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INTENDED, PROPER, AND ACTUAL UTILIZATION OF THE EMERGENCY
DEPARTMENT: A SURVEY OF EMERGENCY NURSES' PERCEPTIONS

A Thesis

Presented in

Partial Fulfillment of the

Requirements of the Degree of

Master of Science

November, 2010

BY

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ABSTRACT

The purpose of this study was to determine the perceptions of emergency nurses on the intended, ideal, and actual utilization of their emergency departments. Emergency nurses who self-identified by membership in a couple of online mailing lists catering to that specialty were invited via email to participate in an online survey. Participants described the purpose of the emergency department in which they work, along with their perception of how it is actually used and should be used. Responses were sorted by content analysis, with some of the resulting themes analyzed using demographic data supplied by participants. A range of responses were received on a continuum ranging from a desire to limit the use of the emergency department to actual emergencies, to accepting patients who perceived their needs were emergent, to allowing all comers to use the emergency department. Using a Salutogenic framework, answers on the former end of the continuum were determined to represent rigid ideals that put nurses at risk for burnout, while those at the latter end were more likely to buffer nurses against burnout. Providing a mission statement specific to the emergency department, which many emergency departments were found not to have, can be one way of providing institutional guidance to emergency nurses and supporting attitudes that protect against burnout.

Chapter 1

Introduction

The American College of Emergency Physicians (ACEP) (2009) defined ‘Emergency Services’ as:

Emergency services are those health care services provided to evaluate and treat medical conditions of recent onset and severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that urgent and/or unscheduled medical care is required. (p. 86)

However, a hospital’s Emergency Department (ED) serves additional functions beyond emergent and urgent treatment, providing general treatment to patients from the community, acting as an initial gateway to many of a hospital’s services, and (from a business standpoint) providing the hospital with a steady stream of new customers. One source of consternation over the past two decades as ED crowding has increased is the increasing number of patients who utilize the ED for primary care. Whether or not these patients carry insurance, they take up both time and space, increasing ED crowding and the amount of time that EDs spend on diversion. The Emergency Nurses Association (ENA) (2005) acknowledged that “[c]rowding is a systems issue that results from increased input as well as inefficient patient flow through the hospital,” and that part of alleviating the increased input will involve efforts to teach patients “when and how to access emergency care” (p. 1). These concerns were echoed the following year in a report by the Institutes of Medicine (2006). The ENA has had a position on crowding since 1989, but the literature on inappropriate attenders, or non-urgent attenders, to the ED stretches back over 150 years (Liggins, 1993). Since the situation has not improved over

the past twenty years, it is perhaps time to reevaluate the primary purpose of the ED and, more broadly, the ways in which the community interacts with and enters into their local hospital(s).

Purpose

The intended uses of the hospital ED and the services it should be providing are two distinct, though overlapping, concepts. Much has been written on the actual use of the ED, but little on how it should be used. As such, this research (1) assessed the current state of the literature on ED usage and staff perceptions of the same, and (2) determined and described the opinions and attitudes of emergency nurses about how the ED is and should be used.

Significance

This work is significant in that nurses' perception of meaningfulness in their jobs have been shown to have a direct impact on burnout (Cilliers, 2003). While outside the scope of this study, it seems reasonable that caring for large numbers of non-urgent patients would lead emergency nurses to question the meaningfulness of their positions. As nurses experience the process of burnout, they experience cynicism and detachment as job stresses take their toll (Maslach, 1993). As cynicism related to burnout is associated with turnover (Leiter & Maslach, 2009), an investigation of emergency nurses' perceptions of how their skills are utilized by the community can provide insights into possible reasons for emergency nurse burnout and turnover. Losing nurses to turnover exposes institutions to the costs of training new nurses to replace those which have departed, as well as the indirect costs associated with losing experienced staff. Further, burned-out nurses experience a litany of physical, cognitive, affective, motivational,

behavioral, and interpersonal symptoms that have a negative impact on ability to effectively care for patients (Cilliers, 2003). This work provides a foundation for understanding emergency nurses' perceived disconnects between what their duties are and how they should be utilized, allowing future researchers the necessary knowledge to plan, implement, and evaluate interventions to alleviate burnout in this population.

Theoretical Framework

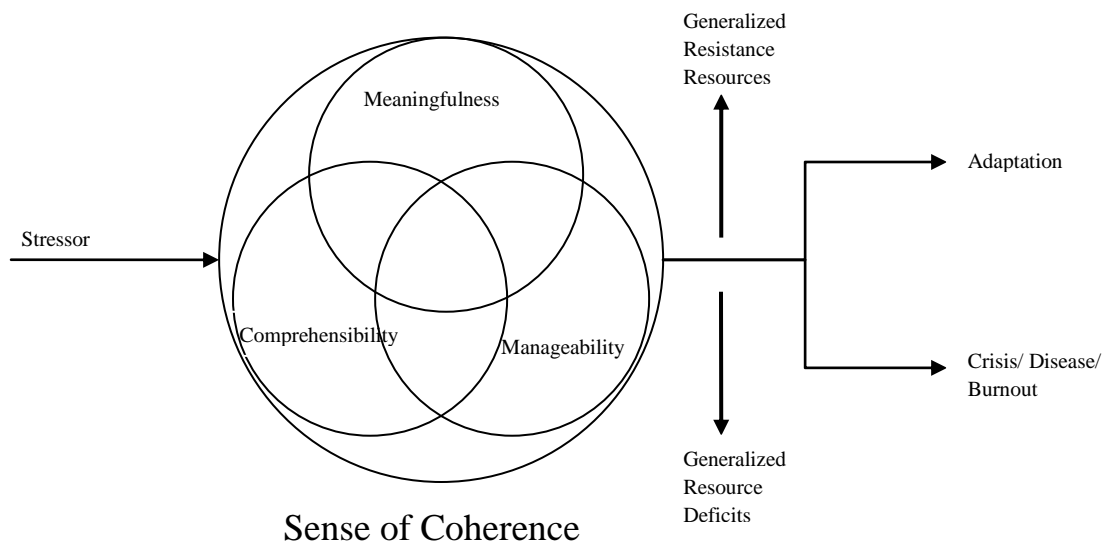
The overarching framework for this study is Salutogenesis, originally designed by Antonovsky (1987), which posits that health exists as “a continuum on an axis between total ill health (dis-ease) and total health (ease)” (Lindström & Eriksson, 2005, p. 440). Although Antonovsky was a medical sociologist, he intended his theory to be interdisciplinary, and explicitly cites nursing as a receptive audience for his theory (1987). In Salutogenesis, awareness of one's situation and ability to mobilize resources to positively change it is referred to a Sense of Coherence (SOC). Assessments of SOC in nurses have been shown to be inversely proportional to levels of burnout (Cilliers, 2003). While this study did not directly assess SOC using Antonovsky's tool for assessing it, the investigation did relate to meaningfulness, a component of the SOC as identified by Antonovsky (Lindström & Eriksson, 2005). Meaningfulness, as defined by Antonovsky (1987) in the context of SOC, is:

[T]he extent to which one feels that life makes sense emotionally, that at least some of the problems and demands posed by living are worth investing energy in, are worthy of commitment and engagement, *are challenges that are 'welcome' rather than burdens that one would much rather do without.* [Emphasis mine] (p. 18)

Specifically, the assumption is that nurses not involved in the type of care that originally attracted them to a particular field will experience reduced meaningfulness in their jobs,

predisposing them to burnout, while those who are involved in such care maintain or improve their sense of meaningfulness, channeling job stress towards positive ends and providing what Antonovsky calls Generalized Resistance Resources (GRR) (1987), thus helping to protect against burnout. Understanding nurses' perceptions of patient utilization of resources is therefore important, due to the protective effects of congruency between the expected and actual utilization of nurses' time and resources by patients. The general Salutogenic model is depicted in Figure 1.

Figure 1. Antonovsky's model of Salutogenesis



Chapter 2

Review of Literature

CINAHL searches through DePaul University's library without limits on the year span using the subject headings of "Emergency Services", "Utilization", and "Emergency Nursing" on 30 January 2010 returned 181 hits English-language articles, though the number of useful articles was far fewer. Articles retrieved by this search served as a base from which other pertinent articles were found by looking up references and using Medline, Google Scholar, and other services to engage in citation searches. Literature from a range of related fields was examined, including Social Work, Public Health, Healthcare Administration, Medicine, and Nursing. Appropriate usage of the ED is usually defined in the literature by what is inappropriate, and even then the definitions are commonly vague, as discussed by Sanders (2000). In fact, a significant amount of literature focuses on explaining why patients become inappropriate attenders of the ED and interventions to prevent or redirect patients to more appropriate locations for treatment. Some further literature was found that examined staff perceptions of inappropriate attenders. Additionally, while the intended role of the British Accident and Emergency (A&E) department was laid out in The Platt Report (1962), no such official definition exists for EDs in the United States, and neither are there updates for A&Es in the Commonwealth nations. The Centers for Disease Control and Prevention National Center for Health Statistics' National Hospital Ambulatory Care Survey has, since 1997, categorized the immediacy of a patient to be seen as 'Emergent' if the patient needs to be

seen in less than 15 minutes, ‘Urgent’ for 15-60 minutes, ‘Semiurgent’ for 1-2 hours, and ‘nonurgent’ for anything greater than two hours, but cites no source to justify the cutoffs between categories (Nourjah, 1999). With this lack of concrete definition in the literature, this review of literature is organized by thematic findings from the literature reviewed: explaining inappropriate attenders, attitudes of clinicians to inappropriate attenders, and interventions to divert inappropriate attenders.

Inappropriate Attenders: Why Do They Come?

A literature review by Liggins (1993) nebulously defined an ‘inappropriate attender’ of A&E as a patient who attends A&E “but whose injury or ailment does not require hospital treatment.” Of more use is Liggins’ catalogue of reasons for inappropriate attendance at A&E departments: after-hours availability, self-perception of severity or urgency, and the perceived quality of care at the hospital/A&E department as opposed to the patients’ own general practitioner (Ibid.). These factors come up time and again in later literature. Concurrently, Padgett and Brodsky (1992) conducted their own review of literature on psychosocial factors influencing use of the ED. While the statistics on usage they cite are now out of date, they highlight accessibility of care and the importance of psychosocial stresses on the decision to utilize the ED, incorporating their findings into a model of how patients decide to use the ED, appropriately or not (Ibid.). Continuing work in this vein, Koziol-McLain and colleagues (2000) conducted a study using narrative interviews with uninsured ED patients who had been triaged as nonurgent. They found that, beyond a lack of resources, a significant number of participants reported psychosocial stressors that magnified the perceived urgency of their situation (Koziol-McLain et al., 2000).

A more recent study by Rust, Ye, Baltrus, and Daniels (2008) analyzed data from the 2005 National Health Interview study and found that patients who had a primary care physician but experienced barriers to primary care, such as being unable to make an appointment or arrange transport, were significantly more likely to utilize the ED than those without such barriers. Interestingly, of the five barriers looked at in the study, only one, a lack of transportation, was not under the control of the primary care physician (Rust et al., 2008).

A retrospective demographic study by Milbrett and Halm (2009) described the ‘common’ frequent user of a 22-bed Midwestern ED, as well as factors predictive of increased attendance at the same institution. The authors found that the common user was “female, 35 years old, white, single, unemployed, living alone, with private insurance/Medicaid and a primary care physician,” although predictors of increased attendance were slightly different: “male, non-Black race, part-time employment, retired/unemployed, having Medicare, and having a chief complaint of upper respiratory infection,” (Milbrett & Halm, 2009).

Internationally, an Israeli study by Rassin, Nasie, Bechor, Weiss, and Silner (2006) reported on ED patients who had self-referred to the ED and were subsequently discharged home, collecting demographic information, reasons for self-referring, and a comparison of the patient’s perceived urgency compared to the urgency of the case as perceived by the ED nurse treating said patient. Using Padgett and Brodsky’s model from 1992, Rassin and colleagues found that most visits were for orthopedic complaints, that relatives’ recommendations to visit the ED were a significant factor in coming to the ED, that increasing age corresponded with increasing willingness to declare their problem

‘urgent’, that nurses were as likely to deem a case as ‘not-urgent’ as patients were to declare it ‘urgent’, and that increasing patient age correlated with a nurse’s willingness to call a case ‘urgent’. They also found that, while patients did report being under stress, psychosocial problems like homelessness, alcoholism, mental disease, and the like “were not salient”, though the authors do note that patients with such problems arrive by ambulance and as such were ruled out by the study’s inclusion criteria (Rassin et al., 2006).

A Canadian study by Hodgins and Wuest (2007) reported that, regardless of urban or rural setting, the major determinants of whether or not patients will self-report to the ED for non-urgent reasons are the perceived need for immediate care along with their own perceptions of urgency or the likelihood that their condition will worsen. They also noted that rural Eds were used much more often for routine care, refills, forms, and follow-ups than urban Eds (Hodgins & Wuest, 2007).

A study by the University of Wollongong’s Centre for Health Science Development found that a population of potential primary-care patients in Australian Eds reported similar reasons for attending the ED as reported by other studies, although they ranked the frequency with which patients in the study group listed each reason (Siminski et al., 2005). A significant finding of the study was the prevalence of patients who cited the complexity of their case as the reason they attended the ED (Ibid.).

In the latter three research studies above, the inability of the patient to pay to see a primary care physician did not rank highly in the reasons the patient chose to attend the ED. This is not surprising, as all three countries have some sort of nationalized health care system that pays for both primary care and emergency care. This differs from the

situation in the US, where the Emergency Medical Treatment and Active Labor Act (EMTALA) of 1986 ensures that the ED is in some cases the only place where patients can receive medical care regardless of social standing or ability to pay. However, as Siminski and colleagues (2005) point out, whether a patient reports to their primary care provider or to an ED has an impact on where the funding for those patient encounters comes from in an international setting, and is thus of import.

Attitudes of Clinicians toward Inappropriate Attenders

The University of Wollongong's Centre for Health Science Development conducted a follow-up study to their 2005 report that investigated the perceptions of ED nurses and attending physicians of the reasons that potential primary care patients report to the ED, using a similar instrument to that used in their previous study (Siminski et al., 2005; Masso et al., 2007). Masso and colleagues (2007) also updated their previous study to enable direct comparisons. They found that while patients once again highlighted the immediacy and complexity of their presenting complaints, the clinical staff perceived these to be middling reasons, instead citing financial reasons and scheduling convenience as the factors that most heavily drive potential primary care patients to use the ED (Ibid.).

The work of Masso and colleagues was preceded in 2000 by a metasynthesis by Sanders, who looked at the attitudes of providers towards inappropriate attenders in previous studies. Sanders (2000) found that there is no universal definition of an inappropriate attender; Liggins' (1993) definition cited earlier is but one of many. This lack of a standard definition is blamed for the wide range of reported frequencies of inappropriate attenders in the literature (Sanders, 2000). Sanders also points out that the attitudes of staff towards inappropriate attenders in prior literature is decidedly negative,

even though many of those patients think they have good reason to report to the A&E department (2000).

Working from a US perspective, Malone (1998) used an ethnographic approach to investigate heavy users of the ED, as well as the views of staff of the same patients. Her findings were that the ED has historically been a gateway not only to hospital services, but also quietly provided a route to public health, mental health, and social services for needy patients. The increasing financial pressures on hospitals to cut costs and the loss of outside resources to refer these patients to have brought this function to the fore, both from a financial perspective and as an irritant to newer staff whose focus is on assigning a diagnosis, immediately treating it, and disposing of the patient either through admission or discharge (Malone, 1998). This identified need to rectify more than just medical problems for this patient population serves as the foundation for the social casework-oriented interventions described below.

Interventions to Divert Inappropriate Attenders

In contrast to most of the previously discussed research, which was conducted internationally, much of the literature on interventions to reduce the rates of inappropriate attenders comes from the US, where EMTALA adds the force of law to the moral obligation to treat all patients who present to the ED. Interventions include a variety of measures, ranging from attempts to promote patient education, to case management of identified frequent users, to opening urgent care centers.

Herman, Young, Espitia, Fu, and Farshidi found that providing brief education as well as literature on appropriate usage of a pediatric ED to parents produced a modest effect in improving parent decision-making in regards to whether or not their child needs

to be brought to the ED as opposed to a primary care provider (2009). Providing a more immediate means of information to help patients decide whether or not to attend the ED, Bearden, Brown, Kirksey, Dansby, and Hillard reported in 2008 on a teletriage service their Texas hospital has run since 2002, but provided no numbers to determine the efficacy of the service in reducing ED utilization, either in general or for inappropriate reasons.

More intensively still, the work of Shurmway, Boccellari, O'Brien, and Okin showed that using case management to divert frequent users of the ED to using other resources is cost effective, in that the quality of care improved even though the costs of case management were equivalent to the patients' usual usage of the ED (2008).

A study by Tennyson in 2003 showed a slight decrease in pediatric ED usage at a children's hospital when the institution opened a suburban urgent care clinic, though the benefit shown by the study was the hospital's capture of a larger patient base and not necessarily any benefit seen by patients. Sanders (2000) pointed out that Minor Injury Units, the British equivalent of an urgent care clinic, which are standalone and not paired with a hospital A&E department will need to advertise their services if they expect to attract patients and relieve the patient load off the local A&E departments.

Chapter 3

Methods

Design

Following a review of the literature on the intended and actual uses of the ED that reflects a Salutogenic conceptual framework, a qualitative, descriptive study was conducted using an online questionnaire to ascertain the views of emergency nurses on the intended, proper, and actual usage of the ED. Nurses were asked to respond in a short answer/narrative format, from which themes were identified using content analysis. The themes were interpreted in light of Salutogenic theory as well as the identified literature.

Setting and Participants

The study was targeted at emergency nurses who were members of the Emergency Nurses Association (ENA). Invitations to the study were emailed to all members of the ENA, which claims an active membership of 36,000, who have signed up and receive emails from the 'Membership' and 'Research' listservs run by the ENA. The full membership of the ENA includes students, allied professionals (including EMTs and LPNs), and retired nurses in addition to actively practicing emergency nurses. These additional groups were not intended to be studied, and though the listservs selected are not targeted at these groups, they were ruled out with the first question in the questionnaire. The response rate to the survey is unknown, as the total number of subscribers to the listserv is not public, but is certainly significantly less than 100% of the ENA's total membership. A minimum of thirty participants were to be recruited. The

survey itself was conducted online. An electronic flier was sent to subscribers to the ENA's 'ED Staff Nurse' listserv (included as Appendix A) that included a hyperlink which led to the survey at surveymonkey.com. The invitation to the survey asked that respondents have their ED's mission statement (or equivalent) handy or readily accessible before beginning the survey.

Protection of Human Subjects

The study was performed online using an anonymous survey with no direct interaction between the investigator and the research participants. While demographic information was collected, no identifying information was obtained by the investigator during the process of identifying potential participants or through the study itself. Participants were not exposed to any additional risk beyond that experienced in their usual daily routines. As such, there was a benign level of risk to participants from participation in the study. Participants viewed information from the DePaul University IRB's Template F form prior to continuing on with the questionnaire. Source data was initially hosted online at a password-protected website and was subsequently downloaded into password-protected Microsoft Excel files. Again, as no identifying information is attached to the data, no destruction of data is necessary. No research or participant gathering was performed until IRB authorization was received.

Data Gathering

The primary objective of the survey was to elicit responses from emergency nurses regarding their perceptions of the actual, intended, and proper use of the ED. The secondary objective was to, should there be sufficient responses to the survey, examine for differences in perceptions between nurses who practice in different settings, in

different types of hospitals, by availability of an alleviating resource, or for generational or cohort effects.

To meet these objectives, participants were recruited from the Emergency Nurses Association via electronic listservs run by the association. Participants were directed via hyperlink to the survey, which was hosted at SurveyMonkey.com. Participants were first asked if they are a practicing ED nurse, so as to sort out respondees who were ENA members but not currently nurses practicing in the ED. Study participants were then asked a number of questions to elicit demographic information. Participants were asked for their gender as well as their birth year, the latter to detect generational effects, if any. They were also asked to describe how long they have been a nurse and how long they have worked in the ED, and the country in which they practice. Participants were then asked the following questions and invited to respond in as much depth as they could.

- What is the stated purpose or mission of the Emergency Department in which you work?
- Do you agree with the purpose or mission statement? Explain.
- How closely does your ED's usage pattern match its stated purpose? How does it differ?
- What is your perception of an appropriate ED visit?
- What, if any, suggestions do you have for provision of emergency or urgent care?

Participants were then asked a number of questions about the hospital at which they are an emergency nurse. Those that worked at multiple EDs were asked to answer for the one at which they spend the most time working. Questions were asked about the setting of the hospital (rural, suburban, or urban), trauma designations possessed by the hospital, and

whether the hospital has an attached urgent care unit or ward. These questions, though demographic in nature, followed the free response section of the survey in order to avoid biasing participant responses by suggesting content. A copy of the survey, including the information form, is included as Appendix B.

Data Analysis

Responses received from participants were sorted into nominal categories by content analysis. Due to the expected large volume of text generated by the questionnaire, the first pass of analysis was made using ATLAS.ti software to identify and code responses into emergent categories. Emergent categories were then organized into themes; frequency counts for each theme are reported below. The identified themes were then be reanalyzed with respect to the acquired demographic data. Using said demographic data, responses were compared based on the setting of the hospital (rural, suburban, or urban) and by the availability of an attached urgent care ward/unit. Statistical analysis was conducted using Microsoft Excel, using a chi-square analysis to detect significant differences between groups.

Chapter 4

Results

Emails inviting ENA members to participate in the study were sent on 25 May 2010; with the study link active until 5 July 2010. During the time the survey was open it received 52 responses. 20 responses stopped at the end of the first “page” of questions and did not answer the open-ended response questions on the following page; 32 respondents completed the survey for a completion percentage of 61.5%. All respondents who completed the survey reported they were practicing emergency nurses in the United States. Demographic information is summarized in Table 1. As the survey was administered in the middle of the year, age was calculated by subtracting the stated birth year from 2010.5 in order to take into account variations of respondents birthdays within their birth year. Years of experience were calculated without modification.

Table 1. Demographic information from respondents

Gender	# Respondents		
Male	4		
Female	28		
		Mean	SD
Age ^a	48.98	48.98	6.15
Years Experience as RN	24.94	24.94	8.5
Years Experience in ED	17.25	17.25	8.65

^a One respondent did not give a birth year, and thus is not included in the age statistics

On the last “page” of the survey, respondents were requested to provide information on the ED in which they spent the most time working. This information is summarized in Table 2.

Table 2. Respondent-supplied data on their primary place of employment

	Level 1	Level 2	Level 3	Level 4	Unknown
Trauma Level	5 (15.6%)	5 (15.6%)	10 (31.3%)	4 (12.5%)	8 (25%)
Urgent Care Availability	24hr	Extended Hours	Business Hours	None	
	1 (3.1%)	15 (46.9%)	1 (3.1%)	15 (46.9%)	
Setting	Rural	Suburban	Urban		
	4 (12.5%)	16 (50%)	12 (37.5%)		

Qualitative Results

The middle “page” of the survey contained the five open-ended response questions outlined previously. Responses were loaded into Atlas.ti, coded and organized into emergent themes for all questions except for respondent agreement with their ED’s mission statement, for reasons discussed below.

Purpose of the ED: Respondent departments’ mission statements.

The first open-response question asked respondents to supply their ED’s statement of purpose or mission in an attempt to ascertain the intended use of the ED. An unexpected finding that quickly became apparent was that many respondents reported that their ED did not have its own mission statement: seven respondents specifically stated that they were supplying the mission statement for their whole hospital; others supplied mission statements which were vague and did not mention the Emergency Department or refer specifically to activities within the ED. All responses were included in the analysis, as the mission statements supplied by respondents represented the guidance and purpose offered by their institutions to their employees.

Even with the lack of specificity provided in some of the statements, there were a number of themes which emerged from the group as a whole. Not every statement incorporated every theme identified in the group, though most were present in each. The overarching mission statement for the hospital missions in general and the ED missions in particular is to provide care. Under that umbrella are a number of themes.

Beneficiaries of care

Many of the mission statements provided included some identification of those whom the department provides care too. In many cases this was stated broadly, using terms like “the Community”, “the Ill or Injured”, “open to all comers”, and “patients across their lifespans”.

Type/Kind of care offered

Another common element in the provided statements was a description of the kind of care offered to patients, e.g. “Emergent”, “Evidence-Based”, and “Timely”. Only seven of the statements provided featured the words “emergent” or “emergency”, while the majority of statements focused more on elements of the other identified themes. One statement included “non-emergent” care as a type of care offered, while another used the term “minor emergency” in addition to “emergency”. These inclusions are examples of institutional acceptance of the expanding scope of care provided by EDs, which is also reflected in the responses to later questions.

Quality of care provided

In addition to describing the type of care offered, many of the provided statements used terms, mostly adjectives, to describe the quality of care provided in the department. These terms included “personal”, “excellent”, “effective”, “patient-centered”, and “thorough”, to highlight a few. Some of these terms were superlatives, such as “finest” and “perfect”, the use of which was referred to by one respondent in a subsequent question.

Methods used to deliver care

The last major theme that emerged from the provided statements included descriptions of how care is provided at that institution. Examples include having/following a plan of operation, collaboration among providers, communication, and creating a caring environment. Within this theme was a sub-group of provider responsibilities in providing care: treating patients with dignity, respect, and compassion, practicing safety, and having personal integrity.

Other noteworthy responses

Of all 32 responses, four respondents’ statements included explicit mention of an organization’s religious health ministry as the reason for providing care, while another included language reflecting EMTALA compliance: “All patients requesting medical care will have a medical screening provided by the Emergency Department physician and stabilization prior to dispositioning of the patient.” Another respondent stated that their ED was in the process of formulating a mission statement, and as such could not provide it.

Congruence between actual and intended mission.

The second open-response question in the survey was intended to be a follow-up to the first, allowing respondents to disagree or expand upon the language decided upon by their institution. Of the 31 respondents who provided mission statements, 28 stated agreement with the mission statements they gave, though one of those agreeing with a general hospital statement admitted that an ED-specific mission statement might be more appropriate. The three who disagreed with their department's statements did so over details specific to those statements. The high proportion of those agreeing with their given statements, usually with only one or two words, along with the specificity of the few disagreements, meant that there was little in the responses from which to identify themes. As such, specific responses are discussed instead.

One respondent disagreed with the inclusion of her institution's religious health ministry in its mission statement. The respondent did not elaborate further on her reasons for objecting to its inclusion in her answer for this question; however, she did state in the answer for the following question that "[r]eligion rarely enters into our usage pattern".

Another respondent, whose departmental mission statement highlighted efficiency and effectiveness, disagreed with her department's statement as the department did not meet those stated goals. The same respondent also disagreed with the subjectivity of the word 'finest' in the mission statement, where it appears as "...to provide the finest...healthcare services..."

The last respondent that disagreed with her department's mission statement, which included a number of specifics as to the methods used to provide care, pointed out that it was "in possible to meet some mission in this economic times [sic]".

Perceptions of how actual usage of the ED matches mission statements.

The third open-response question in the survey was intended to determine perceptions of actual ED usage in comparison to intended usage. The question itself, though, had respondents refer back to mission statements for their own departments, the variation and non-specificity of which has already been mentioned. As the mission statements provided cover a broad range of issues, so too did respondents' evaluations of how well those statements matched the reality they experience working in the ED.

Over half (18) of respondents stated that usage of their ED matches or closely matches the statement for their department, following the trend of agreement seen in the answers to the previous question.

Six respondents highlighted the mismatch between the expectation of treating emergent patients and the patients they actually have, with one stating that "We provide emergency care but to many non-ergemt [sic] patients." Another respondent elaborated on this further, noting that "We also see those who just need a place to stay for the night or a meal." In contrast, one of the respondents whose ED's usage matched its statement pointed out that it did so because the statement covered both emergency and 'minor emergency' care.

A few of the respondents whose departmental statements included meeting the needs of the community addressed how well their EDs accomplished that goal. One of the respondents, who said their ED usage matched its mission statement, noted that "members of our community prefer our emergency department over others because we have designed our processes to meet their needs." However, another respondent acknowledged that not all of the local community, a college town, was encouraged to use

the ED, even though the mission statement mentions the community as a whole and makes no distinctions. Similarly, a respondent whose ED mission statement highlighted compassionate care stated that substance abusers are not always treated well in her ED.

While a number of mission statements included elements about provider responsibilities in providing care, only one respondent noted a discrepancy between those sections of the mission statement and what actually happens in his ED. His ED's mission statement mentions safety, collaboration, formulating plans of care, and providing timely care to patients. He acknowledged that the ability to follow through with such elements varied with patient acuity, patient volume, the level of experience possessed by providers, and the providers' work ethics.

In addition to the respondent whose department was formulating its mission statement at the time the survey was distributed and thus felt she could not answer the question, two other respondents, who had supplied their hospitals' statements, felt that they could not compare the usage in their department to the statement for the whole hospital. One of them elaborated further, stating that her ED's usage "does not match hospital mission; we have additional patient care centered goals the hospital is not publicly focused on". Other non-responses were one respondent who stated that she was not sure what the question was asking (admittedly, the statement she provided, while not stated to be the hospital's mission statement, was rather vague), while another respondent simply stated "50-50" without elaborating further.

Perceptions of an appropriate ED visit.

The penultimate open-ended response question was intended to elicit from respondents what they thought the ED should be used for. As this question was not

dependent on respondents' institutional mission statements, the responses for this question were more focused on the patient experience than responses to prior questions. A number of non-exclusive themes emerged from the responses, with some themes and responses contradicting others.

Immediacy of need

Almost half of the codes generated from the responses for the fourth question (15 out of 32) highlighted immediacy, urgency, emergency, and/or acuity in the needs of the patient. Not every such statement incorporated these words, though: one respondent described an appropriate visit as “A condition for which delay in treatment would cause deterioration/death if not managed in a timely fashion,” before going on to note the connectedness between the decline of primary care in rural areas, the resulting structural causes in delays in treatment, and how that impacts what is appropriate in the ED.

Patient perception of emergent/urgent need for care

Another theme that emerged from the responses was related to the immediacy of need: whether or not a patient needs emergency care, that patient's perception of such a need makes the visit appropriate. Of the nine responses which fell into this theme, one specifically mentioned “People who are in crisis, perceived or actual, that need rapid care,” indirectly highlighting the fact that, for some patients who attend the ED, the emergency in their life is not medical in nature, though a medical problem may have depleted their resources. Another respondent elaborated on this position, stating that “I leave the politics out of my perception if they've presented to my dept. If the numbers are not to administration/government wishes; then I leave it to those powers that be to decide if other avenues of access to care are warranted.”

All visits are appropriate

At the opposite end of the spectrum of perceptions of appropriate ED visits is the view that all visits to the ED are appropriate, for whatever reason, which was expressed by six respondents. Reasons for such visits are primary care, inability of the patient to see their primary care provider, and the reality of current interpretations of EMTALA leading to the ED functioning as a safety net for the community. As stated by one respondent, “The ED is the safety net for the community, so [it] can often function as primary care for those who have limited access to health care.” Other responses mirrored some of those that emphasized the patient’s perception of need: “The definition of appropriate is driven by the patient and should be left to be defined by the patient. The meaning of the symptom to the patient drives the patient’s decision to seek care and, in most cases, the emergency department is the only choice.”

Provider-side measures of an appropriate visit

Four of the responses noted that part of an appropriate visit involves not just the patients but the staff as well. One respondent mentioned that patients should be treated in a timely manner, while another emphasized that the initiation of care needed to be prompt. Other responses included treating patients with respect and providing customer service.

Examples of inappropriate visits

Though they were unsolicited, three respondents provided examples of what they viewed to be inappropriate visits to the ED. These respondents highlighted the perceived inappropriateness of treating chronic conditions in the ED, with one respondent stating, “Those who use the ED as an access point for chronic conditions are clogging up the

system.” Another respondent offered an even more expansive list, citing minor illnesses, inability to get an appointment with a primary care provider, lack of a primary care provider, and a need for a prescription refill as inappropriate reasons to attend the ED in addition to use of the ED for care of chronic conditions. A third issue raised by a respondent was about patients who reenter the ED: “A patient who has had a clear ED evaluation should not be permitted to walk directly back into the ED to be ‘evaluated’ again.”

Nurse suggestions for the provision of emergent and urgent care.

The final open-response question in the survey asked respondents for their suggestions on the provision of emergency or urgent care. Responses to this question shed further light on the appropriate use of the ED and provided respondents an opportunity to identify possible Generalized Resistance Resources that can/could help emergency nurses deal with stressors and avoid burnout. As with most of the other questions, there were some themes which emerged from the data. Of note is a repeated suggestion that fits into all the themes is the ability to be able to refer patients being triaged to other venues for treatment, be it primary or urgent care. Five respondents expressed this desire to “triage out” patients. There were also four respondents who had no suggestions.

Primary care access

A common theme, expressed by nine respondents, was a perceived need to increase access to primary care in the community to reduce the patient load in the ED. These suggestions touched on the need for increased community screening, increased access to primary care after-hours, the need for primary care oversight of patients with

chronic conditions, and the effect of being un- or underinsured on primary care access. An additional suggestion came from a patient education perspective of developing processes to encourage patient follow-up with a primary care provider after discharge from the ED.

Urgent care

Another theme which emerged from the suggestions was a perceived need for more sites providing urgent care, expressed by seven of the respondents. A few of the respondents made the suggestion to have an attached urgent care facility along with the ED. Others just wanted to increase the number of urgent care settings in general, with one respondent suggesting that urgent care facilities be held to the same EMTALA obligations as emergency rooms. One suggestion that fits both here and in the next theme was the facility-specific suggestion to restore the ability to fill prescriptions for ED patients, helping to provide convenient, immediate service to patients, especially in the middle of the night.

Workplace suggestions

Eight of the respondents focused on their workplaces as areas which could be improved for better patient care. While some suggestions in this theme were somewhat general, such as providing more resources and improving the workplace environment, others were more specific. Two respondents highlighted improving patient flow through the ED, with one emphasizing the need for nurses to be more proactive in doing so. Another suggested simplifying insurance rules for those patients who still have insurance. One interesting suggestion was to divide patients by acuity, with patients who are more acute receiving a lower patient-to-nurse ratio.

Who the ED treats

While there were a number of respondents who expressed opinions on the kinds of patients the ED treats, those four opinions ranged from inclusiveness to being very specific. One respondent simply suggested that the ED “treat everyone.” Another cited the aging population as a reason to make EDs more geriatric-friendly. On the less-inclusive side, one respondent listed off several acute/emergent conditions. Along those lines, another respondent went so far as to suggest returning to “requiring clearance from primary practitioners.”

Quantitative Results

Prior to data collection, the original intent of this project was to compare frequencies of various themes to other collected quantitative data, such as respondent age, years experience, hospital trauma level, presence of an urgent care center, and setting (rural, suburban, or urban). However, the degree of overlap between responses, plus the low frequency of some response categories, meant that many possible quantitative comparisons violate the assumptions of even the chi-squared test, let alone any other, more robust statistical tests.

That said, the responses to the final question, which asked respondents for suggestions to improve emergent and urgent care, produced data fit for comparison using the chi-square test. Comparing those who made suggestions regarding the ability to provide urgent care to those who did not by the presence or absence of an attached urgent care facility found that there was no significant relationship between the two ($\chi^2 = 1.66$; $p = .20$; $df = 1$). Comparing urgent care suggestions by hospital setting (rural, suburban, or urban) also found no significance between the two variables ($\chi^2 = 1.49$; $p = .47$; $df =$

4). Lastly, comparing suggestions for the provision of primary care by hospital setting also found no relationship between the two ($X^2 = 4.59$; $p = .10$; $df = 4$).

Chapter 5

Discussion

This project was designed to determine the intended, proper, and actual purpose of the ED as perceived by emergency nurses. Besides filling a number of observed gaps in the literature on this and related topics, shedding light on this area allows for a greater understanding of the expectations that emergency nurses have of their jobs and the congruency between what they expect and what they observe and experience. This congruency, or its lack, is linked to the phenomenon of burnout through the Salutogenic concept of meaningfulness as a component of one's Sense of Coherence (SOC): those nurses practicing in the manner they expect to experience more meaning in their work and are thus better able to adapt to stresses they encounter, while those whose expectations conflict with their lived experience find less meaning and are thus more exposed to the negative effects of stress. The questionnaire and the data obtained with it were analyzed to determine the perceptions of respondents and, in a limited manner, to determine if responses changed according to the work environment as reported by respondents later in the questionnaire.

The first question of the questionnaire was designed to elicit the intended use of the ED by surveying the mission statements, statements of purpose, and other similar documents applied to EDs by their institutions as reported by respondents. This led to the surprising finding that many nurses reported that their EDs did not have mission statements or the like. This lack of an explicit statement for many EDs may be a

reflection of an assumed or implied definition or purpose. Without such a statement, employees are left to supply their own concepts for the intended and proper use of the ED, which may or may not agree with their employing institution's concept for emergency care or the reality of emergency treatment in their community and lead to incongruence in expectations. (Admittedly, employees are free to supply their own expectations even in the presence of an explicit purpose, but in such circumstances, this tendency is at least partially balanced out by the institution's imposed perspective.) In such cases where nurse expectations do not match up with reality, nurses can feel that their work is not as meaningful, predisposing them to burnout.

Although statements universally cited the provision of care as the reason for the ED or institution to exist, some of the supplied mission statements single out emergent or timely care as what the ED provides; not all were so specific, and one even included emergency and "minor emergency" care. While the latter, inclusive statement helps prepare staff for the types of cases they should expect to see, vague or idealistically narrow statements can both leave emergency nurses open to incongruence between their expectations and actual conditions. Again, if an emergency nurse expects to treat patients with a degree of acuity in their conditions, and instead deals with patients who present to the ED for primary care or management of chronic conditions, they may end up lacking a sense of meaningfulness for their work, and thus be more vulnerable to the negative effects, leading to burnout.

Conversely, if an ED provides guidance to its staff on the type of patients it treats, even to the point of including "minor emergencies" or the like in the mission statement it can guide nurse expectations of the type of care they will provide, increasing their

perceived meaningfulness in the care they provide and thus provide a buffer against burnout by increasing nurses' overall SOC. While not directly assessed in this study, an indirect indication of this process at work is the level of agreement expressed by respondents with their departmental mission statements. Over half of respondents agreed with their departments' statements, with the support of their institution, on paper at least, providing a Generalized Resistance Resource (GRR) against stressors encountered by emergency nurses.

The potential for conflict between nurse expectations and reality was directly addressed by the third question in the survey. Of all the responses, six highlighted the provision of emergent care to non-emergent patients, even though only two respondents reported institutional mission statements that contained the word "emergent". This pattern continues with the results of the question on an appropriate ED visit, where almost half of respondents (15 out of 32) emphasized emergent, urgent, or acute needs, where immediacy of treatment is paramount. These findings, along with the lack of explicit mission statements for EDs, speak to an implied purpose of the ED to provide emergent care. As a whole, these respondents would be considered at an increased risk for burnout under a Salutogenic model since, as stated before, the dissonance between the kinds of care they expect to give and what they end up providing can negatively impact the meaningfulness they perceive in what they do, with resulting decrease in their SOC leaving emergency nurses open to the negative effects of stress.

Looking beyond the large number of respondents who emphasized immediacy of care in their responses to the question on appropriate ED visits, there is a continuum of opinions on the matter represented in the responses. While many do focus on the

immediacy of the care needed, nine others highlighted the patient's perception of need as the major determinant of whether an ED visit is appropriate. Not only is this appropriate from a medical standpoint, as a "sense of impending doom" is associated with myocardial infarctions, but it also makes sense from a Salutogenic point of view in light of the work of Padgett and Brodsky and Koziol-McLain and colleagues (1992; 2000): a person experiencing a combination of chronic and acute stressors, both health-related and otherwise, experiences a final health-related stressor that they are unable to manage, leading them to go to the ED for treatment, which they receive, returning the patient's problems to a level they can manage and thus ending the crisis. From the nurses' perspective, recognizing this dynamic helps reconcile their expectations to the reality that a patient's perceived emergency may not constitute a medical emergency or urgency, with the resulting congruency reinforcing these nurses' perceived meaningfulness in their work, increasing their SOC and thus helping to insulate them from burnout.

Compared to the other categories arising from the answers to this question question, relatively few (6 out of 32) described an openness to any level of acuity in their description of the proper use of the ED, including the provision of primary care in the ED. While a minority opinion, this is a helpful one in that it allows an emergency nurse to find meaning in all his or her patient encounters, rather than grow frustrated with providing care to what they perceive to be inappropriate attenders.

Of the suggestions received from respondents on the final question of the survey, the ones that were expected called for expansion of Urgent care, both alongside EDs and as standalone centers. Even though Urgent Care and "Fast-track" units that are associated with EDs are often staffed by the ED, they provide a separate physical and

cognitive space in which to place patients whose conditions are not serious enough to merit full “emergency” treatment in the minds of nurses whose concept of emergency care is otherwise too rigid to accept non-acute care in the ED. Placing such patients elsewhere removes them as a stressor, at least during the hours that the urgent care ward or fast-track unit is open, while still ensuring that they are seen in a timely manner and allowing more acutely ill and injured patients to be seen faster.

Another suggestion that deals more with removing a stressor than providing a resistance resource is to grant triage nurses the ability to “triage out” patients not needing emergency care, as is possible in the UK. The general sentiment is to, following an assessment, direct the patient to other places to receive care besides the ED if emergency care is not required for the patient. Rather than changing how emergency nurses deal with patients who they view as inappropriate attenders and challenges to the meaningfulness of their work, this type of intervention would remove the stressor entirely. The practical issue with this suggestion is that in the UK, patients are guaranteed access to health care while, in the US, the only location such care is guaranteed is in the ED under EMTALA. While attached urgent care facilities do make this somewhat possible, a triage nurse is still unable to make a primary care appointment for a patient and have the provider be required to honor it. Whether recent changes in Federal health care rules expanding health care coverage will eventually make this a legal and ethical possibility remains to be seen.

One last, large group of suggestions from respondents involved the improvement of primary care provision in the community. The focus on this element of the US health care system shows that emergency nurses are aware of at least some of the causes of

stressors that originate outside the ED yet still impact them. While increasing the number of patients being successfully cared for in primary care would reduce the load in the ED both by reducing the number of primary care patients in the ED and also by hopefully reducing the number of acute exacerbations of chronic conditions and life-threatening complications of untreated issues that are seen in the ED. This would not impact the meaningfulness that nurses perceive in the care they give, per se, but would instead increase the manageability of the patients in the ED – manageability being another component of the Salutogenic concept of SOC. Recently passed legislation in the US should increase the amount of primary care received through various mechanisms that expand insurance coverage; whether it will do so remains to be seen. If universal coverage moves from aim to reality, though, this type of triage outcome should be reevaluated from an ethical and a policy standpoint.

Continuing along this policy perspective, changes at the institutional and state/national levels could both improve the SOC of emergency nurses and, arguably, improve the overall delivery of health care in the United States. As noted above, nurses who are not given specific guidance about the type of care they can expect to provide in the ED will substitute their own expectations of immediacy of need, which can vary drastically from reality and thus predispose them to burnout. To avoid burnout, institutions should use various means to communicate to employees some reasonable expectations of the kinds of care they will be providing. Among those means should be the establishment and communication of a department-specific mission statement for the ED that conveys the breadth of patient acuity that nurses and other ED staff are likely to encounter.

At the broader state and national levels, policies and programs need to be instituted or amended to further encourage the availability and utilization of primary care options, as well as urgent care options. Not only is the care provided in such venues much less expensive than that provided in the ED, reducing unnecessary expenditures on health care, but implementing such policies would result in fewer non- or low-acuity patients presenting to the ED, bringing the real case load in most EDs closer to the ideal expected by many emergency nurses that patients presenting to the ED will be those who have a perceived need for immediate care. By ultimately bringing the reality of who presents to the ED closer in-line with the implied purpose of the ED, such policies would increase emergency nurses' perceived meaningfulness and thus their SOC, insulating them further from burnout.

Some of the qualitative findings are harder to discuss under a Salutogenic framework, but are also worth mentioning. Regarding actual use of the ED, the response noting the use of the ED for meals or places to sleep reflects the findings of Malone (1998), who described the historical and continuing use of the ED by many patients as a gateway to social services. This raises the question of whether patients should expect only their medical needs to be addressed by the ED, or should other counseling needs be met as well, increasing the role of the ED as a generalized resource. While Malone states that other social needs were commonly seen to by EDs in the past (1998), making such services a regular part of ED care would be an uphill battle at best, from a financial standpoint, from a logistical standpoint of seeing patients quickly, and in getting staff to buy in to the idea when a majority perceive the ED as a place for patients to go for actual or perceived acute medical needs.

To deal with a response from the question on agreement with the respondent's institutional mission statement, at least one institution needs to clarify to its staff the difference between having a religious reason for providing care and using religious criteria for deciding who receives care. The former is ethically fine, and quite common in the US health care system, while the latter is blatantly illegal.

Addressing the quantitative data, suggestions regarding urgent care were unaffected by the presence or absence of an urgent care center, or by the setting of the institution at which a respondent works. As such, it appears from the data that the desire for increased urgent care is universal in the US amongst emergency nurses, and that the current distribution of urgent care facilities is insufficient to meet this perceived need. Suggestions for providing more/better primary care was also not significantly related to hospital setting in a rural, suburban, or an urban environment – but the p-value was only $\approx .10$, so it may not be prudent to reject the any possibility of significance outright, especially as a finding of significance would reinforce the findings of Hodgins and Wuest in a Canadian context (2007). Rather, this relationship should be further explored in any follow-up research to the current project.

Implications for Future Exploration

The most obvious avenue for future exploration of this topic is for study replication with an increased number of respondents. In order to make data collection and analysis simpler, the repeat survey should take some of the themes identified in this work create a new survey instrument asking whether respondents agree or disagree using a Likert scale. While some of the fine detail and freedom of expression possible with

open-ended questions would be lost, the ability to analyze the responses quantitatively would be greatly enhanced.

Another avenue to explore is the type of care provided by emergency rooms as compared to the perceptions of staff of the care provided. The US government collects data on ED patient acuity, but only a direct comparison can provide an objective measure of the magnitude of difference between patient acuity and provider perceptions of patient acuity. The University of Wallongong has done work along these lines in Australia (Siminski et al., 2005; Masso et al., 2007), while Rassin and colleagues compared nurse and patient perceptions of patient acuity in an Israeli setting (2006). However, both of these groups took provider perceptions as an objective baseline, which may not be the case. Also, as stated previously, both of these countries have guaranteed health care for their citizens and thus do not operate under the same health and economic conditions as US institutions. As such, their work should be replicated in the US with an additional component comparing both patient- and provider-perceived acuity to an objective assessment of the cases walking through the door.

Further, the economic model under which the US healthcare system operates is undergoing a series of changes as a result of the health insurance reform which was passed in 2010 and is slowly being phased in. As primary care coverage for the general population should hopefully increase under the new legislation, a before-and-after study of ED utilization and nurse perceptions of the same would be useful to measure the effects of the new legislation in the ED.

Limitations of the Present Work

The first limitation in the study occurred while the project was waiting to be approved by the IRB: the study was originally intended to be sent out to general members of the Emergency Nurse's Association via the "ED Staff Nurse" listserv hosted by the ENA. Between the time that the project was initially written-up and proposed and when it was finally approved, the ENA had discontinued that listserv. Instead, the "Membership" and "Research" listservs were used instead. This is a possible source of skew in age and experience reported by respondents; however, without resurrecting the old listserv and redistributing the survey via it, the exact extent of the skew resulting from this change cannot be measured.

While the survey was active, a report was received from one person attempting to respond that they were unable to access the survey. Some simple troubleshooting was attempted, but the issue was not able to be resolved remotely. The prevalence of this issue is unknown, and likely related to the host for the questionnaire, SurveyMonkey.com, and/or possible IT issues at the user's place of work if that is where they attempted to take the survey.

Another user responded via email, stating that she had chosen "Unknown" for her hospital's trauma level when, according to her, it had no trauma level. The author finds this hard to believe, as the lower levels are determined by state agencies rather than accredited by the American College of Surgeons Committee on Trauma, but this could be the case. As such, it is known that at least one "unknown" response and possibly more are really responses of "no level", although the full extent of the issue is unknown.

Lastly, one of the most pervasive issues was discovered during data analysis, that the underlying assumption that most/all EDs had their own mission statement, or something to that effect, was incorrect. This assumption underpinned three of the five open-ended response questions, leaving the ability of respondents to fully answer two of the questions up to institutional whim rather than the respondent's own knowledge and experience. Another assumption that was not explicitly violated, but should still be mentioned, is that departmental mission statements are directly related to clinical practice within the department. In light of the existence of these two assumptions, any further investigations in this area should attempt to use other means to identify the intended use of the ED.

Conclusion

The results of this study provide a glimpse into how emergency nurses perceive the role of the ED and, by extension, their role within the ED, as well as their perceptions of the types of patients they should be seeing. Some of the observed dynamics can be conceptualized as generalized resistance resources under a Salutogenic framework, while others are stressors, or resource deficits. These positive and negative dynamics are both institutional and personal in origin, and as such no single strategy would be successful in combating burnout in the ED setting. One thing institutions and administrators can do is to go beyond educating patients on criteria for appropriate ED usage and to educate their own providers, including nurses, as to what kinds of patients are expected in the ED, beginning with creating an ED-specific mission statement.

Planned changes in the US health care and health insurance system may affect the dynamics observed and reported on in this project. Whether these changes are for better

or for worse remain to be seen. Regardless, further policies promoting urgent care and primary care should be instituted to ensure that patients have access to health care in places besides the ED.

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Appendix A

Electronic Flier for Recruiting Participants

Hello, my name is Kyle Bergan. I am a graduate student at DePaul University investigating emergency nurses' perceptions of intended, actual, and proper Emergency Department utilization under the supervision of my research advisor, Matthew Sorenson. As such, I am requesting your participation in my online survey, located at [URL]. My research has been approved by DePaul University's IRB and should take approximately twenty to thirty minutes of your time. The anonymous survey includes questions on basic demographic information about yourself and where you currently work, for purposes of comparison, as well as your opinions on Emergency Department usage. Participation is obviously voluntary; there are no negative consequences should you choose not to participate.

Should you choose to participate, please have a copy of your emergency department's mission statement or statement of purpose handy, as this will facilitate your taking of the survey. If you have any questions about the survey before you take it, feel free to contact me at either this address or at kbergan@mail.depaul.edu, or to contact Susan Loess-Perez, DePaul University's Director of Research Protections at sloesspe@depaul.edu.

Thank you for time; I hope you choose to help me through participating in the survey.

Sincerely,

Kyle T. Bergan

Appendix B

Survey Instrument: Emergency Nurse Perceptions of ED Utilization

Emergency Nurse Perceptions of ED Utilization

1. INFORMATION SCREEN FOR PARTICIPATION IN RESEARCH STUDY

Intended, Proper, and Actual Utilization of the Emergency Department: A Survey of Emergency Nurses' Perceptions

You are being asked to participate in a research study being conducted by Kyle T. Bergan, a graduate student at DePaul University, as a requirement to obtain his Masters degree. This research is being supervised by his faculty advisor, Matthew Sorenson. We are asking you to participate in this study because we are trying to learn more about emergency nurses' perceptions of intended, actual, and proper Emergency Department utilization. This online survey will take about twenty to thirty minutes of your time. If you agree to be in this study, you will be asked to fill out a survey. The survey will include questions about basic demographic information for yourself and where you currently work, as well as your opinions on Emergency Department usage. You can choose not to participate. There will be no negative consequences if you decide not to participate or change your mind later.

If you have questions about this study, please contact Kyle T. Bergan at 217-714-4713 or by email at kbergan@mail.depaul.edu. If you have questions about your rights as a research subject, you may contact Susan Loess-Perez, DePaul University's Director of Research Protections at 312-362-7593 or by email at sloesspe@depaul.edu.

You may keep a copy of this information for your records.

Note: clicking "next" below implies your consent to participate in the study. If you choose not to consent to participate, you may navigate away from this screen without proceeding further.

Emergency Nurse Perceptions of ED Utilization

2. Demographic information

*** 1. Are you a practicing emergency nurse?**

Yes

No

*** 2. What is your gender?**

Female

Male

*** 3. Numerical Demographics**

In what year were you
born?

How many years have
you been an RN?

How many years have
you worked in the ED?

4. What country do you practice in?

Country:

Emergency Nurse Perceptions of ED Utilization

3. Survey Questions

Please answer these questions as in-depth as you can.

- * 1. What is the stated purpose or mission of the Emergency Department in which you work?**

- * 2. Do you agree with the purpose or mission statement? Explain.**

- * 3. How closely does your ED's usage pattern match its stated purpose? How does it differ?**

- * 4. What is your perception of an appropriate ED visit?**

- * 5. What, if any, suggestions do you have for provision of emergency or urgent care?**

Emergency Nurse Perceptions of ED Utilization

4. Work Demographics

Please answer these questions for the Emergency Department at which you work. If you work at more than one ED, please answer for the one at which you spend the most time.

*** 1. What is your hospital's trauma designation?**

- Level 1 Level 2 Level 3 Level 4 Unknown

*** 2. What is the setting of the hospital in which you work?**

- Rural Suburban Urban

*** 3. Does your ED have an attached Urgent Care ward or center, and if so, how long is it open?**

- Yes, the Urgent Care ward/center is open during normal business hours
- Yes, the Urgent Care ward/center is open during extended hours, but not 24 hours
- Yes, the Urgent Care ward/center is open 24 hours
- No, my ED does not have an Urgent Care ward/center