An Ethnographic Study: The Culture of an Emergency Department

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Background

- In an environment of change & social interaction, hospital emergency departments (ED) create a unique sub-culture within healthcare.
- Patient-centered care, stressful situations, social gaps within the department, pressure to perform, teamwork, & maintaining a work-life balance were examined as influences that have developed this culture into its current state.
- Each organization has the capacity to create their own culture, meaning they can create underlying beliefs, traditions, & values that go beyond what is written down as organizational values.
- The organization’s culture can significantly impact its ability to produce positive patient outcomes, manage human resources, & succeed financially.
Background: Business Anthropology

• Using culture theory and ethnographic methods to understand an employee and consumer culture started in the 1980s

• Research and consulting based on 4 areas of study:
  – Consumer behavior
  – Organizational theory and culture
  – International business and marketing
  – Product design and development
Literature Review

• Researchers have shown a link between organizational culture
  – Patient outcomes (1-4)
  – Patient satisfaction (5)
  – Safety (6-8)
  – Employee satisfaction (2-3, 9-10)
  – Clinical performance (11-12)
  – Financial viability (6)

• Researchers demonstrate that organizational culture can influence
  the success or failure of organizational outcomes
Study Purpose & Research Design

Study Purpose

To examine the professional culture in an emergency department

Study Design

Focused Ethnographic Approach
Ethnographic Method

- Central focus is Culture
- Ethnography is both a process and a product
- The participant observer is a core concept that sets ethnography apart as a research method
- 3 phases: Exploratory, Definitional, Confirmatory
Ethnographic Method

- **Exploratory Phase**
  - Background Research
  - Introduction
  - Unstructured data collection

- **Definitional Phase**
  - Hypothesis development/interpretive analysis
  - Structured data collection
  - Constant comparative method

- **Confirmatory Phase**
  - Modification of hypothesis based on participants
  - Presentation to participants
Methodology

• Approval received from WellStar Nursing Research Committee & Kennesaw State University IRB
• Data were gathered by an anthropologist from August 2011 to January 2012 including: examination of documents, field notes, direct observations (430 hours), surveys, & structured interviews
• The constant comparative method of data analysis was used\(^{(13)}\). Data were analyzed into codes & categories
• The use of a journal, interaction with a research team, member checks, & maintenance of documents for audit purposes served to enhance trustworthiness \(^{(14)}\)
Characteristics of Participants

• The survey & structured interview sample included 34 employees and the population observed during 120 observation periods included 250 staff working in an ED located in the Southeastern US
  – Nurses (n = 22), Physicians (n = 4), Clinical Care Partners (n = 3), Support Staff (n = 3), & Leadership (n = 2)
• Age Range: 25 to 60 years (M = 35, SD = 8.74).
• Race: Caucasian (n = 29), African American (n = 3), & Other (n = 2)
• Education: BSN (n = 13), Associate (n = 9), Medical (n = 4), Other (n = 8)
• Staff tenure: Less than 1 year to 30 years (M = 7, SD = 6.61)
• 24 participants worked full-time
• Future work plans: 16 planned to remain in current position for 8 years or longer & 14 planned to leave in the next 5 years
Interpretative Analysis

Data revealed identification of four categories: **cognitive, environmental, linguistic, & social attributes** that described the ED culture

- Stories were told about attributes that shaped the ED culture. Professional & personal gratification & reward exhibited through staff experiences were essential elements that made a stressful & unpredictable environment tolerable

- Teamwork was an essential element to achieve optimal patient outcomes. The environmental influences contributed to shaping the culture

- Cultural influences shape patterns of behavior in care delivery. Thus, implicit or explicit values & beliefs of the staff shape the culture
Cognitive Attributes

Cognitive attributes that described the staff’s work: **gratifying, rewarding, & punctual**

- Being able to make a difference in a patient’s life provided staff a sense of gratification & made it easier to return to work. When staff were able to intervene for a patient & visualize a positive patient outcome, they felt a sense of reward

  “You see a lot of bad things, but you make a difference and it’s gratifying. The most rewarding is a stroke patient placid and no movement. You administer TPA [tissue plasminogen activator] to the patient and all of a sudden the patient regains their movement and able to talk. **It is rewarding.**”

- Being able to impact a positive patient outcome was rewarding to staff. The importance of being punctual when caring for critical patients was critical to the patient’s outcome

  “For a patient experiencing a stroke, time is of the essence and how quick you do things makes the difference in the quality of the outcome. The person will probably live, but how “good” the outcome is depends on how quickly things get done. You’re in the forefront of that patient’s outcome. If it takes you a while to do your task, others get behind and the patient is losing brain cells that can never be returned.”

- Time was of the essence when caring for critically ill patients requiring life-saving medical interventions
Cognitive Attributes

Shared values of teamwork, working equipment, & the ability to multitask were attributes to succeed in their job

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ED staff felt compassion, time, & explanation were necessary to patient comfort

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Environmental Influences

- Environmental influences that described the physical environment: **high volumes, stressful, fast paced, & unpredictable**. Frustration & concerns about physical space, work flow, & technology were expressed.

- When the ED experienced high patient volumes, the environment appeared to be more chaotic & stressful:
  
  "A bad day is when you come in, sit down for a huddle, and they say no huddle just go out there. It is horrible, stretchers lining the halls and nowhere to put the patients, 10 strokes occurring at once, two traumas, one coming in, slow doctors, and angry patients. You’ll go into the waiting room and there’s nowhere to sit. You can barely walk through."

- Staff complained about overcrowding & high patient acuity:
  
  "You have more barriers with volume and high acuity. You have capacity issues, needs that change, and high variation. You can’t always know what will happen that day."

- Daily, staff adapted to an unpredictable environment.
Environmental Influences

• All staff discussed how stressful the work environment was & how staff must cope with acute & chronic stressors on a daily basis. Many described their work as physically exhausting & stressful
  
  “The ED is physically stressful and when you get home you’re exhausted. If I had a family when I got home from a 12 hour day, I would have nothing to give to them. You’re tired when you get home, and you want to relax.”

• Another area of frustration was inappropriate patient admissions
  
  “The ED is misused a lot now and that’s frustrating. We see toothaches or splinters and that’s more for fast track or urgent care. A lot of people use the ED as a primary care office because they don’t have insurance. The ED needs to be for emergencies. You need to take care of patients who need to be taken care of. The people who misuse it are taking away from the people who really need it.”
Environmental Influences

The following disruptions created stress, especially when it came to having the right tools, & disruption in communication

• **At times, staff felt they did not have the necessary equipment to adequately care for patients**
  “Level six rooms are never prepared because of the psychiatric patients are there. Everything has to be broken down; the side cables and everything is out of the rooms. If a medical patient is assigned to one of those rooms, it takes 30 minutes to put it back together and find everything. The rooms are not stocked and something missing out of every room. It’s frustrating because it’s a busy job and you don’t have the things you need to do your job. It takes up time and you’ll fall behind. “

• **Staff felt improvements were needed with the work flow**
  “The work flow has improved over the past years. We have significant areas of fragmented function and the flow does not work. It is defined in their own little worlds, which can be good, but level six can be its own entity. There are issues with the physical layout. It needs to flow better and the equipment is old and small rooms.”

• **The computers slowed down the workflow due to either lack of computers or connectivity issues**
  “The computers are a challenge because when you’re busy and admitting lots of people, there are physicians and nurses that need to use the computers. We don’t have enough. The internet connection can be challenging because everyone can get on them at once. So we’re trying to get computers in all the rooms, but space is a challenge. Without them you can’t chart in real time, nurses will still write on a paper towel until they can find a free computer to properly do what they need to do. “
Linguistic Attributes: Communication

• The outcome of an emergency can balance on the edge of effective communication & miss-communication. No matter what was going on before a trauma was announced, the team was able to work together as if they had choreographed it months in advance. Each employee had this quality, the ability to snap into action. Unfortunately, communication breakdowns would occur in downtime.

• At times, staff would shout at individual team members to convey their needs or wishes, not in a negative connotation, but it is simply the quickest way to communicate across a short distance. This could have a deleterious effect to staff, causing embarrassment and visible reduction in confidence.

  “You can’t take offence to what anyone says, because they don’t mean it…if they tell you to get out of the way it’s because they need to do things quickly because someone is sick and it just comes out that way.”

• Communication can affect the team’s performance regardless of how clinically skilled the staff are.
Linguistic Attributes: Communication

- Occasionally, technology limited communication between staff. The electronic medical record (EMR) appeared to impede human-to-human communication & contact
  
  “Having an electronic product that allows me to go off to my desk and nurses going to theirs after seeing the patient, those are the wrong increments and make it a dissatisfying experience. There are challenges with the electronic world. We have gotten away from the human to human communication, and we have gotten into own individual processing order entry silos. Prior to the electronic world, I could look at a nurse and the nurse would look at me and there would be an understanding of that patient.”

- The spatial effect of the physical presence & location of the EMR appeared to decrease interactions between physicians, patients, & nurses

- It is important to note how individuals view their communication with others. When asking for participation in interviews, we were occasionally met with trepidation, fear that conveying one’s opinions would result in retaliation from the leadership. There is a discrepancy between staff & leadership where the staff feels they are complaining about their work situation & the leadership values those opinions for the purpose of impacting improvement
Social Attributes

• Staff described the importance of teamwork, concerns raised about on-boarding junior staff, working in a silo, & subgroups within the ED

  “There are sub-groups in the ED. They have a lot in common. They will be cordial but you’re not welcomed. You’re not invited to participate. Someone new will come along and if they are in that right age and station in their life they’ll let them in. It’s hard to get into that group. They take care of each other, not only inside the ED but outside. If there are two of them working on the same team, they’ll help each other out. It’s noticeable to the other people in the ED because they only help each other. They don’t think about it. It’s just their natural way. They love each other and more protective of each other, and will help each other keep their heads above water. There is another group of people who are extremely jealous and want to be in the group and they’re not. They can’t stand it and so they have a lot of negative feelings for that group.”

• Several staff felt these groups were unprofessional

  “It’s like high school where everything is very cliquey. I try to avoid the cliques. I guess that’s just the nature of it and you can’t really escape it.”
Social Attributes

• The staff commented on the necessity of teamwork & how they relied on teamwork to manage their work load

  “Working in an ED can be stressful because it’s a stressful atmosphere. You have high volumes and different people working together nurses and doctors (new, seasoned, etc.), so it can be stressful. You always got someone behind you too. If I have a critical patient and I need somebody to check on my other patients, someone will. Even though it’s stressful, it’s manageable because you have people you can turn to.”

• Familiarity is linked to the team’s familiarity with both their role and each other. The staff valued working with a team while recognizing individual contributions

  “When there’s a crisis, we always come out on top. It’s because everybody molds together, and the sub-groups go away, everybody is super and works together. Chaos all of a sudden disappears and we get organized. We are like clockwork. There’s a sense of satisfaction being able to meet the challenges head on and come out on top, and we always do.”

• Teams who are familiar with each other’s work have greater efficacy than teams composed of strangers
Social Attributes

• The constant leadership turnover was a major source of frustration & stress for the staff. “We have had leadership changes and we went through a period, I guess we’re still in it, with some hiccups with our leadership.”

• Staff voiced the need for a strong leader that would listen to staff & not want to come in & change everything.
  “We haven’t had a strong leader in the position for a long time. If there is any negativity in the ED that’s usually what causes it, not having someone in that position.”
Social Attributes

• The clinical confidence & competence affected the culture of the team. Staff did not feel that junior nurses needed to start their careers in the ED, due to lack of experience & not being able to recognize subtle changes in patients’ conditions. Staff were either accepted or rejected. If rejected, the staff left the department.

• Several staff discussed junior staff that were not as experienced & had mixed feelings about junior staff joining the department.

  “I don’t think it is fair to the new nurse because I think they’re scared to ask questions and don’t want anybody to think they don’t know. Some are strong, have worked as a tech in the ED, and have the experience. I don’t think it’s fair to them to put them into one of the busiest EDs. Sometimes new nurses are not safe. They don’t recognize the subtle changes in patients that a more experienced person would recognize. So you have to be possessive of patients.”

• New physicians were also treated in this same manner.

  “We treat doctors the same way. When they are new, we don’t trust them. We have a new doctor right now and he’s having a really hard time. We have had doctors after a month leave because the nurses here treat them so badly.”
Social Attributes

• New staff went through a “right of passage.” Before being accepted into the culture, staff had to prove themselves as a competent team member that could provide safe care. Staff had to show their team they had a right to work in the department.

“The culture existed already in the ED. I wanted to be accepted. I had to prove and show them I belonged. In the beginning it was difficult for me, I thought about it every day. It was the most important thing to show them that I had a right to be there. A year later, I realized I wasn’t thinking about it anymore because I had been accepted, because I had proven that I was good enough or worthy. “

• Once the junior staff exhibited they could handle working in the department & caring for acute patients, the experienced staff appeared to approve of the junior staff.

“It’s possessiveness and that’s how I felt when I came. I was not an experienced nurse and the older nurses were very possessive of patients and didn’t trust me. I had to prove that I was a good and safe nurse. I had the skills to take care of patients, and then they stopped being so possessive. The ED is more so that way then other places, because of patient safety because we HAVE to be that way.”

• It was critical to have a mix of experienced & inexperienced staff
Social Attributes

• Many felt they worked in silos with other departments. “We have to connect with other silos (like admitting staff, radiology, etc.). So the challenge is interfacing with all the other areas too.”

  “The ICU nurses are now more aware of what we do because they come down and get their patients from the ED. They understand why we don’t always give the patients to them in the nice clean way. Sometimes you don’t get the chance to do those types of things, but the ICU perception has changed. They have a whole new respect for the ED. Unless you have had a stroke patient in one hand and two chest pain patients in the other and someone is coding, then you just don’t know what it’s like here.”

• The ED & other departments have different perceptions of each other’s role & workload

• Observations revealed the pediatric ED’s physical environment & space may have caused a silo between the adult & pediatric ED. The pediatric staff felt no one cared about them & appeared to have feelings of resentment

  “Pediatric nurses don’t float to the main ED because they haven’t been cross trained for adults. Nobody really takes care of them now…I think they resent that because they felt better taken care of when they had their own manager, and now they have to do more on their own, and they don’t have somebody to run to, to deal with their issues.”
Discussion

Findings expand & deepen the understanding of an ED’s culture

• Staff felt a tremendous amount of gratification & reward by caring for patients at one of their weakest moments in life
• Staff articulated a team that worked promptly & relied on each other for support (15)

Concerns were expressed with having to spend more time eliminating roadblocks in care processes

• Some experienced staff felt that placement of junior staff in the ED as unsuitable. Junior staff appeared to go through “a right of passage” to gain respect & acceptance from the experienced staff. Experienced nurses & physicians play a critical role in assisting junior staff in the ED
• ED is an intense & stressful environment & staff at times dealt with emotional exhaustion (16)
• Stress associated with the ED environment included overcrowding, inter-staff conflict, & technology barriers (19-20)
• The ED environment changes rapidly in regard to patient numbers, types, & activities creating a stressful environment for staff (17). Work stress in the ED has been shown to impede team effectiveness (18)

Despite the stress, frustration, & exhaustion, most found positive aspects of & meaning in being a team member

• Promoting a culture that values the staff is essential in building an environment that fosters the satisfaction & retention of staff
Implications

- Interpretation of the data suggest that staff education include team training, team management, interprofessional & interdepartmental teamwork, conflict resolution, communication strategies, & leadership development.

- Support systems for role development of new staff should be formalized. Teams drive quality and safety in healthcare. Highly reliable teams must relate to one another, even with members having different skills, knowledge levels, styles, & communication methods. Staff are expected to work symbiotically, act efficiently, & without error when called into action. Patient resuscitation is undertaken by a team & educational training should be multidisciplinary to reflect this.

- Methods used to optimize team performance include: simulation training & proven training programs: TeamSTEPPS® (Team Strategies & Tools to Enhance Performance & Patient Safety) & Crew Resource Management. 

25
Implications

• Training programs could be implemented into professional development to create collaboration & interprofessional practice. To help minimize the affects of role unfamiliarity, pre-assigned zones for staff should be considered.

• Findings provide new insight and knowledge regarding elements that influence culture. As described in this study, the setting created a “culture” of practice unique to the ED \(^{(22)}\).

• More attention be paid to the work environment & process improvement to promote safer, more efficient patient care. This may include more process oriented training, supervised role experiences, increased staffing during high-volume time periods, & implementation of bridge orders.

• The environment of care appears to be a significant factor, & consideration of this element may prove useful in improving patient care. Removing barriers & improving processes will impact patient safety, efficiency, & cost-effectiveness.
Conclusion

• Teams are an essential element for improving patient safety and outcomes. It is evident through the study findings that culture is influenced & created by multiple elements

• True culture change that is both sustainable & able to produce permanent improvements in patient outcomes require teams to work together in a harmonious accord

• Further research would be beneficial in other settings outside the ED setting
References


References


