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REVIEW

The organizational culture of emergency departments and the effect on care of older adults: A modified scoping study

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ABSTRACT

How does the organizational micro culture in emergency departments (EDs) impact the care of older adults presenting with a complaint or condition perceived as non-acute? This scoping study reviews the literature and maps three levels of ED culture (artifacts, values and beliefs, and assumptions). Findings on the *artifact* level indicate that EDs are poorly designed for the needs of older adults. Findings on the ED *value and belief level* indicate that EDs are for urgent cases (not geriatric care), that older adults do not receive the care and respect they should be given, that older adults require too much time, and that the basic nursing needs of older adults are not a priority for ED nurses. Finally, finding on the *assumptions* level underpinning ED behaviors suggest that older adults do not belong in the ED, most older adults in the ED are not critically ill and therefore can wait, and staff need to be available for acute cases at all times. A systematic review on the effect of ED micro culture on the quality of geriatric care is warranted

1. Introduction

Most emergency departments (ED) are ill-equipped to serve the needs of older adults (those age 65 years and older) (Adams and Gerson, 2003; Hwang and Morrison, 2007). Over the last decade, a number of efforts have been made to change practice and improve the quality of care for older adults in EDs (Cooke et al., 2012). The purpose of this scoping study is twofold. First, it describes the ED micro culture (Schein, 2010) – a culture of specialized subgroups or small systems existing within the broader organization – through a review of the literature. Secondly, it reveals how ED culture impacts on the care of older adults perceived as having a non-acute complaint or condition. This paper examines the impact of ED micro culture on geriatric care to understand the problem and to identify what is needed to improve geriatric care and outcomes. In this paper we have used the term 'older adult' to refer to the person receiving care and 'geriatric care' to refer to the care of older adults.

2. Background

In a study of older adults and their hospital experiences Parke and Chappell (2010) identify two groups of older adults. In the first group are older adults with an acute complaint or condition whose needs fit the hospital environment and the organizational culture. In the second group are older adults who are not perceived as having acute care needs because of frailty, reduced functional level, or altered cognition. Both groups are vulnerable on admission to an ED which exposes them to a noxious hospital environment (Inouye, 2006) that increases risk for adverse impacts and outcomes. One example of that risk is the common failure to diagnose delirium, a life threatening emergency affecting 10–16% of older adults admitted in the ED (Voyer and Sych-Norrena, 2003). We argue that delirium is more likely to go unrecognized and undiagnosed because of the characteristics of the ED micro-culture.

Schein (2010) defines organizational culture as "a pattern of shared basic assumptions learned by a group as it solves its problems of external adaptation and internal integration" (p. 18). He argues that cultural phenomena are only made visible by examining them on three levels. The first level is ***artifacts***, the tangible and overtly identifiable elements (e.g., buildings, organization of offices, style of clothing, behaviors) that can be observed. The second level is the stated ***values and beliefs*** espoused by a group. The third level is the taken-for-granted and ***basic assumptions*** that are difficult to recognize because they are so deeply embedded in behaviors.

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In addition, Schein (2010) theorizes two processes to consider when examining organizational culture. These are the processes of ***external adaptation*** to the environment and ***internal integration*** (see Fig. 1). ***External adaptation*** refers to the organizational environment and reflects assumptions about the organization's mission and strategy, its goals, means, measurement, and ways that the organization implements, measures and corrects itself as it executes its strategy. ***Internal integration*** refers to the consensus and consistency processes within a group that underpin assumptions that "permit daily functioning and the ability to adapt and learn" (Schein, 2010, p. 18). This latter process is revealed in the adoption of a common language; agreement on group boundaries about who is included or excluded; how trust, intimacy, and friendship are dealt with; how reward and punishment are structured; and explanations about how and what the group knows (Schein, 2010, p. 94).

3. Methods

A scoping study entails a relatively rapid mapping, typically within 6 months, of a wide range of literature, concepts, or policies for a given area of interest (Anderson et al., 2008; Arksey and O'Malley, 2005; Levac et al., 2010; Valaitis et al., 2012). The purpose of a scoping study is to review the literature, not to evaluate or interpret the findings. Rather it is a pragmatic approach that is useful in grasping the broader issues.

Ideally a scoping study is undertaken by a research team (Anderson et al., 2008; Levac et al., 2010). This scoping study was, however, modified since it was undertaken as a graduate project by a single researcher. The study involved five steps: (1) identifying the research question, (2) identifying relevant studies, (3) selecting studies, (4) charting the data, and (5) collating, summarizing and reporting results (Arksey and O'Malley, 2005; Levac et al., 2010).

Searches were conducted in the Cumulative Index for Nursing and Allied Health (CINAHL®), Medline, Academic Search Complete, and PsychInfo. Search terms included: emergency services, EDs, emergency room, organizational culture, organizational change, and culture. Only articles in English published between 1995 and 2012 were reviewed. Gray literature such as news articles, thesis, government papers, etc. (Mathews, 2004) going back to 2005 were reviewed. Literature describing EDs in acute care settings and ED staff members' experiences with the older adult was included. Literature describing the older adult's experiences in the ED or focusing on clients with mental health concerns or children and their families was excluded.

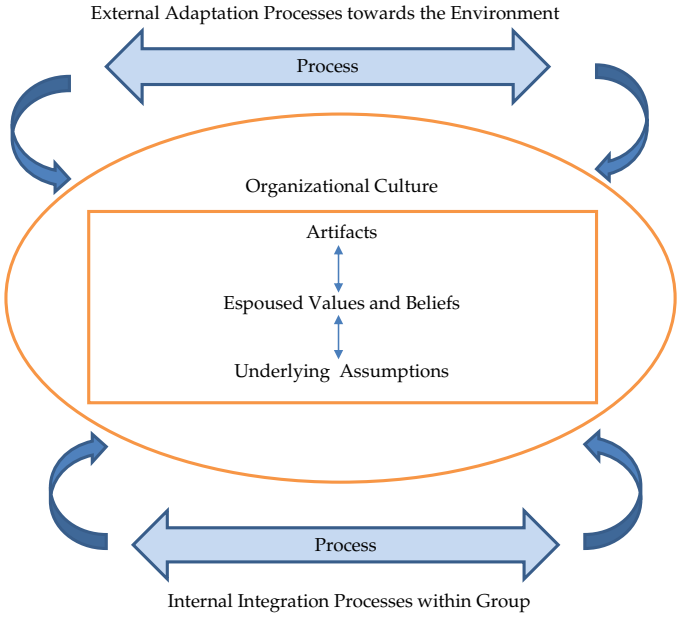

Fig. 1. Conceptual model of relationship between external adaptation, internal integration, and organizational culture. This figure is used by permission by Pål Skar (Skar, P. (2013). *Organizational Culture in Emergency Departments and the Older Adult* (Master's Project). University of Victoria, Victoria, BC. Retrieved from https://dspace.library.uvic.ca/bitstream/handle/1828/4590/Skar_Pal_MN_2013.pdf?sequence=1).

A total of 95 articles were identified; however only two articles that addressed ED staff and their experiences with older adults (Kelly et al., 2011; Kihlgren et al., 2005) and three articles that addressed existing ED design and practices in the context of the older adult (Adams and Gerson, 2003; Hwang and Morrison, 2007; Rosenberg et al., 2010) were found. This study therefore includes 14 additional articles that did not specifically talk about older adults in the ED but offered significant observations, comments or descriptions from the context of the ED of one or more of the three levels of culture assessment as defined by Schein – artifacts, values and beliefs, and assumptions. In all, 19 articles were reviewed with data extraction focusing on each of the three levels of cultural assessment (i.e. artifacts, values and beliefs, and underlying assumptions). This iterative process required reading and rereading each article several times. Finally, the data were collated according to the level of cultural assessment and themes were developed.

3.1. Findings

Findings are presented using the three levels (i.e. artifacts, values and beliefs, and underlying assumptions) of Schein's (2010) framework for organizational culture assessment.

3.2. Artifacts

According to Schein (2010), artifacts are the visible manifestations of organizational culture which can be observed in the environment (p. 24). Twelve articles describe ED micro culture artifacts (Adams and Gerson, 2003; Eisenberg et al., 2006; Fry and Stainton, 2005; Hwang and Morrison, 2007; Kelly et al., 2011; Kihlgren et al., 2005; Moss et al., 2008; Muntlin et al., 2010; Nugus and Braithwaite, 2010; Nyström et al., 2003; Rosenberg et al., 2010; Seltzer et al., 2012). These artifacts portray the ED as the front door of the hospital (Eisenberg et al., 2006; Nugus and Braithwaite, 2010). Access into the ED requires navigating a triage station, a registration desk and a waiting room (Eisenberg et al., 2006; Fry, 2012; Kelly et al., 2011; Nugus and Braithwaite, 2010). People seeking care cannot be turned away and are treated depending on their assigned priority (Eisenberg et al., 2006; Fry, 2012; Nugus and Braithwaite, 2010; Nyström et al., 2003). This culture appears to be the same for Australia, Sweden, the United Kingdom, and the United States. In one article the ED staff is described as "insane ticket taker"(s) (Eisenberg et al., 2006, p. 207) admitting anyone.

Once admitted to the ED patients are assigned to cubicles separated from each other with curtains (Hwang and Morrison, 2007). Cubicles are organized according to care delivery models or treatment processes (Adams and Gerson, 2003; Fry and Stainton, 2005; Hwang and Morrison, 2007; Kihlgren et al., 2005; Nyström et al., 2003; Seltzer et al., 2012). This design allows staff to monitor (Adams and Gerson, 2003) and manage the trajectory of multiple clients through the department (Hwang and Morrison, 2007; Nugus and Braithwaite, 2010). The high volume of clients creates "a bunker mentality of being under siege" (Seltzer et al., 2012, p. 131). The department is described as "a chaotic environment. . .ordered chaos" (p. 133) and "a complex, high pressure, stressful working environment" (Moss et al., 2008, p. 101).

Flooring is designed for easy cleanup (Hwang and Morrison, 2007) and lights are on 24/7 (Hwang and Morrison, 2007). Once seen by a physician, clients undergo diagnostic tests and are often left waiting