



Delivering best care and maintaining emotional wellbeing in the intensive care unit: the perspective of experienced nurses



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ABSTRACT

Aim: This study explored the perspective of experienced intensive care nurses regarding maintenance of their emotional wellbeing.

Background: Caring for critically ill patients has been identified as stressful. The demand for critical care nurses continues to grow in a climate of an ongoing nursing shortage and an aging workforce. This study sought to understand what environmental elements optimized the maintenance of emotional wellbeing.

Methods: Grounded theory.

Results: Fifteen experienced intensive care unit registered nurses from a metropolitan hospital in Western Australia, were interviewed. Five categories were identified: 'achieving best care', 'caring for the patient's family', 'autonomy within the ICU environment', 'teamwork', and 'previous nursing and life experience'.

Conclusions: The findings from this study increase our understanding of the environmental elements that can optimize the emotional wellbeing of intensive care nurses. These findings will assist in the development of strategies to retain nurses in the ICU area.

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1. Introduction

Critical care nursing has never been tougher, patient acuity is high, technology has exploded and increasingly, regulations and documentation requirements dominate practice (Moloney-Harmon, 2010). Repeated exposure to patients with life threatening illness or trauma, and sudden critical events can be difficult for nurses working in intensive care units (ICUs). There is a plethora of research confirming that ICU nurses globally experience prolonged stress culminating in burnout and disengagement from the workforce. For example, high levels of burnout were found in a survey of 80 critical care nurses working at five hospitals in Spain (Iglesias, Vallejo, & Fuentes, 2010). Overall, the Maslach Burnout Inventory revealed high levels of emotional exhaustion, moderate levels of depersonalization and low levels of accomplishment. Older nurses, those who had worked as a nurse for more than 10 years, and smokers had significantly higher levels of emotional exhaustion. These patterns were compared and found to be similar to the results from studies

conducted in other countries using the same measure, including Canada, Norway, Hungary, France and the United States (US).

Feelings of suffering in ICU nurses were explored in a qualitative study with eight registered nurses who worked in a Spanish ICU (Martins & Robazzi, 2009). Most often reported as causing nurses to suffer were critically ill young patients with the effect being felt by the whole team. Nurses had trouble detaching from the suffering of young patients even when they were away from the workplace. Similarly, nurses suffered more when caring for long-term patients and those with whom they had formed a strong attachment.

Moral distress; painful feelings related to morally appropriate action constrained by institutional barriers (Jameton, 1984), has also been found in ICU nurses. McAndrew, Leske, and Garcia (2011) measured moral distress in 78 critical care nurses (excluding emergency department nurses) from a trauma center in the US. Patterns of moral distress were found to be similar to patterns reported elsewhere. Factors in the work environment such as leadership, staffing levels, and relationships with other health professions were found to impact on moral distress. Other studies have also reported a link between moral distress and interpersonal issues between nurses and physicians (Karinikola, Papatthanassathaglou, Kalafati & Stathopoulou, 2012; Wilson, Goettemoeller, Bevan & McCord, 2013).

More recently, compassion fatigue, another measure of distress has been identified in ICU nurses (Elkonin & van der Vyver, 2011; Jenkins & Warren, 2012). First described by Joinson (1992), compassion fatigue

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is a unique form of burnout that manifests as a gradual lessening of compassion in people who work directly with those who have experienced trauma and/or those who are suffering. Although described as a progressive and cumulative process, workers may experience it in response to repeated exposure to suffering, or a single event (Elkonin & van der Vyver, 2011; Mason, Leslie, Lyons, Walke & Griffin, 2014). Compassion fatigue is compounded by feelings of moral distress (Hamric & Blackhall, 2007; Mason et al., 2014; McLendon & Buckner, 2007).

There is evidence that pleasure is also associated with caring for patients in the ICU and this has been explored. Twenty six nurses and 96 nursing technicians employed at a hospital in Brazil were surveyed using the "Pleasure-Suffering at Work Scale". Pleasure with caring activities were found to be at satisfactory levels, however, level of emotional exhaustion and dissatisfaction, and lack of recognition were critically high (Shimizu, Couto & Merchan-Hammann, 2011).

Development of strategies to retain skilled and experienced nurses is essential within the current global nursing shortage (Buchan & Calman, 2004; Kutney-Lee, Wu, Sloane, & Aiken, 2013; Oulton, 2006). The ability of nurses to maintain their emotional wellbeing and to work effectively within the ICU environment contributes to the retention of experienced staff. Studies investigating specific interventions or organizational strategies to prevent burnout are needed to address this problem (Epp, 2012).

This project sought to explore the perspective of experienced ICU nurses to reveal the strategies used by nurses who continue to nurse in ICU. While current literature expounds stressors experienced within this environment, it does not fully describe how ICU nurses maintain their wellbeing. Greater understanding of this phenomenon will assist in the creation of workplace environments that retain nurses in the critical care workforce. Retention of these highly skilled and experienced nurses is important within a climate of nursing shortages and an aging workforce.

2. Research methods

2.1. Design and sample

The qualitative methodology grounded theory was used in this study (Glaser & Strauss, 1967) to explore and describe experienced ICU nurses' perceptions of emotional wellbeing in the ICU work environment. Experienced nurses were sampled because these nurses had demonstrated the desire and ability to remain working in this environment. Grounded theory has been recognized as a useful methodology when theory or explanation about a phenomenon does not exist (Stern, 1994). Developed from symbolic interactionism (Blumer, 1969), grounded theory discovers the meaning individuals derive from interactions while experiencing the phenomena of interest. The original grounded theory approach outlined by Glaser and Strauss (1967) was used in this study. Data analysis was performed to a descriptive rather than theoretical level. The core category of *Nurse Distress* was identified during the analysis and relationships between categories were attempted and developed into a conceptual model, but theoretical abstraction was not achieved completely.

The setting for this study was an ICU in a Western Australian public hospital. The then 18-bed ICU accepted elective and emergency surgical, medical, neurological, trauma and cardiothoracic patients. At the time of this study, the unit employed over 100 full-time equivalent registered nurses.

Purposive sampling was used to select the first four participants. Following initial analysis of these data theoretical sampling (Glaser & Strauss, 1967) guided the invitation of further participants. Theoretical saturation was established by the identification of dense categories and the absence of new concepts in the data (Strauss & Corbin, 1998). Charmaz (2006) described the common understanding of saturation in grounded theory as "I kept finding the same pattern" (p. 113).

The sample consisted of 15 registered nurses who had a minimum of 2 years working in the study area. This period was considered to represent experienced ICU nurses. Ethical approval was obtained from the Human Research Ethics Committee of both the study hospital and administering university.

2.2. Procedures

Formal interviews were conducted with each participant and audio-recorded. Semi-structured questions were developed and referred to throughout the interview as a broad guide. The interview question guide was updated throughout the data collection period, to allow for exploration of emerging themes and ideas that arose from concurrent analysis.

Memos were written during the interviews to capture thoughts about the individual incidents in the data and prompt exploration of ideas introduced. These memos provided leads to pursue in subsequent interviews (Birks, Chapman, & Francis, 2008; Strauss & Corbin, 1998).

2.3. Data analysis

Recorded interviews were transcribed verbatim, then organized and managed for analysis using QSR NVivo (QSR International, Pty. Ltd. Version 7, 2006). Data were simultaneously collected, coded and analyzed using the constant comparative method as described by Glaser and Strauss (1967) to allow exploration and theory development.

Initially, open-coding was undertaken where all data (transcripts) were coded line by line to conceptualize all incidents that were present. The concepts were compared and grouped to find patterns and emergent categories. Axial coding was used to make connections between the major themes and core categories. The purpose of linking categories and subcategories was to begin reassembling the data to describe the phenomena under investigation more precisely (Strauss & Corbin, 1998). The data were constantly compared, some categories were subsumed into higher order categories and a higher level of conceptualization emerged.

The final stage of coding, known as Selective Coding was undertaken. The process of identification and integration of core categories or major themes expanded on the relationships between the categories, explored the dimensions and validated the connections (Strauss & Corbin, 1998).

Strategies were used to ensure rigor of the findings including independent member checks. Findings at different times throughout the analysis procedures were given to participants to confirm interpretation and meaning. An experienced grounded theorist also supervised coding procedures and analysis. Three of the participants were followed up informally after the interview to clarify information for emerging categories (Glaser, 1998) and one participant contacted the researcher via e-mail to provide some further details.

3. Results

Fifteen registered nurses, with a mean age of 39.4 (26–50) years were interviewed. The length of time working in ICU ranged from 3 to 25 years with a mean of 13 years and most ($n = 12$) were female. All 15 nurses indicated their intention to remain in ICU.

The basic psychosocial problem experienced by the nurses in this study was an *inability to protect self from distress*. Nurses who encountered this problem reported feelings of sadness, suffering, unhappiness, anguish, anxiety, fear, grief, frustration, disappointment and dissatisfaction. This was in contrast to the positive experience of emotional wellbeing, characterized by feelings of happiness, enjoyment and personal satisfaction. Emotional wellbeing was experienced when nurses felt that they had done their best working with critically ill patients and their families. The source of happiness and personal satisfaction for nurses was the successful delivery of best care to patients and their families. Nurses also stated that when they experienced feelings of happiness and personal satisfaction, they were motivated to continue working in the ICU.

It was evident that nurses sought to avoid the problem of their own distress and maintain their emotional well-being using a basic psychosocial process called "protecting self from distress". This process involved three independent phases: delivering best care, validating care episodes, and distancing self from distress.

Delivering best care described nursing in the ICU when the conditions enabled nurses to deliver best care to the patient and their family and

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