (2) years after the study is completed. Audiotapes of the interviews will be erased at the completion of the study. The remaining data will be kept in a confidential manner for two years before being destroyed: paper documents will be shredded and electronic data on the USB drive and the principal investigator's computer will be deleted.

Renumeration/ Compensation:

All individuals who participate in the focus group interviews will receive compensation in the form of a \$10.00 Tim Hortons™ gift card and the opportunity to enter a draw for a \$50.00 Chapters™ gift card as a token of appreciation. Individuals who attend the third wave session will also be eligible to have their names entered into a draw for a \$10.00

Chapters™ gift card. Participants will be provided with light refreshments and snacks during the interviews.

Contact for Information about the Study:

If you have any questions at any time or desire additional information with respect to this study, you may contact Mary Ostrowski (principal investigator) or Faith Richardson (faculty advisor) using the contact information provided on the first page of this document.

Contact for Concerns about the Rights of Research Subjects:

This study has been reviewed and approved by the Research Ethics Board at Trinity Western University (File #12G19) and the Tri-Hospital Research Ethics Board (THREB #2012-0504). If you have any concerns about your treatment or rights as a research participant, you may contact Ms. Sue Funk in the Office of Research, Trinity Western University at 604-513-2142 or sue.funk@twu.ca or the Chair of the Tri-Hospital Research Ethics Board, Dr. Michael Coughlin at 519-749-4300 ext. 5367.

Consent:

Your participation in this study is entirely voluntary and you may decline to participate without penalty. If you decide to participate, you may refuse to participate in any or all parts of the study or withdraw from the study at any time without any consequences or explanation. If you withdraw from the study before attending the first focus group interview, your data will not be used in the study. If you withdraw after attending the first focus group interview, your study data will be included in the study, unless you request that it not be used, in which case it will be removed from the study.

Your signature below indicates that you have read and understand the above information and that you have had your questions about the study answered to your satisfaction. It also indicates that you have received a copy of this consent form for your own records.

Your signature indicates that you consent to participate in this study and that your responses may be put in anonymous form (using identification codes) and kept for further use for a period of 2 years after the completion of this study.

Research Participant Signature: _____

Date: _____

Printed Name of the Research Participant signing above:

Principal Investigator Signature: _____

Date: _____

Appendix J: Participant Questionnaire

Participant Demographic Questionnaire
For Research Study by Mary Ostrowski

This questionnaire is part of a research project that is exploring emergency department (ED) nurses' perceptions of practice on promoting the functional status of older adults in the ED of St. Mary's General Hospital (SMGH). Please complete each question to the best of your ability. The final section with your name and contact information will be torn off and kept separate from your completed questionnaire, in order to ensure your anonymity. When you have completed the questionnaire, please place it in the envelope provided and return it directly to me by _____. Thank you for participating in the study.

1. What is your gender?

- Male
- Female
- Prefer not to answer

2. What is your age in years?

- 20 – 24 years
- 25 – 29 years
- 30- 34 years
- 35- 39 years
- 40 – 44 years
- 45 – 49 years
- 50 – 54 years
- 55 – 59 years
- 60 years or greater
- Prefer not to answer

3. What are your total years of experience as a registered nurse?

- 0 - 2 years
- 3 - 5 years
- 6 - 10 years
- 11 - 20 years
- 21 – 30 years
- 30 + years
- Prefer not to answer

4. What are your total years of experience as an ED nurse at SMGH?

- 0 - 2 years
- 3 - 5 years
- 6 - 10 years
- 11 - 20 years
- 21 – 30 years
- 30 + years
- Prefer not to answer

5. What nursing education you have completed? (please check all that apply)

- Diploma
- Baccalaureate degree
- Master’s degree
- Post – basic diploma or certificate in a nursing specialty/area of nursing practice

Program title	Year	Specialty / Area of Practice
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- Prefer not to answer

6. Please describe any education which you have completed that is specific to geriatrics:

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Participant Name: _____

Address: _____

Telephone number(s): _____ (home)
_____ (cell)

Email address: _____

Thank you for completing the questionnaire.

Appendix K: Interview Guide

First Wave Focus Group Interview Guide**Conceptualization of Functional Status and Functional Decline in Older Adults**

1. What comes to your mind when you hear the term *functional status of older adults*?

Functional decline has been described as a devastating but avoidable consequence for older adults (aged 65 years and over) who need hospital care (Graf, 2006; King, 2006).

2. How would you describe *functional decline in older adults*? What thoughts and images come to your mind when you think of this term?

Assessment of Current Nursing Practice in Relation to Functional Decline in Older Adults in the Emergency Department (ED) of St Mary's General Hospital (SMGH)

King (2006) suggests that nurses can significantly impact the functional status outcomes of older adults through interventions to prevent functional decline, such as delirium detection, mobilization, incontinence management, restraint reductions and fall prevention.

3. In your daily practice in the ED of SMGH, what helps or hinders your ability as a nurse to give care that reduces the risk for functional decline in older adults?
4. What are the "best tools" (i.e., strategies or interventions) that you personally use to maintain or enhance the functional status of older adult patients in the ED of SMGH?

References

- Graf, C. (2006). Functional decline in hospitalized older adults: It's often a consequence of hospitalization, but it doesn't have to be. *American Journal of Nursing*, 106(1), 58-67.
- King, B.D. (2006). Functional decline in hospitalized elders. *MEDSURG Nursing*, 15(5), 265-271.

Appendix L: Verbal Evaluation for Wave 1

Questions to be asked after a brief verbal summary of the first-wave interviews and a request to bring a *visual item* to the second-wave sessions, is made to the participants:

- 1) Is there anything else that you would like to add?
- 2) Is there anything that I could have done to clarify the questions asked?
- 3) Any other questions or comments?

Thank you very much for your time and sharing your thoughts during this session.

Appendix M: Group 1, Wave 1 Summary

**Preliminary Summary of Group 1 Focus Group Session:
Monday, March 18, 2013**

- Participants in this group have varied degree of knowledge in geriatrics and experience with emergency department care of older adults
- One participant noted interest in study topic was both professional and personal, able to relate topic to what she is experiencing with what is happening with her own parents (discussion which occurred while group waiting for arrival of third participant)

What comes to your mind when you hear the term “functional status of older adults”?

- Ability to be independent with ADLs and IADLs (i.e. ambulation, shopping, cooking)
- Ability to look after own well being and needs
- Ability to exist in own community, “circle of care” and “circle of friends and family”
- Includes physical and mental/cognitive dimensions
- Knowing how they are adapting in terms of ADLs and IADLs
- Something that is “dynamic”
- Need to know “meaning” for ED visit
- “older adult”= “self”, person who is “65+”, “retirement years or beyond”, someone who is “frail”
- Image of frail adult? = “weak and not as vibrant”, “thin” hunched over”, bones crack when they move”, if you move then the wrong way, something’s going to give”
- “as soon as you put a hospital gown on somebody, they look older and they look more frail”
- Belief that a frail or not frail looking person in hospital will appear different in the community
- When older adults come to hospital, we take them out of their comfort zone and do not provide the supports they are used to at home. Not sure if this is related to how they feel, or environment issues (i.e. being confined to a bed, on O2)
- In hospital there is a tendency to focus on their deficits, on what they can’t do rather than what they can do
- Issues that affect the ED nurses’ ability to promote functional status?- lack of time, staffing, other more acute patients
- Inability to provide care participant(s) would like leaves them feeling guilty, in “turmoil”, struggling with competing priorities (i.e. acute issues such as someone in pain takes priority over assisting older adults)
- “the sicker they are and the more frail they are, the less they want to trouble you”
- Need to know what is considered “normal” for each person and this often requires need to “dig”
- Physical function you can see, but cognitive deficits may not be as evident

How would you define functional decline in older adults?

- Involves a change, “they were on a line and now they’ve come down from that line”
- Dependency that may be a result of depression or anxiety, “just give up”
- Hard to assess early
- Often seen in pts who remain in ED and participant sees when return for next shift (examples shared of how pts more confused and functionally dependent next day)
- Need to provide pts with more control of their situations and increased opportunities to mobilize and be out of bed, ensure meds given, have what is needed to promote orientation (i.e., clocks)
- Feelings of guilt and feeling upset expressed while one participant shared example of seeing a pt become more confused after being in the ED overnight, another while speaking about older pts not getting their pills
- Need for more education though not all staff are open to learning opportunities
- Feel there is limited support for education of front line staff
- “when people become functionally declined, it is like the TIA of a stroke”... “deconditioning is really the TIA of frailty”

Strategies and interventions used personally to maintain or enhance functional status?

- Get patients out of bed, sitting in chair, ambulating with necessary supports and equipment, ensuring they have their meds, ensuring they have their glasses and teeth
- When available time, assisting patients with hygiene (i.e. washing)
- Making referrals to GEM and others for support to help ensure patients needs are met
- Isolation major issue, limits promotion of functional status; also cardiac monitoring
- ED “not set up to look after geriatric patients in any way”
- Need to assess functional status to treat the person
- ED staff need to feel valued
- Need for more education, practical tool for assessing function status, better staffing levels in ER so there is more time to provide necessary care to older adults, compensation for education inservices
- People need to “trust their judgment” and practice to their “full scope”
- “maybe if we did a better job of assessing functional decline and things like this, we would be able to improve the flow through the department of these elderly people”

Appendix N: Group 2, Wave 1 Summary

**Preliminary Summary of Group 2 Focus Group Sessions:
1a-Sat March 23, 2013 and 1b-Thurs March 28, 2013**

- Information in this summary gathered from grouping data from 2 sessions.
- Participants in this group have varied degree of experience as RNs as well as amount of time working in the SMGH ED; none have formal education in geriatrics
- both groups had opportunity to address same 3 preliminary questions
- interest expressed in knowing influence if any, in what hospital staff has on what happens in the community (potential area where education should be provided, along with education on what level of care can be provided in retirement homes and long term care facilities?)
- study topic is as “complex” as the patients themselves
- expectation by some staff and patients alike, that older adults need to be “cared for” when they present to hospital
- primary dilemma in ED is “conflicting priorities”
- “Emerge is not equipped to deal with admitted patients”- “MASH medicine”

What comes to mind when you hear the term “functional status of older adult”?

- Physical function- how mobile; how they manage ADLs and IADLs (ambulation, driving, cooking); whether they are continent
- Mental and emotional functioning- independence; ability/ capability to speak for themselves and make their own decisions; not be bullied; history of confusion; whether managing meds appropriately since can have “profound” effect
- One RN thinks mental status first, then functionality
- Need to have background information i.e. to know their baseline level of function and cognition/ mental capacity/status...also if any disease process (new or existing)- obligation as a nurse to obtain this information even though ER RN often limited in ability to do this due to availability of family to provide information as well as support with care; what else might be happening in the ER (focus more on acute vs chronic issues)
- Inability to get this information can leave ER RN in a real “quandary”
- Personal reflection on how ‘self’ as getting older and personal experiences and background might influence practice
- Important to know current living environment and supports available to older adults
- Need to know why person came to ER and whether option to receive care/treatment in nursing home or retirement home- belief that older adults should not always be sent to ER as it is not always in their best interest- can be traumatic and cause functional/ cognitive decline
- Interest in knowing what services and supports can be provided in retirement and nursing homes, also in knowing stats of how many nursing home patients actually come to ER, and why some patients need to come to ER to be assessed instead of in their home in the community
- Older adults who are admitted and held in ER do not receive the same level of care as they would on inpatient units due to environmental factors such as

- availability of staff, equip, etc and this causes RN to have feelings of guilt, resentment, view that older person can be an intrusion
- Family members can provide adequate information and decrease workload, but sometimes RN ambivalent about asking them for help
- Competing priorities influence care RN can provide
- Care nurses provide influenced more by experience and background rather than age
- Difference in how nurse working in community vs nurse working in hospital views functional status of older adults- community “What is available to enhance this patient’s life?” as opposed to in the ED, “What are going to be my limitations here in the department with this patient?” “What don’t we have?”
- Chronological age not as significant why to describe “older adults’
- Belief that older adults typically know go to their family physician regularly

How would you define “functional decline in older adults”?

- Expect decline with aging
- Memory is one of the first things noticed by one RN, especially when doing assessments and interviewing older adult patients
- Another RN thinks more about safety, risk of falls
- Need to know background information, gather information from as many sources as possible
- Need to know if decline occurred before ER visit, if acute, gradual or chronic; if reason for visit
- Can be distressing to older adults who are unaware and/or unwilling to accept progressive limitations and upsetting to RN who must deal with these distressing situations
- History from family can have HUGE impact
- Description of older adult who has decline- someone who presents to ED with c/o “general weakness”; is unkempt, has weight loss, is dehydrated, unhappy, may look depressed, in distressed
- Presence of functional decline more likely when patients in ED for long periods, typically due to lack of orientation
- Isolation also significant issue that causes decline in ED
- Treatment of fever or other acute disease processes
- Older adults with functional decline can be “labour intensive”, cause ER RNs to be frustrated and fatigued

Strategies and interventions used personally to maintain or enhance functional status of older adults in the ED of SMGH?

- RNs’ backgrounds and experiences direct care, also what is going on in the ER that day (i.e. critical cases), workload, if short staffed (then less time to stay with patients), availability of resources such as GEM and CCAC
- GEM nurse one of best supports
- Family in certain cultures also invaluable
- Interviewing and talking to patients and their families
- Giving them time and listening to them
- Taking them to the bathroom

- Providing patients with support/assist with toileting, personal hygiene, bathing, ambulation, sitting in chair for meals... just even getting out of bed
- Providing support for families who are able to help patients but also being aware and not being judgemental that not all family members are comfortable or willing to help
- Need to take time to talk to patients and treat them as a “whole person”
- Need to know more about the role of volunteers and how they might support older adult patients
- Obtaining adequate information for retirement homes or long term care home
- Need to know DNR status, wishes of patients and family members
- Need to encourage and utilize services of family physician more
- Need to have proper beds, commodes, walkers

Appendix O: Group 3, Wave 1 Summary

**Preliminary Summary of Group 3 Focus Group Session:
Friday April 5, 2013**

- participants in this group have varied degree of knowledge in geriatrics and a minimum of 11-20 years of nursing experience
- numerous personal experiences of older adults were presented- discussed their difficulties and frustrations with access and treatment by various members of the medical community; best experiences have been when adequate time given

What comes to mind when you hear the term “functional status of older adults”

- how they deal with their activities of daily living (ADLs) and instrumental ADLs (IADLs) and whether they are cognitively appropriate—mobility, bathing, dressing, medication management (*There was a request for clarification of IADLs*)
- functionality has physical and cognitive components; cognitive issues can have a significant impact on the practice of ED nurses
- wonder about their home life- where they live, whether they live alone and whether they have adequate supports
- how you approach the patient in Emerg is to see how they are functioning on a daily level
- What has happened to cause them to come to ER? Has there been a change in their function and if so, what has changed how?
- Reason for ED visit often involves change in their functional status, as noted by family members, who may or may not see them on a regular basis
- Older adults sometimes present to the ED in “crisis” with the diagnosis of failure to cope, syncope, pneumonia and chest pain --failure to cope is different than someone who comes in ill
- Important to know how older adults were/are functioning because it can dictate the kind of care they need in the ED and helps to determine their plan of care; also what kind of services/referrals they may need (i.e. GEM or Social Work), what their discharge planning needs could be, and whether they are more apt to return to the ED
- by focusing on functional status, you may conduct a more thorough assessment and uncover “coping issues” that can affect their discharge
- unfortunately, ED nurses are more apt to focus only on the immediate, short term needs of their patients due to time constraints and the needs of other ED patients
- ED nurses also need to do focus but feel constrained by time to do that properly
- perhaps need for ED nurses and primary care physicians to have more training on older adults and elder care, and how best to communicate with older adults
- nurses spend more time with patients than physicians and are more likely to obtain more supplemental information about their patients’ functional status
- appears to be more older adults presenting to ED with mental health issues, possibly related to aging population
- important that ED nurses get as much information as they can about the baseline

functional status of older adult patients and whether lack of motivation or lack of function may be due to depression

- older adults often treated differently than younger adults when it comes to identifying and treating depression, suicidal ideation and issues of neglect
- family physicians need to be more comfortable and take more time to talk to their older adult patients about aging and end of life issues, especially with those who have several co morbidities
- older adults who have numerous co morbidities and/or their family members often have unrealistic expectations and desires this can cause ED nurses to be frustrated- need for patients and families to know that not all things can be “fixed”
- often families want the magic answer and are unable to let older adults patients with chronic conditions, refuse treatment- possibly due to guilt
- advanced care planning for the elderly is especially important- necessary to talk about DNR status which can be viewed as a “taboo topic”, often not talked about by many patients and their families
- Are older adults able to make their own decisions safely?
- functional ability rather than chronological age is the best way to describe an older adult
- differentiation made between *older adult* (seen as more health functioning older person) and *elderly person* or *senior* (not functioning as well, under more physical and functional decline)
- in Emerg,
- older adults present differently than they do in the community- often less independent, we can put them in humiliating and limiting situations
- resources, type of equipment available and ED culture affects the kind of care ED nurses can provide

How would you define functional decline of older adults?

- change in functional and cognitive ability
- we often take away an older adult’s independence in the ED
- lengthy ED stay can be challenging for older adults, especially those who have a dementia along with the ED nurses who care for them as there are not enough resources available to keep them orientated
- often see decline of patients in ER because of this

Appendix P: Verbal Evaluation for Wave 2

Questions to be asked following a brief summary of what was discussed during the second-wave interviews:

- 1) During the interview sessions:
 - (a) Have we looked at your awareness, attitudes and experiences as it pertains to your care in promoting the functional status of older adults in the emergency department?
 - (b) Have we identified the strategies and interventions that you use to prevent functional decline of older adults in the ED?
 - (b) Have we identified the facilitators and barriers that you encounter in providing care to promote the functional status of older adults in the ED?
 - (d) Have we identified what you think are some of the best approaches to improving your care?
- 2) Do you have any final comments or points that you would like to make with the group? If you prefer, you are also welcome to share them with me in private after the session.
- 3) If after you leave, you decide that you would like me to change something in the preliminary summary, please get back to me, otherwise I will assume that you agree with what has been written.
- 4) All of you are invited to attend the third-wave interview session where there will be an opportunity to validate the information from all of the groups. I will inform you of the date and time of the session, when it is confirmed.

Thank you.

Appendix Q: Wave 3, Validation Session Summary

Validation Session for Research Project by Mary Ostrowski
June 19, 2013

**Promoting Functional Status of Older Adults in the Emergency Department:
Exploring Emergency Department Nurses' Perceptions of Care Related to
Functional Decline**

Project Purpose:

- explore ED nurses' perceptions of practice on promoting the functional status of older adults in the ED of SMGH and preventing functional decline within this population.

Project Aims

- explore the awareness, attitudes and experiences of RNs in the ED of SMGH with respect to functional decline in the older adult population;
- identify the strategies and interventions being used by RNs in the ED of SMGH to maintain and/or enhance the functional status of older adults within the ED;
- identify what RNs in the ED of SMGH perceive to be the facilitators and barriers to providing quality care to prevent functional decline in older adults in the ED; and
- identify what RNs in the ED of SMGH perceive as being the best approaches to improving care and preventing functional decline in older adults in the ED

Older adults who present to the ED are a vulnerable population with special needs and expectations.

ED nurses' role in managing older people is complex.

Issues with family and caregivers of older adults exist and can help or hinder care provided by ED nurses.

RN knowledge base and experience can have an impact on quality of care of older adults.

The ED environment/culture does more to promote functional decline than promote functional status.

Background information about older adults' baseline status and reason for ED visit is essential.

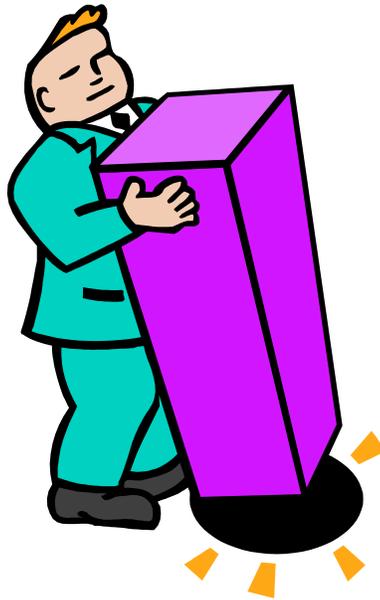
More resources, education and supports are needed to help ED nurses promote the functional status of older adults in the ED.

Care of older adults is often fragmented.

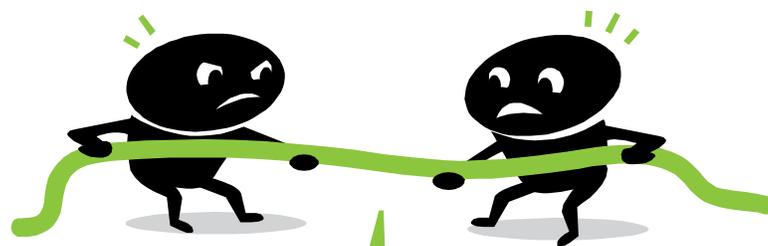
Standardized documentation would be of benefit.

Discussions centered more on what hinders participants' abilities to provide the care they feel is required to meet the comprehensive needs of older adults/elderly patients in the ED:

Opportunities for improvement exist at all levels.



HOW ELDERLY AND ADMITTED PATIENTS 'FIT' WITHIN THE ED DEPARTMENT?



CONFLICTING VARIABLES
COMPETING PRIORITIES
OPPOSING MODELS OF CARE
SYSTEM PRESSURES
LEADS TO

MORAL DISTRESS



Describe a day when “the stars aligned” and you left work feeling good about the nursing care you provided to your patients.

Appendix R: Debriefing Letter



Dear Participant,

Thank you for participating in my study, **Promoting Functional Status of Older Adults in the Emergency Department: Exploring Emergency Department Nurses' Perceptions of Care Related to Functional Decline**. As a reminder, the purpose of the study was to explore emergency department (ED) nurses' perceptions of practice on promoting the functional status of older adults in the ED of SMGH and preventing functional decline within this population.

In this study, you were asked to complete a demographic questionnaire and participate in at least two focus group interviews. Information gathered from these activities will help fill the gap in nursing literature regarding the experiences of ED nurses and what they perceive as being the best approaches to improving care and preventing functional decline in older adults in the ED.

Please remember that any data pertaining to you as an individual participant will be kept confidential and that all information gathered through the study will not contain any identifying information and will be reported anonymously in any written work. Please respect all participants' right to privacy by not sharing any personal or identifying information with individuals who did not participate in the study, without first receiving permission from the participant(s) to do so.

Once all of the data for the study has been collected and analyzed, I will provide you with a written summary of the study findings and invite you to attend a brief presentation of these findings. If you are interested in receiving more information regarding the results of the study, or if you have questions or concerns, please contact me at the phone number or email address listed at the bottom of the page. You are also welcome to contact me for additional information and references, if you have a more general interest in this area of research.

This research project was reviewed and approved by the Research Ethics Board of Trinity Western University and the Tri-Hospital Research Ethics Board. Should you have any comments or concerns resulting from your participation in this study, please contact Ms. Sue Funk in the Office of Research, Trinity Western University at 604-513-2142 or sue.funk@twu.ca, or the Chair of the Tri-Hospital Research Ethics Board, Dr. Michael Coughlin at 519-749-4300 ext. 5367.

Thanks again for your help and involvement in this nursing study.

Sincerely,

Mary Ostrowski, Master of Science in Nursing (MSN) Student
School of Nursing, Trinity Western University
Contact phone number: xxxxxxxxxxxx
Email address: xxxxxxxxxxxxxxxxxxxx

Appendix S: Confidentiality Agreement for Transcriptionist

CONFIDENTIALITY AGREEMENT FOR TRANSCRIPTIONIST
for Research Study by Mary Ostrowski (Principal Investigator)

I understand that:

- all confidential and/or personal information that I have access to, or learn from my affiliation with the principal investigator of this study, is confidential,
- as a condition of my affiliation with the principal investigator of this study, I must comply with the following:

I agree that I will not access, use or disclose any confidential and/or personal information that I learn of, or possess because of my affiliation with the principal investigator of this study, unless it is necessary for me to do so in order to perform my responsibilities as transcriptionist. I also understand that under no circumstances may confidential and/or personal information be communicated except to the principal investigator.

I agree that I will protect the confidentiality of any information that I access and that I will not alter, destroy, copy or interfere with this information, except with authorization and in accordance with the principal investigator

I agree that I am accountable for the work I do in my role as transcriptionist for this study. I will ensure that while in my possession, I will keep all data pertaining to this study (i.e., interview audiotapes and transcriptions stored on password protected external USB drive) in a locked drawer. If I have reason to believe that any confidential information has been compromised or stolen, I will immediately notify the principal investigator.

I agree to return all data pertaining to this study to the principal investigator as soon as I have completely transcribed the audiotapes of the focus group interviews.

 Signature of Transcriptionist
 Date

 Name of Transcriptionist

 (print)

 Signature of Principal Investigator
 Date

 Name of Principal Investigator

 (print)

