International Emergency Nursing 21 (2013) 222–227

Contents lists available at SciVerse ScienceDirect

International Emergency Nursing

journal homepage: www.elsevier.com/locate/aaen

The culture of an emergency department: An ethnographic study

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ARTICLE INFO

Article history:
Received 17 July 2012
Received in revised form 14 October 2012
Accepted 18 October 2012

Keywords:
Emergency department
Culture
Ethnography
Emergency services
Trauma
Practice environment

ABSTRACT

In an environment of change and social interaction, hospital emergency departments create a unique sub-culture within healthcare. Patient-centered care, stressful situations, social gaps within the department, pressure to perform, teamwork, and maintaining a work-life balance were examined as influences that have developed this culture into its current state. The study aim was to examine the culture in an emergency department.

The sample consisted of 34 employees working in an emergency department, level II trauma center, located in the Southeastern United States. An ethnographic approach was used to gather data from the perspective of the cultural insider.

Data revealed identification of four categories that included cognitive, environmental, linguistic, and social attributes that described the culture. Promoting a culture that values the staff is essential in building an environment that fosters the satisfaction and retention of staff. Findings suggest that efforts be directed at improving workflow and processes. Development and training opportunities are needed to improve relationships to promote safer, more efficient patient care. Removing barriers and improving processes will impact patient safety, efficiency, and cost-effectiveness. Findings show that culture is influenced and created by multiple elements.

Introduction

Healthcare is a unique business in regards to the high amount of human interaction that takes place, especially in the emergency department (ED). Each ED has the capacity to create their own culture, meaning they can create underlying beliefs, traditions, and values that go beyond what is written down as organizational values. The ED's culture can significantly impact its ability to produce positive patient outcomes, manage human resources, and succeed financially. It is therefore important to examine the ED culture.

Organizational culture is defined as "the set of shared, taken-for-granted implicit assumptions that a group holds and that determines how it perceives, thinks about and reacts to its various environments" (Schein, 1996, p. 236). Organizational culture refers to a shared value system that develops over time that guides team members as they experience and solve problems, adapt to their internal and external environments, and engage and manage relationships (Schein, 2004). The phrase, "the way we do things around here" demonstrates the ingrained values, beliefs, norms, and expectations of members within an organization or work unit.

Background

The ED is a high stress, unpredictable, critical care environment (Creswick et al., 2009). A literature synthesis by Handel et al. (2010) noted that organizational culture impacts ED overcrowding, throughput issues, inefficiency, poorer quality outcomes, and reduced profitability. Furthermore, organizational culture has emerged over the last 20 years as a significant factor in explaining workplace behavior and performance (Hatch, 1993; Schein, 1996, 2004). Researchers have shown a link between organizational culture and patient outcomes (Aiken et al., 2011; Trinkoff et al., 2011), patient satisfaction (Meterko et al., 2004), safety (Armellino et al., 2010; Huang et al., 2010), employee satisfaction (Aiken et al., 2011; Tsai, 2011), clinical performance (Brazil et al., 2010), and financial viability (Handel et al., 2010). Research demonstrates that culture can influence the success or failure of organizational outcomes.

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http://dx.doi.org/10.1016/j.ienj.2012.10.001

Ethnography allows us to experience and learn about culture as an insider, but also allows us to articulate beliefs and values from a neutral perspective in a way that insiders cannot. Ethnography provides an effective approach to learn about people directly from the people, to explore, understand, and describe cultures (Roper and Shapira, 2000). It can provide a way to understand the culture, insights into the practice environment, and relationships within the ED. The aim of this study was to examine the culture in an ED.

Methods

Design

A focused ethnographic approach was used to gather data from the perspective of the cultural insider (Magilvy et al., 1987; Muecke, 1992). Staff observed in this study were considered a cultural group within the ED. In order to maintain objectivity, the researchers also distanced themselves from the context in order to gain conceptual clarity. Ethnography is the science of understanding how people live and interact with the world around them. When applied to business cultures, the study of ethnography is used to gain insights into patterns of behavior and predicting future trends. Ethnography combines conversations and interviews with actual observations of people in their real environments. True business ethnography involves not just visiting people in their own environment, but also observing their behavior, listening to their thoughts, and reporting the world as they see it, through their own eyes and using their own language and cognitive models. For these reasons, the researchers felt this research approach was appropriate to study the culture of the ED.

Data collection

The ED is a level II trauma center with three trauma rooms and 63 exam rooms located in the Southeastern United States. Last fiscal year, the ED had 116,000 patient visits. There are approximately 250 staff including registered nurses, clinical care partners, physicians, technicians, customer service representatives, leadership, and other support staff. All 250 staff members were recruited to participate in the study.

Prior to data collection, ethics approval was obtained from the organization's Nursing Research Committee and Institutional Review Board for the Protection of Human Subjects. Data were gathered by an anthropologist through multiple methods from August 2011 to January 2012 including: examination of department documents; ethnographic mapping of the physical and cognitive elements of the environment; and listening to the casual conversations and stories told during social gatherings. Direct observations were conducted for a total of 430 h. Data were collected from interactions between the anthropologist and staff, patients, as well as observations of interactions among staff. Data collection took place in the ED, change of shift report, attending meetings and safety huddles, break room, offices, patient rooms, and social gatherings. A majority of the observations (~250 h) occurred between the times of 7:00 am and 7:00 pm Monday through Friday. The rest of the time was split evenly between nights and weekends. Observations lasted anywhere from 1 to 4 h at a time depending on the availability of researchers.

The researchers gained rapport amongst the participants by participating rather than simply observing. The researchers completed tasks (comfort needs, information, assistance to family members, and customer services) while observing participants that allowed the researchers to work alongside the ED staff promoting personal connections and shared experiences with the staff. In addition, the researchers participated in ED shift huddles, staff meetings, meals, and other events.

Participants completed a 16-item demographic survey and created a list of answers to two questions regarding a domain of their culture. Survey questions included "What does someone need to succeed in your job?" and "What is required to make a patient feel happy and/or comfortable?" Staff created a free list of responses to the two questions.

Interviews were conducted informally during observations and formally during structured interviews. Selected interviews were audio-taped and transcribed for accuracy. Structured interviews lasting 30–45 min were held with leadership, physicians, support staff, and staff nurses.

Extensive field notes were kept of observations and interviews. In addition, the anthropologist recorded personal past experiences and biases that might influence his role as a research instrument. Interaction during data collection also helped to identify and clarify feelings and biases that could impact data interpretation.

Analysis

The constant comparative method of data analysis was used (Lincoln and Guba, 1985) to analyze the data and proceeded in the stages outlined by Diekelmann and Allen (1989) and extended by P. Minick (personal communication, April 11, 2003). Cultural salience was calculated for the free listing data.

Verbatim transcripts of the interviews, direct observations, field notes, and free lists served as the data for analysis. Data analysis was accomplished by using a research team composed of the anthropologist, research investigators, and another researcher.

A written summary was prepared that included key words, phrases, and paragraphs which best represented the participant's message. The team met, interpretations were discussed in-depth, and points of congruence and difference were identified. When interpretations were different, the researchers' explored the possible sources of the differences and returned to the text to come to a level of consensus. Data collection and this initial analysis occurred concurrently. When the initial analysis of the text, field notes, and free lists were completed, *Microsoft Word© 2010* was used to code each section of the interview using the participant's own words to label the data. A code book was developed listing each code and the initial definition of the code to maintain consistency in labeling. Once coding was completed for the individual text, then all data within each code was read and reread individually. Codes containing similar data were collapsed into categories and labeled with participant's words. The entire analysis was reviewed by the team, as well as, by another researcher who is familiar with the research method. The participants read the interpretation and their suggestions were incorporated into the final draft.

Rigour

Credibility was addressed through the use of a research team, member checks, reflexive journal, and audit trail. The circular hermeneutic method (Diekelmann and Allen, 1989) enhanced credibility, as the data were returned to repeatedly by the team. Regular meetings were scheduled to assure that interpretations were grounded in data, giving expert consensual validation.

"Member checks" were made with the participants, to discuss the interpretations of their stories and the categories (Lincoln and Guba, 1985). An "audit trail" was kept, consisting of a reflexive journal, field notes, audiotapes, and transcripts of the interviews, and computer data (Lincoln and Guba, 1985).

Transferability was addressed through a reflexive journal that provided a record of contextual data, including descriptions of