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# Factors Influencing Emergency Registered Nurse Satisfaction and Engagement

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This is to certify that the doctoral dissertation by

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Walden University
2018

Abstract

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MM, University of Phoenix, 2008

BS, Ithaca College, 1976

Dissertation Submitted in Partial Fulfillment

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## Abstract

Employee satisfaction and engagement have a direct impact on customer satisfaction. Dissatisfaction and disengagement lead to an increased intent to leave a job, poor patient outcomes, and decreased productivity. The retention and recruitment of qualified staff becomes an urgent priority to ensure safe and prudent patient care. The purpose of the qualitative research study was to better understand the beliefs, attitudes, perceptions, and reasons for emergency department registered nurses (ED RN) satisfaction and engagement in the workplace focusing on Herzberg's, Vroom's, Yetton's, Maslow's, Benner's, and Kahn's motivation and engagement theoretical frameworks. The qualitative case research study focused on satisfaction and engagement elements using structured interviews of 21 ED nurses from three hospitals of varying sizes and capabilities and included three generational cohorts of Baby Boomer, Generation X, and Millennial RN. Interview analysis showed distinct similarities and differences in nurse satisfaction and work engagement with a consistency in job engagement with no distinct differences among generations. Distinct findings included persistent lack of staff resources, poor communication from leaders, and compassion fatigue among staff. Findings reflected strong interpersonal relationships, teamwork, autonomy, and a strong sense of accomplishment among nurses. Findings indicate that satisfied nurses have improved outcomes, produce happier customers, and feel a sense of accomplishment in the job performed. The positive social impact of this study is in providing guidance on retaining ED RN to provide adequate staffing levels for safe, quality healthcare.

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# Dedication

Sometimes thank you is not enough for those special individuals who supported, educated, or provided a shoulder, an ear, or a hand during this journey. My husband, William, was always there for me, always encouraging me to write, read, and become the person I wanted to be. He was a rock for me and I thank him for that support. My coworkers were a great support for me during this time. Nurses have always been a strong support for me and I would not be the person I am today without all of my nursing friends who have taught me, supported me, and encouraged me through all of my professional years. No thank you would be complete if I did not smile and thank my dogs for always being there, never judging me, and for making sure I was always loved even when the writing was tough or the day was too long. So, Bubby, Brady, and Zeus here's a big hug puppy hug for each of you.

# Acknowledgments

I would like to acknowledge my husband and family for their support during this journey. If not for my coworkers and fellow nurses I would not have been able to write this paper and focus on the issues and challenges healthcare faces on a daily basis.

To my committee members I thank you from the bottom of my heart for your dedication, understanding, and patience throughout this process. Dr. Levasseur provided guidance and knowledge that supported my progress, kept me focused, and encouraged me. Dr. Barbeau and I have walked this journey as a team for the last seven years. Without his support, knowledge, and sense of humor I think my journey would have been less pleasant and far less fun. I thank you both for being there with me during this journey. I would also like to acknowledge my cohort members, led by Dr. Barbeau, who worked with me, provided guidance and support, and worked alongside me to understand the dissertation process, the challenges each student faces, and for providing support, knowledge, and appreciation of how special and important obtaining a PhD is to each of us. A special thanks to Todd and Jean who were my cohort buddies throughout this process.

Lastly, to my fellow ED RN, I thank you for being who you are and for motivating me to undertake this venture. I have always been the eternal optimist facing the challenges we face daily with humor, knowledge, and providing quality care. We laugh, smile, cry, and work as a team and without your input, expertise, and experiences my study would not have provided the valuable information about what makes us happy, satisfied, and engaged in the profession we love and cherish.

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# Chapter 1: Introduction to the Study

Healthcare in the United States has become a source of debate eliciting emotions ranging from frustration to optimism. An environment of escalating costs, limited access to services, the dispute of right versus privilege to healthcare, and an insufficient number of trained and experienced care providers complicates the current United States healthcare system (Agency for Healthcare Research and Quality, 2012; American Association of Critical Care Nurses, 2012). One lingering issue in this chaotic environment is the inadequate supply of nurses to meet the high patient care demands in 21st-century healthcare (American Hospital Association, 2012). Coupled with the inadequate supply of nurses is a disengaged and dissatisfied nursing workforce; a workforce attempting to adjust to increasing numbers of healthcare users, pay for service quality expectations impacting reimbursement, and generational differences, and a workforce that is aging (Auerbach, Buerhaus, & Staiger, 2014; Auerbach, Staiger, Muench, & Buerhaus., 2013; Gianfermi & Buchholz, 2011; Press Ganey Associates, 2010; Sherman, Chiang-Hanisko, & Koszalinski, 2016). Understanding the needs to satisfy and engage nursing staff to maintain adequate nursing staffing levels becomes a challenge in this demanding environment of the limited supply of providers, high demand for services, and a disengaged and dissatisfied nursing workforce (Hussain, Rivers, Glover, & Fottler, 2012).

A Press Ganey Associates survey completed in 2010 reported 30% of staff at participating healthcare facilities as disengaged, disempowered, and dissatisfied, with the younger and direct care providers expressing the highest rate of discontentment. The

survey results provided information showing a direct link between staff satisfaction and subsequent patient satisfaction. This link illustrates that happier employees produce happier customers. With this simple principle in mind, the need to improve satisfaction and engagement requires insight and direction from leaders to successfully retain and attract nurses who remain satisfied and engaged in their work, which will ultimately result in increased consumer satisfaction.

Successful retention and recruitment necessitate an identification and analysis of staff insight of perceived strengths, opportunities, weaknesses, and barriers to improving the work environment including teamwork, relationships, and factors directly or indirectly influencing nurse satisfaction and engagement (American Association of Critical Care Nurses, 2011; Bittner & O'Connor, 2012). These insights provide valuable, relevant, and constructive data to identify commonalities and themes related to what satisfies and engages staff (Dotson, Dave, Cazier, & McLeod, 2013). With only 30% of the healthcare workforce feeling engaged, satisfied, and empowered, determining the factors that directly influence nurse satisfaction and engagement becomes imperative considering the anticipated ongoing nursing shortage.

Four key factors influence the importance of nurse satisfaction and engagement. These factors, described in Chapter 1, include an aging nursing workforce, value-based purchasing (Centers for Medicare and Medicaid, 2013), increased demand for healthcare, and generational differences (Cogin, 2012; Sullivan, Warshawsky, & Vasey, 2013). In Chapter 1, I outline the overall purpose of the qualitative case study design, identifying an overarching and more targeted research questions to discover commonalities, themes,

and descriptors of job satisfaction and engagement. The qualitative case study design and methodology includes data sources, analysis, definitions, scope, delimitations, and study significance focusing on the nurses' experiences, beliefs, and the commonalities of the hard and soft elements influencing emergency department registered nurse (ED RN) satisfaction and engagement. The literature review in Chapter 2 provides an assessment of the global aspects of employee satisfaction and engagement narrowing the focus to healthcare employees and finally assessing ED RN satisfaction and engagement. The analysis, assessment, and in-depth evaluation of the literature from the broad perspective narrowed to the ED RN develops the foundation uniting theory with peer reviewed research specific to satisfaction and engagement.

The study methodology, described in Chapter 3, includes participants, data collection, data collection tools, significance, limitations, implications for social change, and data analysis. In Chapter 4 I present the data analysis of information obtained from interviews of three generational cohorts of Baby Boomer, Generation X, and Millennial participants from three varying sized healthcare facilities located in upstate New York and Vermont. The data includes specific factors directly or indirectly impacting satisfaction and engagement. Chapter 5 provides a summary of the data analysis and the impact of social change related to this research study.

## Background of the Study

The term *perfect storm* has come to describe a series of multifaceted events generating unplanned and unwelcomed outcomes. The book *The Perfect Storm: A True Story of Men Against the Sea* (Junger, 1997) described a convergence of storm fronts

creating a catastrophic event in the north Atlantic leading to death and destruction. The storm predictions, while well communicated, went mostly unheeded. Likewise, the perfect storm, the ongoing nursing shortage coupled with dissatisfied and disengaged nurses, continues to generate and perpetuate concerns about the quality and safety of basic nursing care and services and the compassion provided to ill and injured patients (Atchison, 2014; Jacob, McKenna, & D'Amore, 2015). Determining why nurses are dissatisfied and disengaged and what intrinsic or extrinsic components influence satisfaction and engagement becomes vital to recruitment and retention efforts and, more importantly, to patient outcomes (Auerbach, et al., 2015; Buerhaus, Skinner, Auerbach, & Staiger, 2017). Improving nurse satisfaction also impacts organizational bottom lines as millions of dollars are spent to competitively recruit, orient, employ, and retain current nurses (Blegan, Goode, Spetz, Vaughn, & Park, 2011; Boev, 2012; Choi, Cheung, & Pang, 2013).

## The Nursing Shortage

By 2012 the average age of an RN was projected to be 45 years with nurses in their 50s being the largest segment of the workforce, almost one-quarter of the RN population (American Association of Critical Care Nurses, 2010). The U.S. Bureau of Labor Statistics (2011, 2012, 2013) reported that job growth in healthcare was outpacing prior predictions. In 2007, the American Hospital Association published *The State of American Hospitals—Taking the Pulse* and outlined difficulties in recruiting new staff and how hospitals were attempting to increase staff and maintain a standard of quality in patient care.

The Institute of Medicine's (2007, 2008, 2010) *The Future of Nursing: Focus on Education*, *Preventing Medication Errors,* and *Crossing the Quality Chasm* outlined the critical state of patient safety as related to the nursing shortage. The reports detailed a healthcare system stressed at a variety of breaking points. Stress points included the nursing shortage, quality of care concerns, and patient safety, all of which contribute to an increase in patient mortality and morbidity (Agency for Healthcare Research and Quality, 2012; National Institute of Health, 2013; Smith, 2018).

These reports, especially the evidence related to mortality, morbidity, and medical errors, became the driving force for healthcare change, especially for fee for service reimbursement directed by the Centers for Medicare and Medicaid (2011). This impetus prompted an escalation in measures and mandates to improve patient safety, integrate quality with service, and provide adequate resources to assure safe patient care (Raven, Doran, Kostrowski, Gillespie, & Elbel, 2011). As hospitals worked to meet the mandates, quality and safety issues remained a looming threat related to the high demand for and low supply of qualified RNs to care for patients.

## Supply, Demand, and Safety

The aging of Baby Boomers and the healthcare system overhaul has impacted current and future healthcare demand, cost, and quantity of adequate resources (American Association of Retired Persons, 2010; Taylor, Pilkington, Feist, DalGrande, & Hugo, 2014). Every month more than one-quarter of a million individuals turn 65 (American Association of Retired Persons, 2014; Bloom, Boersch-Supan, McGee, & Seike, 2011). These individuals are living longer, requiring more healthcare resources, and are placing

a strain on the healthcare industry (Atchison, 2014). As demand for healthcare resources increases, the ongoing nursing shortage presents challenges to providing safe care.

The demand for nurses increases as Baby Boomers reach retirement age and aging nurses retire. Cimotti, Aiken, Sloane, and Wu (2011) identified high patient-to-nurse ratios and nurse burnout with associated risks of patient infection, illness, and stress. Safe staffing ratios (lower nurse-to-patient ratios) yielded fewer deaths, lower failure to rescue incidents, lower rates of infection, and shorter hospital stays. Unfortunately, as demand has increased, the supply of skilled healthcare providers has not kept up with the demand. A key factor for consideration in light of the ongoing nurse shortage is the aging nursing workforce and the subsequent impact on patient quality and safety.

## The Aging Nursing Workforce

As the aging nursing workforce retires, leading to staffing that is insufficient to meet projected demands, a multitude of quality issues become apparent. The retiring nurses possess strong clinical skills, a wealth of knowledge, and their exodus from healthcare leaves a gap in quality and continuity (Sherman et al., 2016; Uthaman, Chua, & Ang, 2016). As the aging nurses retire, the loss of proven knowledge and expertise earned through clinical experience, which is also a valuable source to mentor and train new nurses, presents challenges to healthcare leaders. These retirements can potentially lead to short staffing, increased overtime, and increased expenses for recruitment, training, and quality assurance (McGlynn, Griffin, Donahue, & Fitzpatrick, 2012). The aging nurse also is challenged with an overload of demanding work assignments,

potentially impacting their personal health from increased mental and physical stressors (Negussie & Demissie, 2013).

Equally concerning is the increase in dissatisfaction among younger nurses resulting in mounting frustrations that can lead to safety and quality concerns (Glerean, Hupli, Talman, & Haavisto, 2017; Negussie & Demissie, 2013). Nurses face heavy workloads, shift work, violence, increased patient acuity, and the physiological implications of aging (Parsons, Gaudine, & Swab, 2015). As the aging nurse workforce prepares for retirement, many questions remain unanswered. These questions include who will lead, what changes will occur in care provided, and will outcomes change with novice, ill prepared nurses caring for the ill and injured patients in today's healthcare system (Keys, 2014). The impact of the newer, inexperienced nurses presents implications influencing financial outcomes, patient outcomes, and the safety of the work environment. This may threaten the ultimate goal of healthcare, which is to provide quality, safe, cost effective, and efficient delivery of services.

## Healthcare Cost and Quality Issues

The Agency for Healthcare and Quality's *National Healthcare Quality Report* (2012) outlined basic standards for patient care and expectations from healthcare providers for the services provided by the healthcare system. These standards include safe, timely, patient centered, efficient, and equitable services. The Institute of Medicine 2011 report outlined problems with medication errors resulting in approximately 100,000 deaths per year and a quality chasm of preventable errors, patient dissatisfaction, surgical mistakes, and other quality issues impacting patient outcomes. These quality issues lead

to an overhaul of the financial reimbursement standards and expectations by the Centers for Medicare and Medicaid (2014) and the development of quality standards, expected results, and benchmarks for every hospital receiving federal reimbursement for care.

The Centers for Medicare and Medicaid bases reimbursement on patient satisfaction scores and scores based on quality, results, and preventable mistakes using a standardized reporting system that in turn determines compensation (Mazurenko, Collum, Ferdinand, & Menachemi, 2017; Orique, Patty, Sandidge, Camarena, & Newsom, 2017). Both customer satisfaction and quality become significant factors for hospitals seeking to remain fiscally solvent (Blumenthal & Jena, 2013; McCaughey, Stalley, & Williams, 2013). Because staff satisfaction has been shown to impact customer satisfaction, maintaining or exceeding quality benchmarks coupled with high levels of customer satisfaction becomes crucial for reimbursement, organizational financial security, and a favorable market share (Aroh, Colella, Douglas, & Eddings, 2015; Sherman et al., 2016).

The evolving workforce also presents challenges to obtaining high standards of care and outcomes. Healthcare workers include a multigenerational mix of care providers. Multigenerational workers challenge leaders to meet individual generational needs and expectations as both a patient and a worker. How leaders utilize the strengths of the multiple generations, adapt to generational differences, needs, and expectations, and develop programs to mentor, retain, and recruit nurses is a dilemma faced throughout the healthcare industry. The question facing the healthcare industry is whether the multigenerational workforce meet the anticipated needs of the 21st-century healthcare system and, if not, what options lie ahead for healthcare patients and staff.

## Multigenerational Workforce

One important challenge to healthcare leaders is the desirability of younger individuals to choose healthcare as their primary occupation (Flinkman & Sarenterä, 2015; Lancaster & Stillman, 2002). Individuals entering today's job market have multiple opportunities for employment in a variety of professions, are less committed long term to a single job, and have less allegiance to a single organization or career versus their Baby Boomer counterparts. Each generation offers different demands, expectations, requirements, and ethical needs, which influence teamwork, expectations, morale, and communication (Joint Commission for the Accreditation of Healthcare Organizations, 2012; Lyons & Juron, 2014; Sparks, 2012). Research studies have shown no significant differences in work related outcomes among the generational cohorts, but they have illustrated that older individuals are more satisfied and committed to the organization (Costanza, Badger, Fraser, & Severt, 2012; Lyons, Ulick, Juron, & Schweitzer, 2015).

The retention of nurses was examined by Clendon and Walker (2012) who identified strategic themes for nurse satisfaction and engagement. These themes included rewards, alternative opportunities, and generational needs, wants, and demands as key factors influencing why an individual remains in a profession. Key subthemes included the work environment, a work environment more prone to bullying in healthcare environments, and stress from the type of work performed. These subthemes described issues relating to having to work off shifts, a lack of voice or input into decision making, and mobility to move upward and progress within the healthcare profession (Campbell, Campbell, Seidor, & Twenge, 2015; Coletti, Davis, Guessferd, Hayes, & Skeith, 2012).

Four generational groups characterize the 21st-century workforce. These groups include the Traditionalist, Baby Boomer, Generation X, and Millennial worker (Kriegel, 2016). Each group has specific influences, core values, attributes, education, work ethics, work life balance needs, ideals, and work assets.

## Generational Groups

**Traditionalist.** The Traditionalist is a person born between 1900 and 1945. Traditionalists are also known the Veteran, Moral Authority, or Forgotten Generation born before, during, or relatively soon after the Great Depression, with the trademarks of loyalty, patriotism, respect for authority, and a robust trust in government (Pew Research Center, 2017; Twenge, Campbell, & Freeman, 2012). This generation is known as thrifty, hardworking, rule abiding, and honored to work a lifetime for one organization. These individuals work linearly, are task oriented, and possess a strong work ethic with little questioning of job performance. Traditionalists expect recognition and depend upon clearly defined rules and discrete, logical feedback and communication (Lyons & Juron, 2014)

**Baby Boomer.** The Baby Boomer generation was born between 1946 and 1968 and are known as the "me" generation, seeking a standard of living better than their parents (Pew Research Center, 2017; Twenge et al., 2012). Baby Boomers pursue the American dream and believe anything is possible and are willing to spend now and pay later. Baby Boomers challenge authority, compete in the work environment, and find worth in their work performance (Vermont Nurses in Partnership, 2012). The Vermont Nurses in Partnership (2012) described the individuals of this generation as focusing on

work while sacrificing family to get ahead, resulting in an inadequate work life balance (Lyons & Juron, 2014, 2010; Schullery, 2013). The career defines the Baby Boomer with expectations of direct communication and financial compensation for performance.

**Generation X**. Born between 1965 and 1981 are frequently named Gen Xer's, post-Boomers, or the 13th Generation, Generation X is the generation of working mothers, latchkey kids, and single-family homes. Generation Xer individuals learned self-care resulting in independent thinking and task completion (Lyons & Juron, 2014). Gen Xers are self-starters with a high sense of fulfillment and want diversity, fun, independence, and technology. The Generation X individual craves responsibility while seeking tasks as long as the task ends before 5 p.m. and fits into their weekend plans (Hills, Ryan, Warren-Forward, & Smith, 2013). Gen Xers value time and are frugal because the individuals are not as fiscally stable as their parents. The Generation X individuals build portable resumes with a *WIIFM* (what's in it for me?) mentality toward work.

**Millennial.** Born between 1982 and 2004 the Millennial is viewed as the digital generation. They are scheduled, organized and service consumers, and have a strong commitment to civic duty and diversity (Lyons & Juron, 2014; Pew Research Center, 2017). Millennial individuals are competitive, self-confident, highly educated, and gadget and parent attached. Millennials may live at home, love spending money, and possess technology savviness. Millennials are optimistic, loyal, and sociable in the workplace (Hendricks & Cope, 2013; Twenge et al., 2012). The Millennial individual works seeking

to fill the gap between work and the next fun activity and requires flexibility and immediate feedback (Twenge et al., 2012)

The challenges to recruit, retain, satisfy, and engage nurses to provide quality, efficient care become evident as the demands in healthcare increased in the 21st-century (Metetoja, Numminen, Isoaho, & Leino-Kilpi, 2015). Identifying and embracing the information nurses articulate as factors influencing satisfaction and engagement provides leaders with valuable information to plan, implement, and develop programs to counter the nursing shortage.

## Problem Statement

A 2012 U.S. Bureau of Labor Statistics report projected a 26% increased demand for RNs to provide care to the aging and retiring Baby Boomers (approximately 10,000 individuals per day) in the 21st-century healthcare arena (Bureau of Labor and Statistics, 2012). Beyond an increased number of retiring, aging Baby Boomers is an aging nursing workforce, a fee-for-service reimbursement system, and unlimited opportunities outside of healthcare for younger individuals (Agency for Healthcare and Quality, 2007; Lancaster & Stillman, 2002; Negussie & Demissie, 2013; Sherman et al., 2016). The demand for nurses far exceeds the supply. As healthcare leaders attempt to fill vacancies, recruit and retain current staff and remain fiscally solvent, efforts to maintain and improve present-day staff satisfaction and engagement become paramount (Cleary & Rice, 2005; Conway & Briner, 2014; Institute for Healthcare Improvement, 2011).

Armed with the knowledge that a mere 30% of staff surveyed by Press Ganey (2010) expressed satisfaction in their healthcare job, leaders require a concentrated,

broader, and focused understanding of the factors, influencers, and distractors of satisfaction and engagement in the workplace. Employee satisfaction has a direct impact on customer satisfaction. The general business problem is the lack of qualified, capable, and trained staff to care for patients in an environment of retiring Baby Boomer nurses, reimbursement focused on patient satisfaction, an increased number of healthcare users, and decreased numbers of younger persons entering the nursing profession. The specific business problem is the lack of satisfied and engaged front-line nursing staff to maintain customer satisfaction, remain in the nursing profession, and provide safe, effective, and efficient care in the prolonged nursing shortage. The specific business problem focuses on the factors influencing satisfaction and engagement needed to retain, recruit, and emotionally, psychologically, and physically support qualified multigenerational ED RNs.

## Purpose of the Study

The purpose of this qualitative multiple case study was to explore, describe, and interpret factors influencing ED RN satisfaction and engagement. The focus was to explore how the ED RNs interpret, believe, or perceive their work environments and components influencing satisfaction and engagement. Factors include direct, indirect, subjective, and objective elements. These elements include resource allocation, availability, and utilization, relationships between peers and with leaders, and how leaders interact and work with staff. System elements focus on the assignment of work, fairness, communication, and supervisor-subordinate relationships. The elements of engagement include specific factors influencing the cognitive, physical, and emotional

connection of workers to coworkers, the work (where work is performed), the job (the tasks involved in the work performed), and the organization (physical location, mission, vision, and values of the workplace). Understanding the social implications of satisfaction and engagement and determining if generational differences or hospital size provides commonalities, similarities, or differences in RN perceptions, beliefs, and ideas related to satisfaction and engagement underlies the study purpose.

## Research Questions

Work satisfaction and engagement are complex, compound ideas, and individualized for every nurse. The research questions focus on satisfaction and engagement components. Merriam (2014) discussed the importance of developing broad overarching research questions that begin with *how* or *what* in order to convey an open and emerging design instead of asking *why* questions, which suggest a cause-and-effect. Research questions should focus on a single phenomenon and use exploratory verbs aiding in discovering, seeking understanding, exploring a process, describing experiences, or reporting stories (Merriam, 2014). The study research questions include:

Overarching RQ: How do ED RNs describe satisfaction, satisfiers, engagement, and disengagement in the professional work environment?

RQ1: What are the satisfiers and dissatisfiers identified by ED RNs as contributors to personal and professional satisfaction?

RQ2: What factors contribute to ED RN engagement at the personal, department, and organizational levels?

RQ3: How do hard and soft work elements such as direct management, teamwork, leaders, and resources influence nurse satisfaction and engagement?

RQ4: What emotional and psychological connections do nurses describe as making them feel engaged in individual, team, job, and organizational work and performance, or as providing a feeling of accomplishment and use of personal skills?

RQ5: What themes, perceptions, impressions, barriers, frustrations, and opportunities to improve satisfaction and engagement emerge related to the influence of direct management, teamwork, systems, leaders, and resources?

## Conceptual Framework

The concepts of satisfaction and engagement are complex, personal, and individualized. Clarifying concepts requires developing a relationship between the literature, gaps in the literature, research questions, and pre-existing theory. The constructs of satisfaction and engagement build the structure for the research study. My individual experiences as an RN, existing literature, reviewed concepts, assumptions, beliefs, and theories build upon the framework. Existing in the current healthcare environment is a dissatisfied, disengaged workforce facing challenges as the number of healthcare users increases, an aging RN workforce retires, demands to improve patient satisfaction increases, and leaders face challenges to retain, recruit, and maintain nursing staffing levels.

This qualitative case study uses components of Herzberg's (1966, 1976) motivation-hygiene or two-factor theory, Vroom's (1964, 1970), Vroom and Yetton's

(1973) expectancy theory, Maslow's (1999) hierarchy of needs theory, Benner's (2001) stages of clinical competence theory, and Kahn's (1990) personal engagement theory as the framework. Each theory contains specific attributes impacting job satisfaction and engagement. The theory components outline work perceptions, subjective and objective components of the tasks, work environment, and the individual's ability to advance and develop within the workplace. The RN, as with other professionals, becomes a nurse for specific reasons with professional objectives ranging from simple to complex. Whether the intention is altruistic, career driven, or dependent upon available resources the individual's work environment, tasks, and types of work performed influence personal satisfaction and engagement. The reasons for becoming a nurse, the expectations from the vocation, and how those expectations have changed during a nurse's career, also play a role in determining the individual's satisfaction and engagement. Understanding what factors contribute to satisfaction and engagement of the workforce becomes essential to sustain the individual's sense of accomplishment, self-realization, and expectations.

The research focuses on the satisfaction elements of resources, leadership, communication, autonomy, opportunities for improvement, teamwork, work relationships, coaching/mentoring and education, stress, compassion fatigue/burnout, violence, sense of accomplishment, and overcrowding (Bell, 2011). The focus for engagement includes trust, the connection with coworkers, utilization of skills, fulfillment, physical, cognitive, and emotional levels of engagement at work, in the job performed, and at the organizational level. An assessment of both hard and soft elements

influencing nurse satisfaction and engagement was completed using the fundamental aspects of the theories of Herzberg, Vroom, Yetton, Maslow, Benner, and Kahn.

Herzberg theorized that real motivation comes from within and not from external sources seen with hygiene factors. The elements of Herzberg's theory provided a foundation for further research to outline essential requirements for leaders to use in the development of programs fostering a motivated and engaged worker and workplace. Vroom and Yetton described employee behavior as a selective process based on expectations. The selective process requires conscious thought and organization by the individual based on a variety of subjective and objective elements. Maslow's hierarchy defined satisfaction and engagement on the acquisition of comfort and success at varying levels with progression toward higher intellectual and emotional growth, development, or retreat to a level of individual comfort. Kahn's (1992) engagement theory defined engagement as the physical, cognizant, emotional, and mental expression into work performance. Benner's stages of clinical competency explored the expectations, needs, and strengths as a nurse gains professional experience. These theories provide hard (objective) and soft (subjective) factors influencing satisfaction and engagement. The theories coupled with the research questions provide the foundation for multiple case study to assess, inquire, and analyze the ED RN in their natural environment and discover the commonalities of beliefs, experiences, and practices influencing satisfaction and engagement garnered through interviews.

## Nature of the Study

The study is a qualitative multiple case study focusing on the ED RN experiences, perceptions, motives, and attitudes of satisfaction and engagement. The study focused on generational differences and hospital size differences, commonalities, and similarities in ED RN satisfaction and engagement. Yin (2014) noted that qualitative research becomes essential when inquiring about individual perceptions of the lived experience. Yin (2014) stressed the importance of organizing, analyzing, and breaking gathered data into meaningful units to understand the research fundamental concepts or phenomena. Yin's (2014) multiple case study methodology provides an opportunity to focus on how the ED RN describes, perceives, and identifies satisfaction and engagement. The case study analysis provided opportunities to explore and illustrate satisfaction and engagement through the interpretation of the nurse thoughts, ideas, and perceptions. The case study approach sought to describe, examine, and explore how and why specific factors sway and control nurse satisfaction and engagement (Yin, 2014).

The use of the multiple case study approach provided abundant, rich information holistically examining the phenomenon of nurse satisfaction and engagement using an interview format. The case study method afforded a fuller understanding of the nature and complexity of satisfaction and engagement (Merriam, 2014). The multiple case study method also provided an opportunity to delve deeper, gain a fuller understanding, and further explain nurse satisfaction and engagement in today's work environment (Creswell, 2013; Yin, 2014). The information obtained using multiple case study aided in describing and explaining the nurses' perceptions of how factors such as resources,

leadership, teamwork, systems, and process and resulting impact on satisfaction and engagement.

This qualitative case study represented an interpretation of the multiple facets of the phenomenon through a variety of lens allowing for a richer understanding and revelation of the concept of satisfaction and engagement. The design began with assumptions and was inductive while being sensitive to meanings voiced and described by participants (Yin, 2014). The focus became one of learning the ED RN sense of satisfaction and engagement by creating a holistic account and identification of complex interactions using interpretative inquiry. Questioning the broad generalizations of information gathered aided in focusing on the context of the nurse workplace needs, expectations, and assumptions regarding satisfaction and employee engagement.

The rationale for selecting qualitative case study was to focus and describe the concepts of satisfaction and engagement in broad philosophical terms (Creswell, 2013; Yin, 2014). The concepts of satisfaction and engagement are abstract and outline personal descriptors of an individual's observations, beliefs, and attitudes toward their environment and role within that environment. Each perception or belief defines the experience of the individual's treatment, connection, relationships, and input into decision making. The case study approach provided opportunities to ask questions specific to the individuals identified level or degree of satisfaction and engagement. The case study approach provided for direct observation and information on the lived experience of the ED RN. The key attributes focused on individuals and how the individual senses their role within the system.

## Population and Sample

The study uses non-probability purposive or purposeful sampling. Purposeful sampling provides opportunities to discover, understand, and gain insight by selecting a sample from which the most can be learned (Merriam, 2014). Interview results provided rich information. The sample crosses age, generational cohorts, RN tenure, and ED RN tenure. The purposeful sampling also provided cases bounded within the ED focusing on RN actively participating in direct patient care.

Participants were selected from three generational cohort groups working as ED RN at three hospitals of differing sizes and capabilities located in upstate New York and Vermont. ED RN selection provided a similarity of work environment, patient encounters, and types of work performed in the ED. Twenty-four ED RN were interviewed using a semi-structured script of questions. Three of the 24 participants participated in the pilot study which included one Baby Boomer, one Generation X, and one Millennial RN. The remaining 21 participants included a cross-section of ED RN from three generational cohorts with varying tenures of nursing and ED experience.

The number of interviews were modified from the planned seven ED RN interviews from each hospital. Modifications occurred secondary to the number of available staff and generational cohort selections at the mid-sized and critical access facilities. ED RN at the critical access hospital included a total of seven nurses with five nurses agreeing to participate in the study. Due to staffing shortages, only six ED RN decided to participate at the mid-sized hospital. Numbers were adjusted, and the number of participants from the tertiary care hospital was increased to acquire data saturation.

The following represents the initial number of interviews and the modified number of interviews completed.

Table 1

*Generational Cohort Participants*

| Initial numbers | Amended numbers |
|---|---|
| Baby Boomer | |
| 2 Critical access hospitals | 3 Critical access hospitals |
| 2 Mid-level hospitals | 2 Mid-level hospitals |
| 3 University hospitals | 3 University hospitals |
| Generation X | |
| 2 Critical access hospitals | 2 Critical access hospitals |
| 2 Mid-level hospitals | 2 Mid-level hospitals |
| 3 University hospitals | 4 University hospitals |
| Millennial | |
| 2 Critical access hospitals | 0 Critical access hospitals |
| 2 Mid-level hospitals | 2 Mid-level hospitals |
| 3 University hospitals | 3 University hospitals |

## Pilot Study

Three ED RN provided valuable information for the pilot study. The pilot study participants included an ED RN from the Baby Boomer, Generation X, and Millennial cohort. The pilot study provided an opportunity to adjust, modify, or add specific

elements to clarify interview questions, probe more deeply, or refine the semi-structured script of questions. The pilot study offered an opportunity to remove question ambiguity, clarify terms, and refine interview questions. The initial script of questions was modified based on the communication from the pilot study RNs. The pilot interviews included three phases: initial interview lasting 45 minutes, telephone follow-up call for clarification, and secondary meeting to validate finalized interview questions.

## Sources of Data and Data Analysis

After the pilot study, the remaining 21 participants were interviewed using a revised semi-structured script of questions. The semi-structured script provided an opportunity to explore specific responses, seek clarification, and evaluate RN responses. All interview data was member checked by providing each participant with a transcript of the interview. Data elements were coded using a constant comparative data analysis method. The constant comparative data analysis allowed for accurate comparison of units or incidents of data in an ongoing comparison of data bits. The constant comparative method assisted in coding newly collected data through comparison with previously collected information. Data analysis was analyzed using a seven-step process.

Data elements were organized and refined or interconnected leading to the development of the story presented from the interview data and personal memos. The final product produced a set of theoretical propositions. Interview data were hand-coded guiding the development of themes and patterns. Hand-coded data were entered into NVivo® software prompting further assessment and development of patterns, themes, and coding nodes. The overall goal was to identify common themes, central and

subcategories, and commonality of the participant responses while exploring and describing the phenomenon of satisfaction and engagement among ED RN (Creswell, 2013). All data components were treated and maintained in a secure, confidential location.

## Investigator Documentation Sources

Document sources included IRB approved consents, information documents, data collection tools, rosters, and advertisement materials. Letters of agreement were obtained from each participating facility ensuring confidentiality, privacy, and ethical behavior while conducting the research. IRB approval was obtained prior to the conduction of research. All data components were recorded, transcribed, hand delivered (transcripts), and maintained data in a safe, secure, confidential manner.

Approval to conduct research was obtained from each hospital and from the IRB at Walden University. Hospital U and Hospital C required IRB approval. Hospital E had no formal IRB process and approval was obtained from hospital administrators. The IRB approval numbers include Hospital U CHRBSS 18-0148, Hospital C 09-12-2019, and Walden University 70-31-0228833.

## Definitions

*Autonomy:* Independence of actions.

*Burnout:* Psychological stress leading to exhaustion, job stress, and decreased productivity.

*Compassion fatigue:* Tension or preoccupation with caring for ill or injured persons.

*Compassion saturation:* The sense of becoming overwhelmed with providing care for those in need.

*Direct management:* Direct management includes interactions between employee and supervisor including feedback, coaching and mentoring, communication upward, downward, and horizontally, trust, and rewards/recognition (Harter, Schmidt, Killham, & Agrawal, 2009).

*Emotional intelligence:* The ability to recognize one's own/others emotions.

*Empowerment:* To provide or give power.

*Intent to remain:* The plan to remain or stay in the current position and occupation.

*Job engagement:* Job engagement includes work fulfillment, skill use, and the sense of accomplishment in the job performed (Harter et al., 2009).

*Job attachment:* The individual's sense of belonging, enjoyment, or connection to one's job.

*Leadership development:* The progression of teaching, education, and mentoring to an individual in the sole attempt of developing the individual's leadership style, communication, and other factors required to be a leader.

*Organizational engagement:* Organizational engagement describes a willingness to remain with an organization as well as a sense of alignment with the organization's mission, vision, and values (Harter et al., 2009).

*Organizational citizenship:* Voluntary commitment to the individual's organizational commitment, mission, vision, and values.

*Outcomes:* Results or consequences.

*Participatory leadership:* Leadership style involving participation from staff including input into decision-making, communication, teamwork, inclusion, and autonomy.

*Productivity:* The effect of production.

*Psychological climate:* The perception of the work environment and how the psychological, social, and physical components interact and provide a sense of satisfaction, commitment, or stability.

*RN:* A nurse who graduated from an accredited nursing school and licensed by a state authority (New York State Office of Professions, 2014). For this study, the licensed nurses work in New York and Vermont.

*Resources:* Resources include the physical environment, goods, materials, staff, and elements required to complete tasks and jobs (Harter et al., 2009).

*Satisfaction*: Satisfaction is personal gratification, contentment, and fulfillment in various elements of an individual's life. These elements include work, home, school, and other aspects of the act of living one's life (McGlynn et al., 2012; Wang, Tao, Ellenbecker, & Liu, 2012).

*Supervisor-subordinate relationship:* The interactions between the supervisor and the employee on a variety of levels including personal, professional, verbal, and non-verbal.

*Systems and leadership:* Systems and leadership encompass the hard elements of job security, policy and procedures, decision-making input and interaction, communication, and wages (Harter et al., 2009).

*Teamwork:* Teamwork combines the elements of respect, coordination, and collaboration between individuals, management, supervisors, and coworkers (Harter et al., 2009).

*Turnover:* The loss of workers from the workplace environment.

*Work engagement:* Work engagement combines shared attentiveness to quality and customer needs and expectations as well as the sense of connection between the individual, organizational mission, vision, and values, and attentiveness to work details (Harter et al., 2009).

*Workplace culture*: The behavior within the work environment.

## Assumptions

Five assumptions were made related to this study. The first assumption was that nurses from different generations experience different issues and problems that influence personal satisfaction, engagement, and retention, whereas the differences, similarities, and causes may be universal. The second assumption was that an ED nurse's sense of satisfaction, engagement, and retention is different from other nurses. Nursing is not a one-size-fits-all profession.

The third assumption was that nurses do not care about the factors that influence hospital reimbursement. The assumption is that nurses understand the Centers for Medicare and Medicaid standards and need to increase customer satisfaction but are not

engaged or able to provide more than basic care due to a lack of staff or other factors influencing patient care. The higher priority becomes providing care with little regard to the larger vision impacting organizational reimbursement.

The fourth assumption was that personal and job satisfaction is fluid and ebbs and flows with the individual's overall state of happiness, varies with the individual's state of mind and current happiness, and is in a constant state of ebb and flow based on individual situations and reactions to the environment. This study does not address RN happiness. Nurses come to work planning on being happy, satisfied, and engaged. Unfortunately, this may or may not be true. Circumstances impact how the employee will react or engage in work performed. A person's individuality may overshadow the grand plan to keep the employee satisfied, engaged, or willing to remain at a job.

The fifth assumption was that rural nurses have unique needs, perceptions, and perspectives from urban nurses. Nurses working in urban areas frequently have more options for work, specialization, and recreation. If unhappy, dissatisfied, or disengaged, the urban nurse has the option of moving to another hospital or outpatient setting with more choices available to meet the individual's needs. The distance from larger hospitals, family commitments, and financial constraints influence rural nurses' decision to leave their current job. The nurse attitudes, perceptions, and behaviors of the rural nurse require insight and consideration.

## Scope and Delimitations

This scope of this study was two-fold and assessed factors influencing ED RN satisfaction and engagement. First, the study considered commonalities and differences of

factors guiding satisfaction and engagement. Secondly, the study defined the commonalities and hard and soft elements affecting satisfaction, engagement, and retention of nurses. Determining what satisfies and engages an individual provided valuable information to improve conditions in a severe nursing shortage (Mays, Hrabe, & Stevens, 2011). Interviews provided information related to the influence of resources, direct management, teamwork, and systems/leadership, and job, work, and personal engagement of ED RNs. These aspects included a wide-spectrum of hard and soft elements that are catalysts to improve employee satisfaction and engagement. Employees will develop positive or negative satisfiers and engagers based upon adequacy of resources, relationships with coworkers and managers, teamwork, and the sense of job security. Likewise, when a nurse feels engaged they feel fulfilled, attentive, and connected to the organizational mission, vision, and values through a collaborative effort with leaders, coworkers, and managers (Wang et al., 2012).

The study included a subset of hospital nursing and focused on the ED RN. The scope and population outlined in this study involved RNs and excluded technicians, Emergency Medical personnel, managers, and physicians. Herzberg's hygiene-motivation, Vroom and Yetton's expectancy, Maslow's hierarchy of needs, Benner's stages of clinical competence, and Kahn's engagement theories provided the framework describing specific characteristics regarding satisfaction and engagement. These theories frame the research to explore subjective and objective (hard and soft elements) directly or indirectly influencing satisfaction and engagement. The study is easily transferable to other hospital departments as well as other hospital personnel.

## Limitations

The study was limited to three hospitals in upstate New York and Vermont. Many of the nurses working at the three hospitals were born and raised in the region, attended nursing school at a local college, and have strong family ties to the area. With this knowledge, limited insight or perspective is probable. The concerns, perceptions, and aspects causing dissatisfaction, engagement, and leaving the job may be ingrained in the culture and not reflective of satisfaction and engagement occurring in other geographic regions. The study was limited to ED nurses. The culture of the ED may not be reflective of similar problems or issues experienced by nurses in other departments.

Personal biases could potentially influence this study. As an ED nurse, a recognized personal bias potentially exists. For example, ED nurses possess a variety of skill sets and perceptions such as multitasking, interacting with diverse patients over a brief time, and work with the ebbs and flows within the department. Staying impartial, remaining the objective researcher, and listening was imperative. Data analysis required objectivity to ensure that any personal bias did not influence data quality, interpretation, or dependability. As a Baby Boomer, other issues and concerns exist requiring clarification and validation through member checks to decrease potential personal bias. Diligence was demanded to maintain an open mind and objectivity during interviews, data coding, analysis, and interpretation.

## Significance of the Study

A shortage of nurses impacts patient care, safety, and outcomes (American Association of Critical Care Nurses, 2012). Nursing has experienced a prolonged nursing

shortage with no projected end in sight. Nursing, a complicated profession, requires physical, emotional, psychological, and social characteristics essential to define and become the nurse the individual strives to become. Understanding the complex components of the nurse experience and their perceptions of the work environment provides valuable insight into why nurses are satisfied, engaged, and remain in the profession of nursing or job. The perception and knowledge furnish information on how the nurse views the work environment, availability of resources, team functions, direct management, system issues, and processes as well as the personal sense of engagement (Negussie & Demissie, 2013).

**Significance to Practice**

Nursing is not a one size fits all profession. Nurses in each specialty area have unique needs, demands, and expectations (Őzden, Karagöğlu, & Yildirim, 2013; Popescu & Rusko, 2012). For example, nurses in the ED may experience contact with a mother delivering her baby, a newborn with croup, and a 95- year old in congestive heart failure during their eight-hour shift. The sheer volume of patients can range from what is considered a slow shift to one in which patient care providers are challenged to provide even basic care *in a get them in and get them out* treatment mentality. Nurses working in the surgical department might see patients for a brief period requiring preparation for surgery, answering questions, and preparing the patient for the procedure. The interaction may be one where the nurses deal with fear, anticipation, and support for patients, families, and others in a controlled environment.

Conversely, the nurse working on the floor may have a patient assignment of 14 patients in varying degrees of wellness or sickness. The nurse becomes the sole provider of services and interfaces with other departments working to get the patient home or into the correct placement facility as quickly as possible. This nurse works to prepare the patient for disposition and uses their skills to guide the patient's experience while educating, supporting, and encouraging a successful discharge. Patient care, quality of care, and safety remain the common thread throughout these scenarios of treatment. Understanding why nurses feel satisfied versus dissatisfied, engaged versus disengaged and want to stay or leave their job will provide valuable information to assist with increasing satisfaction and engagement.

**Significance to Theory**

A sizable amount of quantitative literature exists that provides an overview of the broad umbrella categories of nurse satisfaction and engagement as well as the nursing shortage. There is limited qualitative literature assessing the components of satisfaction and engagement with even less available at the staff level especially being unit or department specific, for example, the ED. Knowledge of the factors affecting individual and professional satisfaction and engagement allows insight of how and why nurses remain on the job.

This broader understanding necessitates listening to what nurses articulate as essential needs to meet healthcare challenges in the 21st-century. Even with hospitals offering sign-on bonuses, nursing salary increases, and establishing safe staffing ratios, the nursing shortage continues as does the dissatisfaction and disengagement within the

nursing profession (Buerhaus et al., 2017). The need to develop and support an environment of satisfaction, engagement and subsequent retention requires input from current working nurses to gain a fuller understanding of the factors impacting their satisfaction and engagement. The qualitative multiple case study approach investigated the contemporary phenomenon of ED RN satisfaction and engagement within its real-life context and provided valuable insight into the perceptions, thoughts, and ideas of specific needs to improve satisfaction, engagement, and retention.

This study contributed to the understanding of nurse satisfaction and engagement. Why nurses are satisfied, engaged, or stay in a job varies. Acknowledging generational differences and commonalities enriches the study of nursing while focusing on shortages and providing insight specific to the ED nurse satisfaction, engagement, and retention. Advancing current knowledge regarding causes of dissatisfaction, disengagement, and the reasons nurses leave the profession provides valuable information to develop successful retention and recruitment programs. The study offered facts transferable to leaders to improve current working conditions and imparts relevant knowledge to build internal mentoring, coaching, and preceptor programs (Schullery, 2013). These differences can determine how to recognize and reward individuals as well as keep individuals engaged and attentive to work. The study promoted positive social change. The change extended beyond nurse satisfaction, engagement, and retention and expands into the overall healthcare system.

## Significance to Social Change

The shortage of healthcare providers is expected to increase in the 21st-century especially for nurses and physicians (Salka, 2014). In 2014, the American Association of Retired Persons predicted that every month more than one-quarter of a million individuals turned 65 and estimated that by 2020, 12 million individuals will require long-term care assistance. These statistics illustrate the dire need to retain and recruit nurses to care for the expected increase in healthcare patient demands. A qualitative assessment provides a deeper and fuller understanding of how and why ED nurses perceive, describe, and envision the complex phenomena of satisfaction and engagement (Yin, 2014). Understanding these phenomena provides information relevant and pertinent for leaders to develop programs to improve staff satisfaction and engagement.

Improved staff satisfaction is directly related to patient satisfaction and subsequent Federal value-based reimbursement. Providing safe, efficient, and equitable care in the 21st-century requires an understanding of factors influencing nurse satisfaction and engagement. No matter how large or small the healthcare system, nursing plays a significant role in providing patient care and without an adequate nursing presence the potential for grave outcomes, lesser quality, and increased dissatisfaction from workers and customers increases (Blegan et al., 2011).

## Summary and Transition

This research provided an opportunity to examine the perceptions, beliefs, and knowledge of satisfaction and engagement of ED RNs. The nursing shortage impacts current and future healthcare needs. The impact the nursing shortage continues to present

challenges to healthcare leaders. Challenges also include the influence of value-based purchasing influence on reimbursement and patient satisfaction, the aging nursing workforce, and generational impacts on the work environment. The ED RN view of their current work environment provides valuable information for leaders to use in planning, changing, and developing methods to improve satisfaction, engagement, and retention of nurses. The multiple case study methodology using individual interviews provided essential information from a select group of nurses on factors influencing job satisfaction and engagement.

The development and exploration of the nursing shortage, generational differences, value-based purchasing, the aging nursing workforce, and increased demand for healthcare services follow in Chapter 2. The literature review focuses on the broad topics of satisfaction and engagement with the focus narrowing to the hospital, RN, and ED RN satisfaction and engagement. Chapter 3 provides information describing the case study methodology including study methods, framework, components, research questions, data collection, data abstraction, reliability, validity, and analysis.

As a researcher, the questions became: why are satisfaction and engagement significant to the employee and employer? What factors influence these two complex phenomena? To better understand satisfaction and engagement a literature review provided essential descriptors of components required to effectively analyze elements shaping how individuals view the work environment, coworkers, and hard and soft elements affect the daily work performed and subsequent employee satisfaction and engagement.

# Chapter 2: Literature Review

Nursing and healthcare leaders face challenges to maintain and expand the current nursing workforce to meet 21st-century demands. How these leaders motivate, develop, implement, and change the current healthcare system will directly impact patient care, patient outcomes, and both staff and patient satisfaction and engagement. Understanding what satisfies and engages individuals becomes paramount as leaders' plan, implement, and design programs to retain and recruit nurses, and strive to meet standards and initiatives to improve patient outcomes and decrease patient mortality and morbidity.

The foundation of this study comprised theories relevant to satisfaction and engagement. The literature assessment established a foundation that married the theoretical frameworks of Herzberg, Vroom, Yetton, Maslow, Benner, and Kahn with research questions focused on systems and leadership, resources, teamwork, direct management, and engagement at the work, team, and organizational levels. The literature review outlines challenges to differentiate and separate satisfaction and happiness, which are used interchangeably throughout the reviewed literature. In this research I do not separate satisfaction and happiness as distinct aspects of a nurses' beliefs, feelings, and reactions to the work they perform and instead focus solely on satisfaction and engagement.

This chapter continues with an explanation and description of factors influencing satisfaction and engagement. The theoretical and conceptual framework outlines, compares, contrasts, and synthesizes the theories of Herzberg, Vroom, Yetton, Maslow, Kahn, and Benner with current literature focused on employee engagement and

satisfaction. I further analyze the concepts of engagement and satisfaction and define the subsets. The subsets related to engagement include productivity, depression, supervisor-subordinate relationships, teamwork, outcomes, and autonomy. Satisfaction subsets include workplace culture, the development of leaders, employee attitudes, employee feelings, burnout, compassion fatigue, communication, and staffing. The final portion of this chapter contains an assessment and comparison of qualitative and quantitative methods and delineates my choice of research methods as multiple case study.

## Literature Review Strategy and Iterative Process

Both satisfaction and engagement are complex aspects of human behavior. Are we satisfied because of a psychological element influencing us or are learned behaviors factors in how engaged or satisfied we become in the work we do? When developing the research criteria for my literature review, a comprehensive review of the theoretical foundation of the chosen theorists was needed to tie the underlying theory to the research questions and to determine which elements would provide a thorough understanding of satisfaction and engagement. The initial assessment required a review of the broad aspects of employee satisfaction and engagement and a narrowing of the search to hospital employees and subsequently to the ED RN.

For the broader topic of employee satisfaction and engagement, the search included the following keywords: *employee, employee satisfaction, engagement, employee engagement, organizational citizenship, turnover, intent to remain, leadership, job morale, financial gain, outcomes, job commitment, trust, attitude, job attachment, leader-member relationship, communication, job resources, customer satisfaction,*

*emotional intelligence, generational differences in jobs, tangible versus intangible factors for job satisfaction, health issues of dissatisfied employees, dissatisfied employees, pay, justice, empowerment,* and *predictors of job satisfaction*. The broader topics of satisfaction and engagement included a review of approximately 100 peer-reviewed journal articles published within the last 5 years.

The search topic was narrowed to include healthcare workers with approximately 75 peer-reviewed journal articles reviewed and analyzed with keyword identification including: *satisfaction, engagement, turnover, leadership, outcomes, trust, attitude, organizational citizenship, work life quality, justice, empowerment, supervisor-subordinate relationships, organizational trust, psychosomatic elements of dissatisfied employees, fairness, pay, productivity, outcomes, communication, participative leadership, performance, psychological capital, emotional intelligence, organizational climate, human resources, attitudes, poor performance, ethical climate, customer perceptions, compassion fatigue, compassion satisfaction,* and *antisocial behavior (bullying).*

The final search included a narrowed focus to the ED RN with a review and analysis of approximately 100 peer-reviewed research studies. Keywords focused on common and relevant elements incorporating elements of specific to ED RN satisfaction including: *satisfaction, engagement, empowerment, leadership, communication, input into decision-making, violence in ER, resources, mentoring, teamwork, patient outcomes, physician relationships, generational differences, acuity, skill levels, compassion fatigue, compassion satisfaction, burnout, involvement in unit activity, organizational*

*commitment, organizational citizenship, workload, satisfaction as an antecedent or consequence of psychological burnout, stress, psychosomatic illness, fatigue, stressors, worklife balance, administrative commitment, managerial support, training, emotional intelligence, overcrowding, patient satisfaction/outcomes,* and *leadership style.*

For keyword and data searches I used the, Walden University library, the Hospital U medical library, the University of Phoenix library, Google Search, and cited articles/studies from the journal subject databases used. The subject databases included Business Source Complete, Emerald Management, ABI/INFORM Complete, SAGE stats, ProQuest, Academic Search Complete, ProQuest Nursing and Allied Health Source, SAGE Premier, Medline, Expanded Academic ASAP, and PsycARTICLES, and multi-database search opportunities such as Thoreau and Google Scholar.

The articles/studies selected used qualitative, quantitative, mixed methods, meta-analysis, and a summary analysis research methodology and were peer reviewed. In the literature review I provide a summary analysis, interpretation of results, comparison and contrast, and research analysis. The literature review provides opportunities to understand, apply, analyze, evaluate, and create ideas, frameworks, and interpretations from the current literature related to satisfaction and engagement.

The literature review also aids to establish a connection between the underlying theoretical and conceptual frameworks of this study. The tie allows validation to the relevance of the research questions by drawing new insight from the literature and self-reflection on the focus of the qualitative case study investigation. A persuasive and

comprehensive literature review provided the foundation to conceptualize the complex elements of satisfaction and engagement.

## Conceptual Foundation

The concepts of satisfaction and engagement are complex. Personal experience as an RN provides a portion of the conceptual framework for this study. A substantial amount of research is available related to satisfaction and engagement. Narrowing the focus to concepts related to hospital care providers, nurses, and ED RN aided in establishing concepts that influence satisfaction and engagement specific to the professional nurse. From these ideas, a connection was formed to build upon the research questions and established theories to gain a fuller understanding of the factors influencing an individual's satisfaction and engagement. The theories of Herzberg, Vroom and Yetton, Maslow, Benner, and Kahn form a connection with the conceptual framework to align both hard and soft elements influencing satisfaction and engagement. The objective, tangible elements coupled with the intangible, more subjective variables assist in defining key elements that drive an individual's satisfaction or engagement in the job.

### Herzberg's Theoretical Framework

Herzberg's hygiene-motivation theory outlined both qualitative and quantitative elements. Hygiene or maintenance elements include objective, tangible variables including salary, interpersonal growth and relationships, status, supervision, policy/procedures, working conditions, personal life, and job security (Herzberg, 1976). These elements include easily defined and measured individual perceptions. By

themselves, these elements do not motivate individuals to perform better or be satisfied in individual work performance.

Conversely, motivators influence job satisfaction and are more subjective for the individual (Herzberg, 1966). The elements of motivation include achievement, individual recognition, the work itself, advancement, and personal growth. These subjective elements require more direct input and the establishment of a relationship between the employee and direct supervisor. A sense of social responsibility assists the employee to grow and develop at work both professionally and psychologically. The relationship forms an emotional contract between the employee and employer. Herzberg's motivation elements lead to a correlation between employee perception, beliefs, attitudes, or behaviors of events leading to subsequent satisfaction, engagement, and retention from this contract. Herzberg (1966) also theorized that true motivators include the relationship or feel-good interaction between motivators, employees, and leaders. For job enrichment to occur, leaders must provide challenges, communication, and opportunities for growth and development. Herzberg's hygiene-motivation theory lends itself nicely as a foundation for my qualitative case study assessment of ED RN satisfaction motivators.

**Vroom and Yetton's Theoretical Framework**

Vroom and Yetton's (1973) motivation theory described why employees choose to follow expected courses of action within an organization. These courses of action define and relate directly to decision-making and impact within the organization on both leadership and work performed (Vroom, 1964, 1970; Vroom & Yetton, 1973). Vroom (1964, 1970) theorized that behavior results from conscious choices to maximize pleasure

and minimize pain. When employees feel outcomes merit effort (valence), individuals work harder to attain the goal. The depth of the want is either extrinsic (money, promotion, time-off), outlined by Herzberg as hygiene, or intrinsic shown as satisfaction or as motivators by Herzberg.

Vroom and Yetton also postulated that employees have expectations. With unmet expectations comes a lack of motivation to perform at a high level. A relationship is required between the employee and the employer to determine what resources, training, or supervision are needed to improve employee motivation and satisfaction to perform at the highest level possible. This relationship is similar to the rationale for emotional contract outlined by Herzberg. Lastly, the emotional contract in Vroom and Yetton's expectancy theory outlined the need for employees to obtain perceived rewards for work performed.

As with Herzberg, Vroom and Yetton posited the need for the psychological contract to be formed to maximize pleasure and minimize pain. The conscious choices made help to predict the individual's occupational choice, the likelihood of remaining on the job or with the company, and the expected effort to be applied to work done while on the job. Effort leads to performance and subsequent outcome. Effort first leads to the expectancy seen through performance, creativity, tardiness, or reliability at work. The effort to produce or excel precedes secondary expectations or valence seen as praise from the boss, salary incentives, demotion, job security, or acceptance by coworkers (Vroom, 1970). Expectancy outlines subjective probability or beliefs about whether individuals believe they can complete the task. Skills required, support and expectations of

coworkers, availability of resources, required experience, and work environment influence expectancy. A positive correlation exists between effort and performance (Vroom, 1970).

Vroom and Yetton's expectancy theory (1973) outlined both qualitative and quantitative elements. The intrinsic elements illustrate more qualitative components while the extrinsic reward or outcomes describe the hard variables that are easily quantifiable. Extrinsic elements include money, promotion, and time-off with intrinsic elements focusing on respect, acknowledgment, favorable acceptance by management and coworkers, and praise for work performed. These data elements are similar to the hygiene elements outlined by Herzberg.

The expectancy elements define a combination of qualitative and quantitative data elements working together to build the emotional or psychological contract between worker and employer. The availability of resources, training, supervision, and elements such as policy and procedures describe the expectancy or hygiene elements outlined by Herzberg. Instrumentality becomes an essential component of qualitative data assessment related to the perception, beliefs, and expectations of the employee from the employer.

**Maslow's Theoretical Framework**

Maslow provided a multitude of qualitative and quantitative factors. The quantitative factors represent the lower rungs of the pyramid and relate to the pain factors outlined by Vroom and the hygiene elements of Herzberg. The higher the employee progresses of Maslow's hierarchy of needs the more qualitative the elements become. As the individual progresses from physiological and safety needs, the individual exposes

more personal attributes of him or herself. The individual transcends the pyramid seeking to find love and belonging, esteem, self-actualization, and transcendence (Maslow, 1999). The first two levels define quantitative elements, while the qualitative elements expand throughout the remainder of the pyramid. The physiological and safety needs correspond with Vroom and Yetton's valence and expectancy levels and Herzberg's hygiene factors. The higher levels of Maslow's hierarchy associate more with expectancy and instrumentality as outlined by Vroom and Yetton and as Herzberg's motivators. The beliefs, expectations, and experiences relate strongly to the need for pleasure and avoidance of pain.

In Maslow's theory, the individual reverts to a safer level when challenged or stressed to meet a goal or expectation. Vroom, Yetton, and Herzberg described this reversion as an inability or conscious decision to underperform. Without the interaction and relationship with management and the provision of needed resources, education, and tools the individual underperforms and is unable to move upward or forward from quantitative or hard element needs. Maslow's hierarchy of needs outlined basic to advanced thinking, realization, desires, expectations, and requirements for an individual to find satisfaction in whatever they attempt. Maslow acknowledges that individuals move through the stages when the individual meets their needs and develops a sense of comfort. When needs remain unmet, the individual does not progress forward. Without the formation of a relationship to meet the individual employee needs, the individual will not move upward, and a sense of dissatisfaction develops.

**Kahn's Theoretical Framework**

Kahn (1990) developed the concept of personal engagement and described such engagement as "the harnessing of organization members' selves to their role" (p. 694). In engagement "people employ and express themselves physically, cognitively, and emotionally during role performance" (p. 694). Kahn also postulated that personal engagement was an expression of a "preferred self" that promotes and coordinates connections to work, coworkers, and physical presence (p. 695). Kahn described disengagement as the "uncoupling of selves from work roles" and viewed disengagement as a withdrawing physically, cognitively, or emotionally from work (p. 694).

Disengagement leads to not being involved in the job, not cognitively attached, and emotionally detached from work. Kahn also stated that a worker draws deeply from him or herself when performing roles. Engagement refers to the focus on role activity, which in turn translates into effective role performance. Becoming engaged requires an interrelationship between thoughts and feelings, questions, assumptions, and innovation in role involvement. Cognitive engagement includes the individual's understanding, personal expectations, requirements of the work, sense of fulfillment, interface with coworkers, and selection of opportunities to improve and develop. Attention describes material resources that the individual can apply through multiple means while absorption outlines the softer or intrinsic elements of engagement.

Kahn (1990) stated that engagement measures how much the worker puts into the job, interactions, and connections between the worker, peers, and leaders. Engaged workers include the physically involved, cognitively alert, and emotionally connected

worker. Kahn's work embraces attention to or the amount of time spent thinking about the work role and absorption or engrossment into the work role. In *The Truth About Burnout*, Maslach and Leiter (1997) expanded Kahn's preliminary research describing engagement as the antithesis to exhaustion, cynicism, and inefficacy (burnout dimensions). The dimensions of engagement include vigor, dedication, and absorption. Vigor is the opposite of burnout while dedication is a sense of enthusiasm, pride, or challenge. Absorption referred to deep engrossment in the individual's work.

Kahn's initial study provided valuable information on the complexity of engagement. Engagement includes elements of the job, the work, and organizational engagement (Harter et al., 2009). Job engagement refers specifically to self-fulfillment from work performed, using individual skills, and a sense of accomplishment from job performance. Work engagement also incorporates components of Kahn's personal engagement and includes working within a team that has a shared sense of attentiveness to quality and customer needs as well as a sense of connection to the job and coworkers. Finally, organizational engagement provides an umbrella sense of connection, alignment, and cohesiveness between the individual and organizational concepts such as mission, vision, and values.

Kahn (1990) speculated that engagement required a simultaneous investment of cognitive, affective, and physical energies into roles performed. These investments help to define task performance and organizational citizenship. Kahn further outlined his theory to include value congruence, perceived organizational support, and core self-evaluations. When the individual senses any of these elements, they become engaged and

involved and invest energies into the job. Kahn did not provide a direct link between engagement and job performance. As the individual became more involved and engaged, the connection of vigor, attentiveness, and dedication became apparent in work performed and the relationships formed in the workplace. Cognitive engagement promotes attentive, focused behaviors. The emotional connection further bonds the employee to the organization, workers, and leaders. Each element fosters a healthy outlook and cohesiveness between the individual and others.

**Benner's Theoretical Framework**

Benner's stages of clinical competence range from novice to expert (2001). The novice or beginner (year 0-2) has little to no clinical experience and lack the confidence to work safely without continual verbal and physical cues. The nurse's practice skills improve over time but require insight and direction through mentoring and direct oversight of the work the nurse performs. The second stage (year 3-5) is that of advanced beginner or a nurse who has prior experience in care provision. The nurse demonstrates efficiency and skill while requiring supportive cues. During the advanced beginner stage, the nurse continues to pursue and gain knowledge and critical thinking skills. As the nurse works, they gain knowledge, efficiency, coordination of care, and confidence in nursing skills, communication, and critical thinking and becomes a competent provider. The competent provider stage occurs after 4-5 years of experience and illustrates providing conscious, abstract, and analytic care based on self-direction, self-assuredness, and confidence. The seasoned or tenured nurse progresses to the proficiency and expert stages using their ability to understand situations as the whole and direct, oversee, and

critically analyze patient care. Nurses functioning at this higher level develop sound decision-making practices, become flexible, and become role models and mentors to younger less experienced nurses.

While Benner's theory did not directly outline components of satisfaction or engagement the growth of the nurse from novice to polished professional outline the direct development in critical thinking, analysis, and understanding of the work performed, personal value in the workplace, and sense of belonging experienced by the nurse. Each stage of Benner's stages of clinical development illustrated opportunities for nurses to become satisfied or engaged in their job. These opportunities can be either negative or positive based on how the nurse senses need fulfillment. Benner's theory aligns with Maslow's hierarchy of needs. Once the nurse gains the experience, meets the goal, and feels safe, they can move toward the next goal. The sense of satisfaction and engagement correlate with Maslow's levels of higher need development. A nurse not meeting lower needs in the hierarchy will have difficulty meeting or moving toward a higher level of self-actualization and realization.

While Kahn's theory (1990) provided basic insight into the complex nature of engagement the elements outlined both hard and soft elements as essential for individual satisfaction and engagement, Benner's model looked more specifically at progression toward expertise. Similarly, Kahn, Herzberg, Vroom, Yetton, and Maslow addressed basic levels of need and more complex needs. Kahn's physical elements are similar to Herzberg's hygiene elements, Benner's novice and advanced beginner, and Maslow's physical and safety needs. As the individual becomes more engaged, higher cognitive and

emotional involvement is required. As with Maslow, the individual searches for a connection at a higher level of understanding to fulfill their need for involvement and safety. Herzberg, Vroom, Yetton, Maslow, and Kahn outline specific components influencing or required for an individual's satisfaction.

The concepts of satisfaction and engagement are broad, multidimensional, and individualized. The theories outlined provide valuable information about satisfaction and engagement as well as provided opportunities for me to analyze the current conceptual framework based on personal and professional nursing experiences, educational background, educational preparation, completion of a master's degree in management from the University of Phoenix, and my current and ongoing education at Walden University. These experiences provided an opportunity to tie theoretical framework, proposed research questions, and the journey and ambitions to embark toward completion of this dissertation.

While doing the preliminary research for the literature review, I wrote a description of my typical day at work the night before beginning the dissertation proposal. The dissertation process required motivation to obtain relevant information about the ED, an environment of endless patient volume and flow, personal fatigue, witnessed violence within my work environment, and the overall quality of care provided to my patients. As a practicing RNs, the goal is to provide care to the sick and injured. In reality, providing this care includes caring for those not requiring ED care, being verbally abused and assaulted on a regular basis, and many times functioning as a machine trying to wade through the multitude of patients waiting in line for care. Reflecting on a '*bad*'

night at work stimulated thoughts of the '*saves*', the successful resuscitations, and the thank-you from patients and families impacted during the hospital stay.

Through this assessment, my thoughts expanded to look beyond the obvious and see the intricate details of the daily life of an ED RNs. The concept became more than simply going to work and doing a job. The concept became the living, breathing environment of the ED. This visualization provided opportunities to search for the broader meaning of factors such as empowerment, violence, communication, teamwork, and management. The theories touch on both tangible and intangible aspects of satisfaction and engagement. The theories, however, do not touch on many of the intimate aspects of nursing. During the literature review, an attempt was made to understand the factors driving satisfaction and engagement and determining the key elements that require leaders to focus, embrace, and use to retain, recruit, and improve the experience of the practicing ED RNs.

## Satisfaction and Engagement Literature Review

Satisfaction and engagement are complex factors influenced by a multitude of variables. The factors range from tangible and objective variables to abstract, subjective emotions, feelings, or beliefs of the individual. The assessment of the literature outlined the broad spectrum of objective and subjective elements influencing how and why individuals perceive, demonstrate, react to, or withdraw from the work environment. A problem identified in the literature review was the blending of definitions or descriptors of the terms satisfaction and engagement. This blending or lack of clarity made finding specific factors that influenced satisfaction and engagement difficult. Satisfaction was

many times tied either directly or indirectly to happiness, which is a specific and broad category of characteristics outside the scope of this study.

New definitions or descriptors of factors influencing satisfaction and engagement such as compassion fatigue, compassion satisfaction, and the psychological contract also made finding commonality among terms difficult. The literature analysis outlined multiple explanations and descriptors of satisfaction and engagement and new emerging concepts or ways to describe the symptoms associated with stress. New terms such as compassion fatigue and compassion satisfaction are described in the literature and help to define the stress, overwhelming feelings of empathy, and inability to fulfill individual needs. Nurses are tired of providing compassion. The tiredness is not from a lack of caring but a multitude of factors including workload, assignment, and acuity or not being able to meet the needs of the many due to being too busy or overwhelmed to meet the needs.

The literature review focused on system and leadership issues, resources including staffing, equipment, and supplies, teamwork, direct management, and communication. Engagement components concentrated on trust, skill utilization, connection with the job, with coworkers, the work, and the organization. Systems and leadership centered on communication, listening to employees, leader planning, input into decision-making, individual influence in policy making, recognition, and the sense of fairness. System leadership addresses issues involving senior leadership or the organization. Resources include adequacy of staffing, equipment, supplies, and physical workspace. Teamwork related to interactions and relationships between team members

and focused on coordination of efforts, culture, and group interactions. Coaching, rewards and recognition, bi-directional communication, and trust concentrated on the role of direct management or the employee-to-supervisor relationship.

Work engagement concentrates on individual work, teamwork, and organizational connection. Job engagement or the individual work focuses on the employee perception that their work provided a sense of accomplishment and made appropriate use of their skills. Our work or teamwork captures the level of engagement the employee senses as a whole within the group or department they work within. The organizational engagement dimension acknowledges the employee connection with the organization's mission, vision, values, and community importance.

**Engagement**

Multiple factors influence the sense of belonging or engagement of an employee. The literature reflected on three distinct dimensions of engagement including the job, the work, and the organizational engagement (Harter et al., 2009). The first dimension is job engagement or the individual's work defined as whether or not the employee perceives that their work provides a feeling of accomplishment and makes effective use of their skills. The job engagement dimension reflects an emotional or psychological connection to the work performed. Higher connections lead to increased productivity and a positive partnership between the employee and the organizational outcomes at specific levels within the organization. Does the work/job leave the employee with a sense of accomplishment, suitable use of skills and abilities, opportunities to be creative and

innovative, opportunities for ongoing education and professional development, and a sense of meaningfulness? Lastly, is the employee satisfied with their job?

The second element of engagement assesses the level of engagement the employee has with their work. Specific factors at this level include employee interactions, expressions of concern, attentiveness to others, and outcomes of quality. Work engagement embraces the level of '*togetherness*' and direction toward goal accomplishment. Individuals with high or strong work connections have an improved partnership with the organization. Individual work engagement focuses on regular expression or communication between coworkers about concerns or suggestions about the work performed. The group attention to quality and attentiveness plays a chief role in how engaged an employee feels about work performance. Work engagement also fosters a powerful sense of connection to the work and a stronger sense of connection to make the organization successful.

The final component of engagement is the organizational engagement factor or employee feelings of quality work and strong organizational community regard. This dimension illustrates the commitment toward employee to organizational mission, vision, and values and a true, strong bond between employee and organizational outcomes, processes, and successes. The employee with strong organizational engagement plans on remaining with the company, recommends others to the services of the company, believes in the quality and excellence of the organization, and values the organization on a personal and community level. Based on the three components of engagement the

literature search narrowed the focus to nurse specific elements related to the individual, the job, and connection with the organization.

Employee engagement comprises the individual work, sense of accomplishment, use of skills, work group commitment, and employee feeling about the work done by the organization (Bjarnadottir, 2011; Orgambidez-Ramos & de Almeida, 2017). Engagement occurs at any or all levels within the organization. The employee may feel engaged in the work performed but may not feel engaged in the organizational mission and vision. Vice versa, an individual may feel engaged in the workgroup and not engaged at the organizational level secondary to skill misuse or inappropriate skill utilization. Engagement does not necessarily mean or provide individual happiness (Ali, Hussain, & Axim, 2013). Organizational leaders must understand that engagement requires looking beyond the obvious and seeking the elements that directly or indirectly influence employee individual, group, or organizational engagement (Lu & Gursoy, 2016). This involvement requires viewing employees as social capital and developing employees to retain, maintain, and foster organizational citizenship, commitment, and product outcomes (Ali et al., 2013; Gruman & Saks, 2011; Truss, Delbridge, Alfes, Shantz, & Soane, 2014).

Engagement means many things to many people (Shuck, 2011). Shuck described engagement on both micro and macro levels using Kahn's need-satisfaction, Maslach and Leiter (1997) burnout-antithesis, the satisfaction-engagement approach of Harter, Schmidt, and Hayes (2002), and Saks (2008) multi-dimensional approach as the foundation. Each approach illustrated the importance of engagement to the organizational

outcome. Kahn (1990) focused on the physical, emotional, and cognitive elements of the meaningfulness, safety, and resources for the individual. Maslach and Leiter (1997) described emotional exhaustion, depersonalization, and level of accomplishment as key variables for engagement.

Lastly, Saks (2008) reviewed antecedents (job characteristics, organizational support) and consequences (engagement, job satisfaction) and this model serves as the foundation for the Gallup survey. Shuck, Reio, and Rocco (2011) also outlined the importance of job fit, affective commitment or the bond with the organization, and psychological climate as factors, influencing engagement and the intent to leave the organization. This research focused on race, age, gender, and location as principle factors in how and why employees form a bond within the organization. Saks (2008) further defined specific antecedents and consequences of employee engagement. The employee's underlying state of satisfaction, communication skills, and feeling of self-worth coupled with adequate staffing, communication, and autonomy influence employee engagement as well as the intent to leave.

Schaufeli (2013) included the components of involvement, commitment, passion, enthusiasm, absorption, focus, dedication, and energy when describing engagement. Welch (2011) postulated that the difficulty is based entirely on communication and that engagement is dynamic and changeable. Welch described the dynamic, changeable state as a psychological bond that links the employee to the organization. This linkage manifests in organizational membership based on physical, cognitive, and emotional states similar to those outlined by Kahn. Wollard and Shuck (2011) further expanded

employee engagement to include meaningfulness, job fit, availability, job concurrent with interest and values, affective commitment, psychological climate, discretionary effort, intent to turnover, positive manager, and personal control. These elements mirror Saks (2008) satisfaction-engagement theory in content related to antecedents and consequences. Othman, Ghazali, and Ahmad (2013) assessed the individual's resiliency and subsequent work engagement. Each element provides evidence that engagement is multifaceted.

**Productivity.** Engaged employees are more productive employees while non-engaged employees deliver lesser outcomes. An active dynamic exists between an engaged employee's productivity and motivation leading to increased outcomes, output, and positive organizational commitment. Jenaro, Flores, Orgaz, and Cruz (2011) assessed how individual characteristics, job features, vigor, dedication, and co-morbid factors influenced employee engagement. Specific negative stressors influenced employee engagement, as well as the quality of the individual's work life balance. Employees with low engagement had a higher incidence of somatic illnesses, anxiety, insomnia, social dysfunction, and depression, which in turn predicted lower outcomes and higher stress. The lowered psychological contract or sense of unfairness or deceit further exaggerates the somatic symptoms and ultimate employee engagement (Rodwell & Gulyas, 2013).

**Symptomatic illness.** A dynamic exists between engagement (vigor and dedication) and depression (Innstrand, Langballe, & Falkum, 2011). Bargagliotti (2012) described engagement as a positive state of work mindfulness. The emotional exhaustion, depersonalization, and level of personal accomplishment emulate Maslach's burnout-

antitheses theory (Maslach, Schaufeli, & Leiter, 2001). The engagement includes vigor, dedication, and absorption. The engagement requires trust at the managerial, organizational, and collegial levels, sensitivity, momentum, teamwork, autonomy, and communication throughout the work environment (Brunetto et al., 2013; Davidson & Brown, 2014).

Disengaged employees are less productive leading to poorer patient outcomes, increased intention to leave, more somatic complaints. and subsequently increased absenteeism (Neville & Cole, 2013). The increased somatic complaints also foster increased burnout, compassion fatigue, and decreased compassion satisfaction (Fiabana, Giorgi, Sguazzin, & Argentero, 2013; van Beek, Schaufeli, Taris, & Schreurs, 2012). Leaders must fully understand the need to develop cultures to promote and sustain engagement to prevent higher absenteeism, reduce retention and recruitment costs, decrease potential recruitment issues, and promote retention, loyalty, and productivity (Andrew & Sofian, 2012; van der Doef, Mbazzi, & Verhoeven, 2012). Leaders must identify barriers to providing and promoting engagement. How to maintain momentum, contain costs, increase satisfaction, and promote safety become key concerns of leaders and supervisors (Davidson & Brown, 2014).

**Supervisor and subordinate relationship.** The employee-supervisor relationship influences engagement (Wollard & Shuck, 2011). This relationship impacts nurse intentions to leave or to quit their job leading to poorer patient outcomes, increased stress, physical manifestations, decreased productivity, and lower involvement. Negative attributes include abusive supervision, limited communication, and psychological stress.

These factors lead to individual isolation, psychological strain, and a sense of personal persecution (Rodwell, Brunetto, Demir, Shacklock, & Farr-Wharton, 2014).

Rivera, Fitzpatrick, and Boyle (2011) presented data illustrating the importance of the employee-manager relationship as a key factor in determining the nurse intent to remain. The research results described ineffective, limited, or retaliatory management actions or reactions as the largest contributor to intent to leave, with salary and benefits as the lowest indicator. The reasons nurses are leaving the profession of nursing has also been attributed to lack of managerial support, putting business before care, and a lack of organizational efforts geared toward engaging employees (Gray, 2012; Tuckett, Winters-Chang, Bogossian, & Wood, 2014).

Valentine, Nembhard, and Edmondson (2015) promoted the use of teamwork measurements to aid leaders in determining where employees felt most comfortable, motivated, and producing stimulating intrinsic motivators. Engaging staff under the supervisor assists in providing safer care secondary to a more motivated and engaged employee. This supervisor engagement focuses on workgroups, leadership skills, coaching, and increasing engagement through a connection to the strategic organizational initiative (Day, 2014). Cho and Perry (2012) outlined the role of the supervisor in promoting engagement and positively influencing employee behavior and output as affirmative drivers of employee attitudes, fostering managerial trustworthiness, and assisting in cementing goal development. Cho and Perry further outlined the ultimate organizational outcomes as retention, integrity, and reward with a warning to beware that either can reinforce or erode the other.

Clancy and Graban (2014) promoted the use of staff as problem solvers. The employee needs to be involved drives inclusion and involvement. Clancy and Graban expanded on the use of Kaizen as an approach to problem-solving. The '*quickness*' or streamlined process of Kaizen involves individuals, increases communication, provides constructive feedback, and supports coaching. Each of these factors was felt by Clancy and Graban to motivate staff to become engaged in projects leading to an individual-job fit.

Conversely, Bargagliotti (2012) described engagement as an outcome or occurring with experience and professional development. Bargagliotti outlined the need to adapt or resilience as a positive asset required for engagement. Resilience influences the comfort of experience and professional development rather than simply by joining into an activity, event, or organization. Thereby if the nurse is new, they may not feel comfortable or capable of being engaged in projects.

The literature analysis outlined and described multiple leadership strategies successfully influencing and promoting employee engagement. Leadership strategies include increasing engagement by promoting caring environments, building environments focused on a positive a sense of belonging, teamwork, providing time for decompression, and relationship building (Bishop, 2013). The individual need for reward and recognition as well as the importance of daily engagement between supervisor and subordinate emphasize the importance of a positive state of mind engagement (Bishop, 2013; Breevaart et al., 2014). Building the culture of engagement requires input from a

variety of levels within the organization and requires top-down leadership commitment to change and a priority to have employees, stay, strive, and grow within the organization.

**Outcomes**. Wick et al. (2015) emphasized the need to evaluate the pathways to improve outcomes and decrease injury while increasing the patient experience and decreasing waste within the healthcare system. Understanding the importance of patient outcomes is imperative. Coupled with the outcomes is the need to recruit and retain employees requiring an organizational commitment to engaging the retained employees. Ball, Kooiu, and DeJong (2013) focused on human resource initiatives to develop strategies to build relational rather than a transactional relationship with employees. The relationship requires effective communication, valuing of people, cooperation, ethics, and trust (Wick et al., 2015). The social exchange in workplace relationships provides an atmosphere that supports employees and encourages the employee to succeed (Trinchero, Brunetto, & Borgonovi, 2013). These relationships enhance autonomy while promoting teamwork, unity, and safety. This relationship building aids developing a culture of quality, care, and safety (Tillott, Walsh, & Moxham, 2013).

Building this positive engagement relationship is imperative in today's global recession. The cost versus benefit of the decisions made by an organization and leaders influences social decision-making (Andrew & Sofian, 2012). The question becomes how to increase retention, improve recruitment, and engage employees in a cost conservative healthcare environment? A myriad of factors can influence employee engagement. What is the current workload? Does the employee feel insecure about their job?

Taştan (2014) outlined specific elements required to adequately assess the current status and develop programs to understand the importance of engagement to the employee and within the workplace. Leaders must evaluate the work overload, role conflicts, role ambiguities, job resources, supervisor support, and autonomy to understand the needs of their employees. Leadership behaviors influence engagement (Taştan, 2014). These behaviors help to shape and define the cognitive, emotional, and physical abilities of employees and distinguish specifically required leadership styles to promote autonomy, self-direction, and competency (Shuck & Herd, 2012). Transformational leadership coupled with motivation strategies builds stronger, more dedicated, and engaged employees (Shuck & Herd, 2012).

**Teamwork.** Pfaff, Baxter, Ploeg, and Jack (2014) outlined specific elements that directly influenced retention and engagement. The research study focused on satisfaction with the team, the number and value of team strategies, mentoring, accessibility, proximity to education, need for direct face-to-face interactions, supportive leadership, and time. Mengue, Auh, Fisher, and Haddad (2013) expanded these elements to include autonomy, feedback, support, and customer perception to describe factors that employees seek to become engaged or remain engaged in the work, the job, or the organization.

The quality of care outlined in the 2014 research of Ulrich, Lavandero, Woods, and Early focused on safe staffing, communication, collaboration, responsibility, physical and mental safety, moral distress, support for certification, continuing education, meaningful recognition, job satisfaction, and career planning as key factors influencing employee engagement. Brunetto et al. (2013) expanded the research to include perceived

organizational support and sense of well-being as key predictors of employee engagement. The inclusion of employees becomes a crucial element in stimulating communication, organization-personal fit, and organizational citizenship behavior (Brunetto et al., 2013; Cho & Perry, 2012).

**Autonomy**. Autonomy was a common theme in the literature reviewed. Trinchero et al. (2013) examined the role of workplace relationships and defined these relationships as essential in establishing engagement within the workplace. Coupled with workplace relationships was the need to adequately train and allow nurses to be autonomous in decision-making and clinical practice. Stress also plays a key role employee engagement (Skinner, Madison, & Humphries, 2012). Are the employees suited for what they are doing or will do, do they want to stay where they are, and how does stress impact the individual or group? The essential nature of autonomy also aids in building a positive culture of self-determination and motivation (Gagné & Bhave, 2011). Gagné and Bhave were careful to quantify the differences between motivation and engagement clarifying that they are not mutually exclusive. Fiabana et al. (2013) described the best predictors of engagement leading to autonomy as energy, workload, mental health, satisfaction, involvement-commitment, communication, proficiency, and values.

Engagement is a multi-faceted and fluid dynamic based on cognitive, emotional, psychological, and physical characteristics. Trossman (2011) described disengaged employees as less productive and less willing or motivated to go above and beyond when performing the job. Engaged employees are less absent from work, have less somatic illness, less depression, and are less hostile within the work environment. The analysis of

the literature revealed common themes and phrases related to expectations, predictors, and needs of satisfied employees. Engagement focused on the degree the employee performed the work, the workgroup, and to or with the organization. Through the assessment, four common categories emerged. These categories were psychological, cognition, emotional, and physical characteristics required for engagement. Contained within each category were traits or expectations of my key focus areas of individual or personal (I), group (G), and organizational (O) engagement as outlined in Table 2.

Specific psychological components were common in the literature. Psychological components outlined in Table 2 included a sense of meaningfulness (I), positive communication and interactions with managers and coworkers (G), a state of well-being or satisfaction (I), and expressions of concern by managers or supervisors (O). The psychological components also included the sense of organizational support for the work performed (O), a positive psychological climate (O), autonomy (I), fairness (O), trust (I), support for burnout (G), and integrity of supervisors (O). The research results illustrated a common theme focused on quality and outcomes (O), goal completion and alignment with organizational goals (G), organizational commitment (O), compassion satisfaction and fatigue (I, G), and organizational citizenship (O).

Table 2

*Psychological Characteristics of Engagement*

| Characteristic | Personal | Group | Organizational |
|---|---|---|---|
| Psychological | + | | |
| Communication | + | + | |
| Peer interactions | + | + | |
| Satisfaction | + | | |
| Manager concern | | | + |
| Org. support | | | + |
| Psych climate | | | + |
| Autonomy | + | | |
| Trust | + | | |
| Burnout support | | + | |
| Manager integrity | | | + |
| Fairness | | | + |
| Goal completion | | + | |
| Org alignment | | | + |
| Org commitment | | | + |
| Compassion | + | + | |
| Fatigue | | | |
| Org citizenship | | | + |

The cognitive elements essential for successful employee engagement included the person, within a group, or with the organization. Cognitive elements encompassed professional and personal growth and development (I, O), level of expertise and experience (I), communication (I, G, O), leadership skills (O), dedication (I), creativity (I), and innovation (I). Cognitive elements also included mentoring (I), effective

communication (I, G), alignment with organizational goals (O), and affective commitment (O) and are included in Table 3.

Table 3

*Cognitive Characteristics of Engagement*

| Characteristic | Personal | Group | Organizational |
|---|---|---|---|
| Professional G/D | + | | + |
| Personal G/D | + | | + |
| Level of expertise | + | | |
| Communication | + | + | + |
| Leadership skills | | | + |
| Dedication | + | | |
| Creativity | + | | |
| Innovation | + | | |
| Mentoring | + | | |
| Communication | + | + | |
| Managerial | | | + |
| Integrity | | | |
| Org organization | | | + |
| Affective comm. | | | + |

The assessment established that emotional attachment, a sense of belonging, and communication were key factors influencing engagement. The key elements linked to emotions included attentiveness to others (G), sense of accomplishment (I), creativity (I), innovation (I), employee interactions (I, G), safety (I), interactions with leaders (I, O), and compassion satisfaction and fatigue (I, O). Subjective elements of the emotional elements also included autonomy or self-direction (I), affective commitment (I, O), vigor

(I), loyalty (I), comfort (I), and a sense of belonging (I, G). Table 4 contains emotional characteristics of engagement obtained through the literature review.

Table 4

*Emotional Characteristics of Engagement*

| Characteristic | Personal | Group | Organizational |
|---|---|---|---|
| Attentiveness | | + | |
| Accomplishment | + | | |
| Creativity | + | | |
| Innovation | + | | |
| Emp. interactions | + | + | |
| Safety | + | | |
| Interactions | + | | + |
| Comp. fatigue | + | + | |
| Autonomy | + | | |
| Affective commit. | + | + | |
| Vigor | + | | |
| Loyalty | + | | |
| Comfort | + | | |
| Belonging | + | + | |

The final category or theme emerging from the research review, noted in Table 5, was physical characteristics required for the employee to feel engaged in the work performed, group effectiveness, and organizational commitment. These themes included resources (I), safety (I, O), adequate staffing (I, G), somatic illness (I, G), productivity (I), and outcomes (I, O). Essential physical characteristics comprised equipment and supplies (I), shift work (I), work life balance (I), age (I), workload (I), time (I), patient outcomes

(I, G, O), and depression (I). Each of the identified physical elements influence the employee, the group, outcomes, and the organization.

Table 5

*Physical Characteristics of Engagement*

| Characteristic | Personal | Group | Organizational |
|---|---|---|---|
| Resources | + | | |
| Safety | + | | + |
| Adequate staffing | + | + | |
| Somatic illness | + | + | |
| Productivity | + | | |
| Outcomes | + | + | |
| Equipment and supplies | + | | |
| Shift work | + | | |
| Work life Balance | + | | |
| Age | + | | |
| Workload | + | | |
| Time | + | | |
| Patient outcomes | + | + | + |
| Depression | + | | |

A commonality in the needs of workers to be included, have a voice in decision-making, and align with the organizational mission and outcomes exist as an essential need for engagement was found during the literature analysis. Individuals, leaders, and organizations require communication, commitment, alignment with objectives, and understanding to effectively complete work, retain employees, and remain productive. Different cognitive, psychological, physical, and emotional requirements exist for individuals. These requirements also impact work performed, group dynamics, and the success of the organization. Engagement breeds productive employees. While satisfaction and engagement are different, the terms were used interchangeably in the reviewed

literature and lumped together as outcomes, expectations, antecedents, and consequences using similar terminology. While separate in many cases the information is similar and relevant to the other term. The same was true when assessing the satisfaction literature.

**Satisfaction**

The literature review focus was narrowed to include systems and leadership, resources, teamwork, and direct management dimensions (Harter et al., 2009). Systems and leadership focused on issues relating to communication, input into decision-making, recognition, and compensation. The literature review focuses on leadership listening, response, and planning and an employee's ability to impact decision making or policy formation. The literature review related to resources was straightforward and assessed the adequacy of staffing, equipment and supplies, and physical conditions within the workplace to adequately perform the required work. Teamwork reflects the attitudes, interactions, and relationships between team members seeking to determine how employees felt about the coordinated effort within the group and the dignity and respect between group members. The final satisfaction principle includes an assessment of the role direct management or the relationship between the employee and their direct supervisor. The elements examined include coaching, recognition, effective communication, and trustworthiness.

Employee satisfaction is a broad topic with multiple facets including motivation, work environment, attitude, culture, and autonomy. What causes one person to be satisfied with the job while another is dissatisfied, disillusioned, and ready to leave? The answer to this complex question challenges leaders, drives outcomes, and varies within

each organization and employee (Unruh & Zhang, 2014). What we know is that there are different motivators influencing work and different individual satisfiers and dissatisfiers. Motivators include the challenge and opportunity to work, curiosity, job content, work environment, and monetary incentives. The literature illuminates that no common denominator or motivator drives satisfaction or dissatisfaction or the employee's intent to leave their job (Hoonakker et al., 2013).

Unfortunately, the terms satisfaction and engagement I reviewed in the literature became blurred and definitions varied from study to study (Gaki, Kontodimopoulos, & Niakas, 2013). The challenge was to separate the terms and define the specific characteristics that mediated employee satisfaction. The review identified motivators as intrinsic and extrinsic rewards or expectations (based similarly on Herzberg's and Vroom's principles). A focus highlighted the psychological components or subjective elements (using Maslow's hierarchy). Benner's theory of clinical competence was expanded and used to differentiate experience expectations and challenges to obtaining or maintaining satisfaction. Lastly, the cognitive, psychological, and emotional aspects of Kahn's theory form a framework for elements outside of the subjective and objective elements influencing employee satisfaction.

**Workplace culture.** An overarching theme in the literature is the importance of the organization to build a workplace culture fostering satisfaction and engagement, safety, and quality outcomes (Brunges & Foley-Brinza, 2014; Burke, Koyuncu, & Fiksenbaum, 2011). Workplace culture ultimately drives commitment, satisfaction, and engagement (Brunges & Foley-Brinza, 2014). This organizational culture leads to more

satisfied employees, requires that all individuals '*get on board'*, a commitment to organizational values, professional and personal development, and fair, equitable compensation and benefits (Sageer, Rafat, & Agarwal, 2012). The development of a culture of commitment to satisfaction requires financial assessment and stewardship. Healthcare organizations must build a business relationship between employee satisfaction, engagement, and business outcomes (Harter et al., 2002).

Person-to-organizational fit was also a key variable discussed and addressed in the research. Satisfied individuals have increased organizational identification and increased satisfaction (Cha, Young, & Kim, 2014). This identification leads to more productivity, belief in the organization, improved teamwork, and increased communication. The satisfied employee is more loyal, but satisfaction is a moving target that is easy swayed or influenced by personal, professional, or emotional upheavals (Sageer et al., 2012). The organization and the leaders must live the organizational mission, vision, and values. This commitment includes providing fair, equitable, secure jobs, and work environments while consistently building, directing, and improving leaders, professional development, and teamwork.

Asiedu (2015) outlined key elements required for effective employee satisfaction development. Building a culture of rewards and recognition aids in developing self-confidence and a sense of accomplishment for the employee. Asiedu also discussed the need for professional development, compensation, and defining the organization soul, individual value of employees, and determining how to foster employees from dissatisfied to satisfied. The length of work experience also influences the competency of

the individual. Increased competency leads to increased satisfaction (Meretoja, Numminen, Isoaho, & Leino-Kilpi, 2015). Similarly, when organizations do not spend the money or use the time to train, develop, or nurture individuals, the outcomes reflect negatively on patient outcomes, dissatisfaction, and intention to leave the organization.

Developing a culture of structural empowerment was addressed by Cicolini, Comparcini, and Simonetti (2014). The researchers promoted building an environment in which individuals can perform, can influence the work performed, and feel that the work performed has importance. Through the development of positive empowerment, employee satisfaction will flourish and expand. Building this culture requires adequate resources to perform the work. Essential requirements include adequate technical resources and the development of strong ties between workers and subordinates (Bragard et al., 2015). Graban (2016) suggested that LEAN management skills involve employees early in the process of change and culture development, encourage group interactions, align with organizational goals, and make rapid change possible. With technology comes the need to alter or modify work environments for the employee's ergonomic safety (McIntosh, Palumbo, & Rambur, 2010). Building the better mousetrap may provide the impetus to motivate employees and improve satisfaction and engagement.

**Leadership.** The development of transformational leaders becomes key as organizational leaders strive to cultivate employees. Fedock, Young, Qualls-Harris, Gibson, and Diggs (2013) outlined a direct link between transformational leaders and positive employee satisfaction. The role of nurses at the bedside requires redefining leader roles to meet the current needs and expectations especially those of Medicare and

Medicaid. The HCAPHS (Hospital Consumer Association of Healthcare Providers and Systems) used by the Centers for Medicare and Medicaid (2013) has placed new expectations on hospitals to provide safe and effective care as well as meet quality expectations and meet patient satisfaction standards. The driving force in healthcare is patient satisfaction with little to no concern or discussion about healthcare employee satisfaction or demands. HCAPHS also has become the driving force as a measurement tool for patient satisfaction replacing the Press Ganey survey tool to assess employee satisfaction (Zusman, 2012). Strangely enough, we have two opposing tools: one tool to survey patients and another tool to survey employees with limited connections between the questions, outcomes, and needs of each group. The looming question becomes what matters most? Is the accountable culture of patient safety, satisfaction, and the bottom line more important than the care providers needs and expectations (Wong & Koloroutis, 2015)?

Amiresmali and Moosazadeh (2013) discussed the importance of developing a culture of satisfaction. Understanding attitudes and feelings about the job are imperative as leaders work to maintain adequate staffing levels. The key becomes understanding the link between employee and patient satisfaction. Without understanding what employees believe, feel, or experience, a disconnect occurs (Ahmad et al., 2013). Leaders must ask employees specific questions about leadership, direct supervision, teamwork, resources, and both hard and soft requirements to ensure that employees have a voice in decision-making, involvement in planning and strategy, and are more than a person providing services. This preparation requires defining leaders versus managers.

**Employee attitudes and feelings.** Employee attitudes and feelings about the job, groups, and organization vary and are individualized (Amiresmali & Moosazadeh, 2013). The drivers are also not consistent and vary with emotions, workload, work life stressors, and fatigue (Hoonakker et al., 2013). Simple elements such as taking a meal break, having opportunities for serenity, addressing bullying and workplace violence, offering fun activities, and receiving recognition or rewards can easily sway how satisfied an employee feels about their job (Brunges & Foley-Brinza, 2014). Burke et al. (2011) described the need for supportive cultures within organizations to promote and provide a healthy and safe environment. Nurses saturated with heavy workloads, high acuity patients, and short staffing voiced autonomy as a key indicator for satisfaction (Wu et al., 2014). The nurses viewed autonomy as a means to gain confidence and control leading to an increased satisfaction about the work performed.

Benner's stages of clinical competence development theory explored the challenges of gaining experience, credibility, and expertise as a nurse. Mahon (2014) assessed Pediatric Intensive Care RNs and discovered that the level of expertise and mutual respect aids in retaining nurses. Nurses who are clinically competent, have gained experience, are comfortable with their practice, and feel comfortable working within a group are more likely to remain in their clinical position. This group, however, was frustrated and cited a lack of autonomy and lower than expected responsibility and support by administration as major stressors to satisfaction (Lin & Chang, 2015). Nurses with higher education levels, more experience, and strong leaders were more satisfied in their job (Lorber & Savič, 2012). This sense of well-being also was discussed by Lorber,

Treven, and Mumel (2015). The research assessed the importance of well-being to nurses in the workplace Serrone, Marcus, & Longmore, 2018). Were the nurses satisfied and what was the level of well-being among those nurses? Strong organizational commitment plays a role in staff satisfaction and personal well-being.

Zhang, Tao, Ellenbecker, and Liu (2013) assessed critical care and non-critical care nurses and found that work life balance played a significant role in their satisfaction. Low satisfiers included pay and professional promotion. In support of the work life balance, Carter and Tourangeau (2012) cited psychological engagement as a key attribute to employee satisfaction. Nurses surveyed wanted professional development, work life balance, proper and adequate equipment and supplies, and the ability to do their job (autonomy). Resources were both physical and monetary. The use of traveler or temporary nurses did not have an impact on employee satisfaction in the critical care units (Cimotti et al., 2011).

Numerous objective and subjective factors influence employee satisfaction. Hu, Schaufeli, & Taris (2013) discussed job demands versus job resources and employee well-being. Increased job demands coupled with decreased resources lead to burn out and disengagement without mention of impact on satisfaction. This becomes especially relevant as the aging Baby Boomers flood the healthcare system (the tsunami effect), nurse retention decreases, and the aging nursing workforce retires (Hussain et al., 2012). The work environment, salary, nurse-patient ratio, autonomy, lack of time, and inadequate communication were cited as key factors influencing nurse satisfaction (Tarcan, Hikmet, Schooley, Mehmet, & Tarcan, 2017). The results showed 50% of

surveyed nurses felt overworked with inadequate communication with their supervisor (Tarcan et al., 2017). Burnout was defined as a key outcome of dissatisfaction. The attachment to work was stronger in Millennials while the supervisor-subordinate relationship expectations was stronger in Generation X. The Baby Boomers sought relationships with the supervisor and identified the importance of interpersonal relationships, autonomy, attachment to work, and flexibility to personal and professional satisfaction (Shacklock & Brunetto, 2012).

A principal factor includes the perception of work performed. If an individual considers the job too difficult, too demanding, lacking resources, or other negative factors then the person will probably be dissatisfied with the job performed (Grover, Porter, & Morphet, 2017). Conversely, if provided with opportunities to communicate, have autonomy, receive recognition, and the ability to provide compassion the perceptions will be more directed toward being satisfied (Bogossian, Winters-Chang, & Tuckett, 2014; Tellez, 2012). Listening to what nurses say provides excellent opportunities for leaders to identify key factors that influence satisfaction.

**Burnout, compassion fatigue, and compassion satisfaction.** Burnout is a personal, individualized negative reaction to the environment in which an individual works, functions, or lives (Mooney et al., 2017). Similar to the burnout seen with lack of engagement the nurse can manifest a plethora of symptoms both real and imagined. Hayes et al. (2012) designated workload, stress, management style, lack of empowerment, age, relationships within the organization, and career advancement as key features precipitating burnout. The burnout leads to lessened productivity, poorer patient

outcomes, and negative consequences (Abellanoza, Provenzano-Hass, & Gatehel, 2018, Harzer & Ruch, 2015). As stress increases, job satisfaction decreases, and tasks, performance, and work become difficult to perform positively (Davidson & Brown, 2014; Nolte, Downing, Tamane, & Hastings-Tolsma, 2017). Increased motivation leads to increased involvement and subsequently increased satisfaction (Ramoo, Abdullan, & Piaw, 2013).

Women are more susceptible to increased conflict and retaliation (Sparks, 2012). Since nursing is a predominately female profession these two negative attributes can significantly impact stress. Mechanisms to decrease stress become important as individuals become more dissatisfied with their job (Sliter, Boyd, Sinclair, Cheung, & McFadden, 2014). Davis et al. (2012) summarized issues of novice RNs and the hostile treatment of the new graduates by seasoned veteran nurses who, in many cases, are burned out. Thian, Kannusamy, & Klainin-Yobas (2013) reviewed the impact of stress among nurses. Stress plays a key role in satisfaction and productivity. Kim and Choi (2012) described factors that influence overall employee satisfaction and influenced burnout. These factors carry over into outcomes and productivity.

Precipitating the burnout may be a phase now known as compassion fatigue. Compassion fatigue describes a condition where an individual becomes stressed to meet the demands of the family and patient (Dev, Fenando, Lim, & Consedine, 2018). The nurse becomes reactive to the environment, coworkers, and patients leading to physical, emotional, and somatic symptoms influencing performance and patient outcomes (Lombardo & Eyre, 2011). The depletion of energy leads to decreasing caring and coping

skills seen as emotional, spiritual, and physical depletion (Hegney et al., 2014). The compassion fatigue becomes overwhelming and progresses with decreased coping skills, inability to keep perspective, and hostility toward coworker and patients.

Unfortunately, the lack of managerial support, lack of available resources to aid in the treatment, and individual acceptance of the behaviors outline key factors leading to dissatisfaction (Rosales, Labrague, & Rosales, 2013). These negative or exhausting behaviors if left untreated lead to depression, overwhelming anger and frustration, and symptoms of mental, physical, emotional, and spiritual exhaustion (Lombardo & Eyre, 2011; Lorber et al., 2015). Compassion satisfaction relates to the ability to find the balance between stress and providing compassion to patients and others (Rosales et al., 2013). The balance becomes key in defining whether the individual '*develops*' compassion fatigue and subsequent burnout.

**Communication**. Healthcare staff experience numerous opportunities for communication at varying levels within the healthcare system. Poor communication directly links to professional relationships, coping, stress, and job satisfaction (Dass & Baby, 2014; Descorough, Forrest, & Parker, 2013). Communication is key to satisfaction. Job stress and other distancing effects of dissatisfaction directly influence communication (Kalandyk & Penar-Zadarko, 2013). Communication also has a beneficial impact when used as a debriefing method to reduce stress and increase serenity (Ravari, Bazargan-Hejazi, Ebadi, Mirzaei, & Oshvandi, 2013).

The transfer of knowledge is key in the healthcare environment. Whether using the old methods of paper and pen or using computer charting, how and why

communication occurs is paramount (Gaudert & Thébault, 2012). Establishing communication pathways and effective communication impacts organizational outcomes and employee satisfaction. The transmission of information through communication is a priority when rebuilding, revamping, or modifying the work environment. Organizations strive to be current, flexible, and adaptable. These characteristics require leaders to communicate with staff.

**Nursing shortage.** The literature reviewed shows a strong correlation between nurse satisfaction and the nursing shortage seen with overcrowding, short staffing, violence, and emotional fatigue. Fortunately, the retirement of the aging RNs has slowed somewhat with the poor economy. More nurses are working past retirement age, yet the supply will never meet the demand for RNs (Hill, 2011). As the nurse works past retirement, an assortment of physical ailments become apparent with nurses being unable to perform tasks and duties at expected levels. The inability to perform at the expected level places greater demand on other staff and increases stress (Clendon & Walker, 2013; Singh, 2013).

The nurse shortage continues. Hayes et al. (2012) described key elements affecting turnover. The relationships on the individual, the group, or at the organizational levels provide opportunities for system and process breakdown leading to frustrations, lack of communication, or isolation of employees. Factors such as workload, shift work, burnout, management styles, career advancement, and outcomes also shape employee satisfaction. These play a major role in the work life satisfaction balance of the employee.

Work life balance and satisfaction are intimately connected (Spivak, Smith, & Logsdon, 2011).

Personality traits, how individuals deal with stress, workload, time, conflicts with coworkers, and anticipation of impending events directly influence an employee's satisfaction and work life satisfaction (Harzer & Ruch, 2015). Work life balance dissatisfaction facilitates employee dissatisfaction, decreased productivity, absenteeism, and turnover. Similarly, as seen with engagement, leaders must focus on nurturing, debriefing, and providing individual programs to support employees and build intellectual and emotional strength. Another factor to consider is the satisfaction of new graduates. Lin, Viscardi, and McHugh (2014) discussed the impact of negativity, fit within the organization/unit, and flow of new graduates as key influencers of the intent to remain.

Agezegin, Belachew, & Yiman-Chen (2014) described a link between turnover and patient outcomes. Leaders must assess factors influencing job satisfaction and intent to leave. This assessment should include the work environment and group relationships which are two key factors influencing employee satisfaction. Key factors rank differently as the most influence on nurse satisfaction. For example, pay was the number one concern in Ecuador with opportunities for advancement listed as the number two concern (Palmer, 2014).

**Varied factors.** Magnet® hospital leaders have also made attempts to improve satisfaction through the development and establishment of policies, standards, and expectations that meet quality standards for certification (Hagedorn-Wonder, 2012; Hairr,

Salisbury, Johannsson, & Redfern-Vance, 2014). Ravari et al. (2013) described nursing as a divine profession and discussed methods to enhance inner harmony and unity, altruism, and spiritual value to decrease the negative effects of stress. Other studies revealed flexibility, adaptation mechanisms, change management training, and job rotation as factors that influence nurse satisfaction (Stimpfel, Rosen, & McHugh, 2014). Other factors such as job rotation or shift work, changing shifts, or off shift work life balance directly influence employee satisfaction (Atefi, Abdullah, Wong, & Mazlom, 2014; Holm & Severinsson, 2014; Pan, Huang, Lee, & Chang, 2012).

Sparks (2012) addressed psychological empowerment among nurses and found a correlation between age and job satisfaction. Sparks also determined that psychological empowerment increased with age, is personal, and individualized. In the research study, Sparks sorted specific characteristics by age cohorts seeking to determine which elements influenced job satisfaction. These elements included autonomy, work ethics, involvement, view of leaders, innovation, quality, burnout, intent to leave, turnover, structural empowerment, and external factors.

Consumers are keenly aware of healthcare concerns. Stiff competition exists between healthcare agencies for customers, dollars, and recognition (Naseem, Sheikh, & Malik, 2011). Customers are aware of employee satisfaction. Since satisfaction and outcomes are linked, a conscious effort by leaders must be made to improve employee satisfaction to gain the advantage and improve customer/patient outcomes (Wollsin, Ayala, & Fulton, 2012). Employee satisfaction equals organizational success. Hospitals with lower employee satisfaction scores have lower patient satisfaction scores, which are

directly related to Federal reimbursement (McHugh, Kutney-Lee, Cimotti, Sloane, & Aiken, 2011).

The transmission and messages sent during orientation and training directly influenced an individual's satisfaction levels. Mentoring provides a secure method of protecting the new employee and gently guiding the employee into the work environment (Ke, Kuou, & Hung, 2017). Not all mentoring programs are a fit between individuals and the department/unit or organization. Organizational leaders should develop mentoring programs to fit the needs and desires of the employee. Input into mentoring and educational programs must come from all participants. Developing orientation programs to work directly with individual needs versus cookie-cutter orientation plans is essential. Nursing care is more than knowing where to find a resource and requires individualized orientation programs based on the RNs background, needs, and experiences. Breaking from the old requires forward thinking to develop programs that promote self-development and pride in the work performed. Marcinkus-Murphy (2012) provided examples of how reverse mentoring (younger mentoring older) has worked in situations such as GM under the direction of Jack Welch.

In summary, the research review illustrates a strong relationship between the leaders' ability to communicate major developments as well as listen to employees. Cha et al. (2014) linked employee-to-organizational fit and employee relationships with satisfaction. A key factor is a sense of belonging becomes the organization caring about the individual as an integral and essential component to and for the organization. Another key component discovered in the research is the need for the employee to interact, be

involved in, and communicate in the policies, work processes, and systems within the organization, in the work unit, and as a team member.

Communication is seen as an essential and expected dynamic between coworkers, upward, downward, and in the supervisor-subordinate work relationship (Sageer et al., 2012). Employees' expect recognition, reward, and value for the work performed. Key factors influencing employee satisfaction include staffing ratios, nurse-patient ratios, and availability of staff (Boev, 2012). This availability focuses on both individual and team expectations, the quality of work performed, and physical attributes required to complete tasks. Key satisfiers directly impacting patient outcomes included staffing and nurse-patient ratios.

The information obtained through literature analysis illustrates the importance of employee's positive, informative, and relevant interactions and relationships with coworkers. Without solid teamwork, healthcare organizations face decrease productivity, decreased retention, and low morale (Chang et al., 2015). These factors have a negative impact on patient outcomes, employee satisfaction, and productivity. Positive reward, recognition, and communication between the supervisor and subordinate were shown in multiple studies to influence both satisfaction and intent to remain (Agezegin et al., 2014). A minimal number of studies focused on pay and benefits. Cicolini et al. (2014) identified pay as a non-significant individual of satisfaction as compared to significant contributors such as nurse-to-patient ratios, adequate staffing, communication and RNs competency. States with a mandated patient to staff ratios have improved patient

outcomes. A principle variable noted in the quantitative literature was teamwork and the coordination of care within nursing.

The aspects of dignity and respect, teamwork, communication, and fit were addressed throughout the literature (Brunetto et al., 2013). Dignity and respect are factors influencing satisfaction and engagement. Negative elements of dignity and respect included anger, frustration, lack of patience with new hires, and an unsupportive environment. Impatient, hostile, and bullying nursing workplaces are associated with discontentment among staff (Clendon & Walker, 2013). Clendon and Walker (2013) attributed this negative environment as directly impacted by high stress, increased patient acuity, and burnout of frontline nurses. Unfortunately, the label does not adequately portray all nurses and does not excuse the behaviors of a few that impact the many. An increasing number of qualitative studies showed `how and why the nursing teamwork or lack of communication between working staff influenced satisfaction. The qualitative research focused on burnout, compassion fatigue, and compassion satisfaction as key elements influencing how nurses communicate and why the communication or interactions are becoming more negative and non-productive for care in an environment of high acuity and short staffing.

Direct management plays a key role in the satisfaction of nurses (Carter & Tourangeau, 2012). Nurses expect and demand a positive supervisor-subordinate relationship with open lines of communication, input into decision-making, and recognition for work performed. No literature was reviewed supporting the importance of performance reviews on employee satisfaction. Personal experience identified that

unionized hospitals provided little to no impetus to improve behaviors or work habits because employees receive the negotiated annual salary increase regardless of positive or negative productivity. The focus on performance is not about pay but on the manager's ability or persistence in evaluating employee performance. Research supported enhancing and providing professional and personal growth and development supported by a learning culture supported by management (ten Hoeve, Jansen, & Roodbol, 2014). This development supports organizational-fit and employee-to-organizational goal alignment.

Information obtained through the literature assessment stresses the importance of recognizing employee input and suggestions and providing the involvement and open communication. Employees want to be heard and want to have input into the decision-making, policy development, and organizational planning (Dawson, Stasa, Roche, Horner, & Duffield, 2014). How a leader enables the input into decision-making influences the employees' satisfaction. A strong relationship exists between communication and trust between the employee and supervisor. Employees expect to be included and in the communication loop. How an employee feels about the job, the team, and the organization are important variables, which influence satisfaction and engagement. The final component of the literature review focused on ED satisfaction and engagement. The ED sets the stage for the patient experience and depicts the '*window to the hospital'*. The ED is the entry point for a large number of patients into the healthcare system and is a primary care provider for many uninsured or underinsured individuals and families. Understanding the ED culture aids in grasping the role ED RNs play in the healthcare system.

## Emergency Department Registered Nurses

Approximately 90,000 RNs work in healthcare systems in the United States (Waeckerle et al., 2001). Emergency nurses specialize in rapid assessment and triage in an environment where every second counts, lives are on the line, and time is brain/heart/money. The professional nurse deals with a multitude of patients with varying diseases, illness, emergencies, and surgeries. The tasks are easy, diverse, difficult, complicated, simple, and require care, compassion, knowledge, professionalism, and skill. The overall requirement is caring yet overcrowding, staffing concerns, and patient acuity has changed the abilities and capabilities of the ED RNs.

The ED RNs specialty is unlike any other type of nursing. The ED staff must tackle diverse tasks and provide quality care to people of all ages using both general and specific knowledge about health care while meeting the social, emotional, physical, and psychosocial needs of the nurse, the patients, and significant others. The ED RNs must be prepared to treat a wide variety of illnesses or injury ranging from a simple sore throat to a massive stroke. This treatment, while diverse, requires the ED nurse to juggle patient assignments, prioritize patient needs, meet simple demands, work in a hostile, sometimes violent environment, and ensure patient safety while communicating with patients, families, agencies, and other healthcare providers.

### Workplace Culture/Employee Attitudes

Being an ED nurse is being part of an exclusive group of individuals dedicated to caring for the ill and injured. The ED is unlike any other place in the hospital. Nurses deal with a constant stream of people who are experiencing a stressful life event which

the nurse may not view as a crisis, but for the individual, it is a crisis. The ED never closes, there is never a break in the action within an environment ranging from manageable to complete chaos. The nurse deals with a stubbed toe and then rushes off to care for a cardiac arrest or stab wound. Many individuals frequenting the ED may lead dysfunction or non-traditional lives. Many are violent drunks, drug abusers, the homeless, the mentally ill, and manipulative people who can suddenly become violent or out of control. What most people do not understand is that EDs are not like the television version of medicine.

ED staff do not deal with just critical patients. Nurses deal with routine everyday emergencies mixed with critical care patients and those seeking primary care. ED nurses also see a great deal of tragedy in a variety of forms including those dying from cancer, congenital anomalies, unwanted elderly patients, and abuse victims. Families suffer, and many days are sad. The ED frequently becomes a haven for ineffective copers or those that a simple cold or fever sends them directly seeking care or a pill to fix the problem or to provide primary care. Many do not have a primary care physician and do not follow up or seek preventative care. The patients include drug seeks and many times individuals who are angry, disgruntled, and demanding and conversely poor, helpless, and hopeless. These patient yell, demand, verbally abuse the staff, threaten, and can become violent toward the staff or meekly wait for care, food, or warm shelter.

All of these numerous factors influence the daily work life of the ED RNs. ED RNs are described as having a warped sense of humor, fun, hilarious, stressed, cynical, resourceful, skilled, and professional while dealing with an ever-changing environment of

calmness and chaos. Understanding what factors influence and support a satisfied environment of satisfaction and engagement becomes essential to healthcare leaders. The ED is the first step of a very complicated journey of healthcare for many individuals. The satisfaction and outcomes within the ED have a negative or positive impact on the overall outcomes and satisfaction of the hospital experience, remembering that it only takes six seconds to make a lasting impression. The manner in which nurses communicate, work with supervisors, use resources, react to violence, and deal with patients is important in this understanding of the factors that directly or indirectly impacting nurse satisfaction, engagement, and intent to leave.

**Compassion Fatigue, Compassion Satisfaction, and Burnout**

Compassion fatigue, burnout, and compassion satisfaction were key concepts seen throughout the literature review of ED RNs (Hunsaker, Chen, Maughan, & Heaston, 2015; Flarity, Gentry, & Mesnikoff, 2013). Hunsaker et al. provided research assessing compassion fatigue, burnout, and compassion satisfaction revealing that low managerial support leads to increased burnout and compassion fatigue. The research analysis also illustrated the need for organizational support for methods to decompress or allow nurses to address compassion fatigue symptoms and develop programs to alter the current methods of dealing with ED RNs stress. Flarity et al. (2013) described the importance of increasing compassion satisfaction. As compassion satisfaction improves, secondary trauma or stress decreases leading to less stress, increased emotional fortitude, and less psychosomatic illnesses. The research assessed provided information stressing the

importance of helping to prevent compassion fatigue, burnout, and decreased compassion satisfaction as a primary way to improve patient outcomes (Considine et al., 2012).

A traumatized nurse (described as low compassion satisfaction) is unable to help others. If the nurse cannot help themselves then how can they help those in need? The literature assessed provided evidence to support a strong correlation between caregivers and lack of support, poor communication, and burnout. Self-help measures, organizational support measures to address stress, post-traumatic stress disorders, and negative outcomes from compassion fatigue, burnout, and compassion satisfaction (Neville & Cole, 2013).

**Stress**

Healy and Tyrrell (2011) discussed the role stress plays in the ED nurse. Healy and Tyrrell described the ED as a profound, aggressive environment of violence, patient deaths, emotionally and physically draining patients, and events coupled with care and compassion. Non-fatal RN assaults cost $6 billion in 2000 with the ED has the highest rate of workplace violence and ED nurses experiencing the highest rate of healthcare assaults (Gates, Gillespie, & Succop, 2011). These negative experiences affect productivity, increase stress, and make communication more difficult among staff and with patients (Wright, Zammuto, & Liesen, 2015). The sheer expectation of violence leads to withdrawal, avoidance, and distancing of the staff. Unfortunately, most nurses do not report the assault or aggressive behaviors, chalking these events up to normal work environment events. Basińska and Andruszkiewicz (2011) also outlined factors that

influence work behaviors. Stress is a principal factor in how and why employees behave in particular ways while at work.

Stress also leads to a variety of illness which are many times real and other times a result of the stressors produced. The sympathetic nervous system is known as the fight or flight response to stress. As stress increases, the sympathetic nervous system stimulates the release of epinephrine and norepinephrine to deal with the stressor. The heart rate elevates, respirations increase, the liver secretes sugar, and the body readies for battle. Similarly, stress causes these same physiologic events in nurses. Constant sympathetic nervous system stimulation leads to emotional, physical, and psychological exhaustion from the constant state of readiness to go to war or do battle with a stressor (Flarity et al., 2013). If a nurse is under constant stress, is ill-prepared to deal with the stressors, and has little to no support for the stress, then negative outcomes occur leading to decreased satisfaction and engagement and intent to leave. The exhaustion impacts the worker, coworkers, teamwork, relationships, and outcomes (Healy & Tyrrell, 2011). Flarity et al. (2013) described the symptoms of stress as lack of emotional stability, decreased coping, sleep disturbances, physical symptoms, hyperarousal, and other biological factors negatively influencing decision-making, productivity, and outcomes.

**Violence**

Violence is commonplace in ED. Angland, Dowling and Casey (2014) asked the simple question: what causes violence in the ED? The research provided by Angland, Dowling, and Case provided information related to who and what fosters or exacerbates violent behaviors. Specific variables included males 20-30 years of age, inadequate

staffing, long wait times, poor security, alcohol and drugs, lack of communication, and a sense of being undervalued as a profession. Imagine being greeted by an angry patient who has waited six hours for entry into the ED for a finger laceration. The patient does not know or care that the nurse is caring for nine other patients, involved with a sick dying patient, or worked for six hours without a break.

The system problems such as delays, inadequate staffing, and overcrowding compound an already existing and underlying propensity for stress, violence, and frustration. The confrontations, lack of situational control, anger, and other negative interactions cause the ED RNs to feel demoralized. Increased demoralization leads to decreased satisfaction and exhaustion. A follow-up research ethnographic review of ED staff was provided by Lau, May, and Wiechula (2012) provided an ethnographic review describing violence and the resultant staff stress to this violence. Coletti et al. (2012) also addressed issues related to lateral violence and bullying. This violence between or to other staff represents stressors that increase dissatisfaction and a sense of belonging. Lateral violence now pits a nurse or nurses against one another or other healthcare providers in an environment of increased stress, decreased satisfaction, and low self-esteem. A nursing shortage exists, and nurses are making the work environment more stressful secondary to individual needs remaining unmet, a lack of fulfillment, dissatisfaction, and frustration. This lateral violence supports a negative work culture and does nothing to improve satisfaction.

**Overcrowding**

Schmitz and Tull (2012) discussed the impact or unknown impact of the Affordable Care Act (Obamacare) on healthcare and particularly on the ED. Healthcare currently accounts for 17% of the gross domestic product (Schmitz & Tull, 2012). ED overcrowding effects 114 million patients annually (Johnson & Winkelman, 2011). The demand for healthcare services exceeds the capability and capacity of the healthcare system. Hospital boarders (lack of inpatient beds), psychiatric overflow and lack of psychiatric beds for patients, decreased staff, and increased acuity provides a perfect environment for error, delays, death, disability, and negative outcomes. Johnson and Winkelman (2011) described negative outcomes as decreased satisfaction (pay-for-service impact), increased acuity, delay in medication administration, poor pain management, the increased length of stay, under-reporting of errors, falls, and other negative patient events, and too much paperwork.

Tekwani, Kerem, Mistry, Sayger, & Kulstad (2013) illustrated that ED overcrowding reduced patient and staff satisfaction, engagement, and increased nurse frustration. The nurses felt they could not provide safe, effective, and thorough care in an environment of overcrowding leading to compassion fatigue, increased illness, and decreased satisfaction. Fisman (2014) discussed the use of the ED as a primary care service. This factor attributes to the overcrowding. Healthcare providers are dealing with patients using the ED as their primary care providers deal with patients with poor follow up, lack of consistent care, and patients who are generally '*sicker*' when arriving in the department because of a lack of primary or preventative care. This '*sicker*' patient

includes those with uncontrolled chronic problems that are either untreated or inconsistently treated.

George and Evridki (2015) also researched the impact of overcrowding on patient outcomes and identified overcrowding as a negative factor influencing outcomes as well as patient and staff satisfaction. The research provided by McCarthy (2011) also showed that overcrowding produces negative patient outcomes. These outcomes range from minor issues such as pain management and extend into death or disability secondary to the nurses' inability to meet demand secondary to decreased staffing, lack of time/resources, and patient demands.

**Outcomes**

Sun et al. (2012) described poorer outcomes for patients in overcrowded EDs. These outcomes ranged from increased death and disability to medication errors, falls, and pain control. The outcomes also lead to increased patient complaints leading to increased stress among nurses or the cause and consequences of occupational stress in the ED (Adriaenessens, DeGucht, & Maes, 2015). Őzden et al. (2013) described stress as moral distress. Futility leads to negative patient outcomes and increased burnout. The increased burnout, in turn, leads to decreased satisfaction and emotional exhaustion.

Human resource and healthcare organizational leaders must develop programs to decrease the depersonalization of nurses and become more sensitive to the needs that negatively impact the sense of futility. Methods to increase satisfaction include developing programs to counsel, empower, and deal with the everyday work stressors

within the ED while striving to relax, engage, and promote a healthy work environment (Singh, 2013; Stathpoulou, Karanikola, Panagiotopoulou, & Papathanassoglou, 2011).

Educational levels influence patient outcomes. The nurses possessing baccalaureate degrees or higher provided safer care with improved outcomes (Waeckerle et al., 2001). Approximately 32.7% of ED nurses are Baccalaureate degree prepared with 22.6% having diplomas, 34.3% Associate degrees, and 10.2% Masters or Doctorate degrees (Waeckerle et al., 2001). Another factor influencing outcomes is shift work. Nurses described shift work, workload acuity, and lack of autonomy as key variables influencing satisfaction, which in turn influences outcomes (Adriaenessens, DeGucht, van der Doef, & Maes, 2011). Key predictors of outcomes included managerial interaction and support, work time, and rewards. ED nurses felt that time pressure to get things done and meet the work demands was a stressor that negatively impacted satisfaction.

Nurses also felt that they had lower decision authority, limited interactions with managers, and fewer rewards for work performed. These negatives influenced outcomes and productivity evidenced as exhaustion, somatic illnesses, and less happiness in the job performed (Johansen, 2014). Patient satisfaction scores show a direct relationship with the delivery of quality patient care as well as the satisfaction of the staff providing the care (Johansen, 2014). In a time when satisfied staff improves customer satisfaction, the focus remains on patient satisfaction and ignores staff satisfaction.

**Communication**

Communication plays a major role in the satisfaction and engagement of ED nurses. The flow of communication aids in decreasing compassion fatigue and burnout (Hunsaker et al., 2015). Recognition of stressors requires leaders to be aware of both verbal and non-verbal cues or communication. A staff member who acts out, is no longer dealing positively with patients, and is visibly stressed should have direct, positive, and therapeutic communication to determine their level or degree of stress. Managers and leaders must intercede with stress before the staff member decompensates, leaves, or responds inappropriately to a situation.

Verbal communication requires listening to coworkers, externalizing versus internalizing negative experiences, and promoting a healthy work environment. Non-verbal communication demands that leaders work with, observe, interpret, and identify staff needs, expectations, struggles, weaknesses, strengths, and barriers to providing safe care. Communication requires listening, interpretation, acknowledgment, feedback, and flow to be productive and efficient. Providing meaningful reward and recognition for work performed, methods of dealing with issues, and promoting healthy workplace relationships is imperative.

Open communication leads to a culture of safety (Jones, Podila, & Powers, 2013). Team members must communicate, collaborate, and work cohesively to prevent errors, reduce waste, and provide positive patient outcomes. Without effective communication work becomes isolated and workers sense working in a silo. The lack of communication also affords missed opportunities to provide improved care and better outcomes.

Teamwork training becomes an essential element in the ED. A collaborative hospital department or nursing unit in which nurses communicate, work as a team, and provide safe, efficient care is seen as a positive outcome of teamwork (Othman et al., 2013). Understanding the role each person plays in patient care aids in defining roles, determining needs, and collaborating to provide an improved patient experience (Wu et al., 2014).

**Coping Strategies**

Multiple research studies discussed individual nurse coping skills. Gholamzadeh, Sharif, and Rad (2011) outlined the sources of occupational stress among ED and admission nurses. The researchers described various stressors and importance of identifying the stress and working as a team to decrease stress to increase nurse satisfaction and improve patient outcomes. A close relationship develops between the ED nurse and other coworkers most notably the physician-nurse association (Ajeigbe, McNeese-Smith, Leach, & Phillips, 2013). A negative or stressful nurse-physician relationship seen through lack of autonomy, ill-defined communication, and limited teamwork also negatively influenced nurse satisfaction and engagement.

The nurses' felt a lack of autonomy and control over their practice as well as an altered perception of the role provided to the patient (Ajeigbe et al., 2013). The lack of cohesiveness, poor communication, and ill-equipped or dysfunctional teams also influenced satisfaction and turnover (Agezegin et al., 2014). The negative factors of dissatisfaction carry over into the everyday work environment leading to nurses seeking

other means to maintain a positive work life balance, even if this means leaving the current work environment.

The leader's ability to understand job stressors and provide a healthy work environment assisted employees to meet job demands by providing the psychological support required to promote well-being (Burke, Moodie, Dolan, & Fiksenbaum, 2012). Psychological well-being provided nurses with a positive work life balance, which enables them to better cope with the work environment. This coping assisted in providing an environment supporting the nurse and promoted satisfaction, self-actualization, and autonomy. The ability to cope with the day-to-day work grind also promoted a higher sense of organizational trust, justice, and commitment (Chen et al., 2015). As the nurse becomes more secure in their psychological well-being, work life balance, and emotional stability, they are more prepared to give back to the organization, the job, and to the team.

Another role in the coping structure requires that leaders understand, conceptualize, and communicate the strengths, weaknesses, opportunities, and threats of the current work environment. Considine et al. (2012) outlined redesigning strategies to meet increasing ED demands as a key factor for consideration focusing on overcrowding. Redesign requires understanding the current processes, structures, and workload to aid in making changes to streamline processes, redefine work, and reduce barriers to providing safe and efficient care in the ED. Bragard et al. (2015) discussed the quality of life issues associated with ED nurses. The workload, types of patients, violence, and other issues reflect strongly on productivity, outcomes, and satisfaction.

Dawson et al. (2014) also addressed nurse turnover, which correlated directly with the turnover of ED nurses. Beyond defining workload, Dawson et al. (2014) stressed the importance of '*growing*' the nursing workforce. Growing the staff provides meaningful opportunities for the current staff to expand their knowledge and become more skilled, educated, and engaged in the work performed. Davis et al. (2012) discussed the importance of enhancing RNs engagement and contribution through the advancement in clinical and professional competency development. This learning forms a direct connection to input into decision-making and policy development. The sense of engagement and satisfaction comes from this direct involvement and input (Duffield, Roche, Blay, & Stasa, 2011). The empowerment of nurses also provides opportunities for leaders to support and encourage satisfaction and engagement. Micromanagement and methods to undermine autonomy must be discouraged. ED nurses struggle to remain autonomous and empowered due to multiple reasons such as management styles, relationships with physicians, and overcrowding (DeVivo, Griffin, Donahue, & Fitzpatrick, 2013).

**Supervisor and Subordinate Relationship**

ED nurses described a sense of professional, self-concept, role conflict, and job satisfaction related to the relationship with the supervisor and manager (Sun et al., 2012). The nurse themselves torn between the job and the enjoyment of the care they provide. Sun et al. (2012) described nurses as caught in a cycle without progressing toward self-realization. The supervisor-to-subordinate relationship requires a connection to elicit nurse satisfaction. Similarly coupled with the supervisor-subordinate relationship is the

need for a strong coworker or team connection (Duffy, Avalos, & Dowling, 2015). The supervisor-subordinate relationship also perpetuates a sense of trust (Wilkinson, 2014). An awareness of the stressors impacting nursing staff is an important element of the supervisor-subordinate association. Understanding compassion fatigue and the root causes can assist in defusing, removing, or enhancing a positive work environment (Hunsaker et al., 2015). The need exists to promote a strong supervisor-subordinate relationship at all levels within the ED.

Lin et al. (2011) discussed a clear relationship between leader behaviors and unit performance. The leader behaviors affect employee work satisfaction. Employee work satisfaction influences the intent to remain. Task-oriented leadership styles produced less satisfied employees. Hu et al. (2015) discussed the factors directly influencing engagement of nurses in community hospitals. These factors included strong leadership styles coupled with a plan or program implementation, open lines of communication, input into decision-making, and clear lines of authority. Leaders using transformational leadership styles had a greater impact on subordinates. The transformational leader aided nurses by opening lines of communication, promoting and protecting autonomy, and providing feedback, reward, and recognition (Bamford, Wong, & Lachinger, 2013).

ED staff work to help patients. Unfortunately, stress plays a major role in the daily routine of nurses. ED nurses feel a sense of being unfulfilled and unable to do the work required in the allotted time (Sun et al., 2012). Overcrowding, demanding patients, poor outcomes, lack of support, and compassion fatigue produce negative responses to nurse satisfaction. The dissatisfaction leads to exhaustion, fatigue, and poorer outcomes

associated with lower productivity and caring (Adriaenessens et al., 2015). Wolf et al. (2015) described the moral distress in the ED as a burden carried by nurses with too many patients and not enough staff in an overcrowded, demanding work environment. Supervisors must acknowledge the factors causing the dissatisfaction and work collaboratively with staff to improve satisfaction. Developing programs to decrease stress, open communication, and provide feedback are essential to improve outcomes and productivity (Stathpoulou et al., 2011).

The literature review was narrowed and focused directly on ED RNs to better understand factors influencing this specific population and to tie a link between current literature, research questions, and my foundational theories of Herzberg, Vroom, Yetton, Maslow, Kahn, and Benner. Limited qualitative research existed relating to ED RNs satisfaction and engagement. The literature assessment provided minimal information focused on how and why nurses, specifically ED RNs, sense, perceive or describe factors influencing personal and professional satisfaction and engagement. These limitations necessitated a comprehensive assessment of qualitative and quantitative methods to determine the most effective method to obtain relevant, rich, and full information of the satisfaction and engagement.

## Methodology Overview

Quantitative and qualitative data differ primarily in the analytic objectives, types of questions posed, variations in data instruments, forms of data produced, and degree of flexibility in the study design (Arghode, 2012; Creswell, 2013). Quantitative methods are fairly inflexible using surveys or questionnaires and ask questions in the same order or

fashion seeking data that is measurable. Conversely, qualitative data looks to find meaning, description, and rich information from which to form generalizations about the information (Creswell, 2013; Cromby, 2012; Denzin & Lincoln, 2000).

The quantitative methodology uses closed-ended or fixed categories of questions and data causing inflexibility and allows meaningful comparisons of responses. Qualitative seeks to ask open-ended questions pursuing a deeper understanding to guide the researcher to ask further questions. Quantitative seeks to confirm hypotheses about the phenomena eliciting information or responses to questions in a structured manner and generating statistical assumptions and conditions (Ingham-Broomfield, 2015a, 2015b; Marshall & Rossman, 1995; Patton, 1990). Qualitative research methodologies search for the how and why answers and describes, illuminates, and defines the phenomenon.

Quantitative research calculates variation, predicts causal relationships, and describes the characteristics of a defined population (Sánchez-algarra & Anguerra, 2013). The results are numerical with a stable study design in which the participant responses do not influence questions. Quantitative data follows a closed-ended form with answers garnered from responses to a series of questions. Quantitative methodology is numerical using descriptive, inferential statistical data from specific questions or hypotheses (Swaminathan, Jahagirdar, & Kulkarni, 2014; Turner, Balmer, & Cloverdale, 2013). The primary advantage of the quantitative methodology is the use of a large sample with statistical validity to reflect the population while superficially providing an understanding of thoughts or feelings of the participant. Qualitative is narrative with an identified pattern or scheme of data covering a broad, thematic scope providing rich, in-depth

description. The primary disadvantage of qualitative research methods is the small sample size not generalizable to the population at large (Yilmaz, 2013; Yin, 2014).

Various categories of quantitative and qualitative methodology exist and choosing the most appropriate method required a deeper understanding of the methodologies and the relationships to the research questions and theories of Herzberg, Vroom, Yetton, Maslow, Benner, and Kahn. Through the careful evaluation of the benefits, limitations, and types of methodologies the focus centered on determining which specific methodology would provide reliable, accurate, transferable, and quality data regarding satisfaction and engagement.

**Quantitative**

Three types of quantitative methods, which included correlation, casual comparative/quasi-experimental, and true experiment, were assessed. Quantitative research focuses on making observations about something that is unknown, unexplored, or new (Creswell, 2013; Kisely & Kendall, 2011). To reach conclusions, the researcher investigates current theory about the issue, hypothesizes an explanation for those observations, makes predictions, and formulates a plan to test (Creswell, 2013). The researcher collects and processes data, verifies findings, and makes or draws conclusions from the statistical data (Creswell, 2013; DeLyser & Sui, 2014; Yilmaz, 2013).

**Correlation research.** Correlation research attempts to determine the extent of the relationship between two or more variables using statistical data. Relationships are determined to recognize patterns, establish cause and effect, and data relationships (Creswell, 2013; Ingham-Broomfield, 2015a). No variable manipulation occurs. An

identification of study groups ensues leading to comparisons to other groups. Correlation research seeks to determine the relationship between and among the facts to recognize trends in the data (Denzin & Lincoln, 2000). Correlation research does not determine cause and effect between the variables and determines the nature of the variable relationships. Correlations do not imply cause but do allow for making weak causal inferences about the data (Ingham-Broomfield, 2015a).

***Rationale for decision***. Satisfaction and engagement are complex. This complexity exposes multiple variables, which could be used to compare and contrast variables. The literature review provided numerous examples of quantitative assessment of variables influencing satisfaction and engagement. Identified gaps identified in the qualitative expressions and variable explanations of ED RNs beliefs and perceptions related to satisfaction and engagement. No surveys or questionnaires were planned; therefore, correlation research will not be used for this study.

**Causal comparative/quasi-experimental research.** Causal-comparative/quasi-experimental research works to establish cause-effect relationships among the variables. Cause and effect are found through the systematic manipulation of one variable (independent) and observation and assessment of effect on a second (dependent) variable (Creswell, 2013; Pluye, 2013). In causal-comparative methodology, the research uses groups that are naturally formed or pre-existing. Causal comparative/quasi-experimental research is similar to true experiment research with a difference in variable manipulation (Creswell, 2013; Pluye, 2013).

***Rationale for decision.*** The variables influencing satisfaction and engagement are interrelated on some levels and unrelated to other levels. The literature review described the relationship of variables in quantitative studies. No manipulation of variables will occur. Causal comparative/quasi-experimental research would not provide the essential information on how and why ED RNs describe, perceive, or believe specific factors influencing satisfaction and engagement and would not provide the description, insight, and specifics related to these phenomena.

**True experiment research.** The last type of quantitative method assessed was the true experiment methodology. True experiment, viewed as a laboratory study, strives to identify and control all variables except for an independent variable manipulation to determine the effects on the dependent variables (Creswell, 2013; Yilmaz, 2013). Subjects are randomly assigned, rather than identified by pre-existing group or naturally occurring groups.

***Rationale for decision*.** The true experimental research methodology would not fit the criteria defined in the research purpose and research questions. The true experiment will provide a too rigid foundation, which would not provide the rich, in-depth quality of information to define, describe, and outline why ED RNs are satisfied, dissatisfied, engaged, or disengaged. Since no quantitative methodology provided an adequate match to the purpose and research questions, qualitative methodologies were reviewed.

**Qualitative**

Qualitative research focuses on understanding a target audience, perceptions, beliefs, or knowledge of a specific event, topic, circumstance, or phenomenon from a

real-world perspective. The results are descriptive rather than predictive (Creswell, 2013; Patton, 1990; Yin, 2014). Qualitative research developed in the social sciences and focuses on behaviors, ideals, or events creating a synergy between the researcher and the subjects being interviewed or observed (Farokhzadian, Nayeri, & Borhani, 2015). The dynamic energy created through the interview or group discussions engages participants to tell their story, qualify thoughts, observations, and discussions. The interviews and discussions probe deeper looking beyond words to discover the individual's beliefs and perceptions (Ahram, 2013; Arghode, 2012; Creswell, 2013; Lee & Maerz, 2015; Yin, 2014). Qualitative research uses a more flexible and iterative style to elicit and categorize question responses (Guercini, 2014). Qualitative uses semi-structured methods to garner data such as in-depth interviews, focus groups, observation, field notes, and participant observation (Creswell, 2013; Janesick, 2004; Karlsen, 2014; Yin, 2014).

Qualitative research also provides opportunities to observe, record, and interpret non-verbal behaviors related to the participant's feedback seeking to describe variation, explain relationships, individual relationships, and group norms (Poortman & Schildkamp, 2012). The qualitative data is textual while being obtained through audiotapes, transcripts, or field notes. Different from quantitative data that seeks to answer questions in a formal, scripted manner. qualitative seeks to determine how participant answers affect how and which questions the research will ask next to search or attain the fullest description of the sought meaning or information (Karlsen, 2014; Merriam, 2014). This feedback provides a deeper and fuller explanation for the analysis, synthesis, and comparison of the transcribed texts and information. Qualitative research

provides a complex textual description of how individuals experience a specific research issue and provide information about the human side of the investigated phenomenon (Creswell, 2013; Merriam, 2014; Taylor & Bogdan, 1984; Yin, 2014). Qualitative research aids in expressing contradictory behaviors, beliefs, opinions, emotions, and relationships among the participants in the research (Cromby, 2012). The qualitative methodology is effective in identifying intangible factors such as social norms and gender, ethnic, or religious factors occurring within the phenomenon studied (Yin, 2014).

Qualitative research design requires that the researcher "dwell with the subjects' descriptions in quiet contemplation" (Parse, Coyne, & Smith, 1985, p. 5) trying to uncover the meaning of the lived experience; searching to develop themes and patterns from the data. By dwelling in the subject descriptions, the researcher delves into the soft or emotional, feeling, or personal dynamics of the phenomenon. The personal aspects aid in focusing the research questions toward gaining the most complete or fullest explanation of the event or phenomenon. In deciding upon the correct methodology for my research, I investigated and reviewed seven common qualitative designs of phenomenological, ethnographic, grounded theory, descriptive, case study, narrative, and historical methodologies (Creswell, 2013; Yin, 2014). The methodologies were compared and contrasted to determine which method would most fittingly provide insight into how and why ED RNs view satisfaction and engagement in the workplace.

**Phenomenology.** Phenomenological qualitative methodology examines the human experiences through descriptions provided by the individuals involved in the phenomenon or what is more commonly known as the lived experiences of the

individual(s) (Yin, 2014). Phenomenology uses description to determine the meanings of individual experiences when little knowledge exists about the phenomenon or event. Participants describe or write about experiences directly from their unique vantage point. The researcher brackets information (what the researcher expects to discover and deliberately puts aside) to see the phenomenon as clearly as possible through the eyes of the person who has lived or is living the experience. Phenomenology asks questions to determine commonalities of the experiences and seeks to understand the participant's experiences (Creswell, 2013; Patton, 1990; Merriam, 2014; Yin, 2014).

***Rationale for decision.*** During the initial preparation phases of my dissertation, phenomenology was the planned methodology. However, after careful discussion with the mentor/dissertation chair, Dr. Joseph Barbeau, and literature review analysis phenomenology was determined would not provide or garner new insight into the phenomenon of satisfaction and engagement. Phenomenology would not provide the type or quality of data based on my research questions, theoretical/conceptual foundations, and literature review. The lack of uniqueness of satisfaction and engagement insight would not provide relevant information to warrant using phenomenology as my primary research methodology.

**Ethnographic studies.** Ethnography involves the collection and analysis of data about cultural groups. The methodology focuses on making sense of another world, culture, or phenomenon (Creswell, 2013; Yin, 2014). The methodology allows the reader to learn something from people through a systematic process of observing, documenting and analyzing the lifestyles, cultures, or patterns of behaviors in better understand the

person in their familiar environment. The ethnographic researcher frequently lives with the people and becomes part of the culture exploring the rituals and customs of the group (Arghode, 2012). The researcher brackets their ideas and sets aside preconceived personal biases and beliefs to understand the individual, group, or personal social situation (Janesick, 2004). Data collection and analysis transpire simultaneously seeking to understand and develop cultural theories.

***Rationale for decision***. Hospital experiences are unique to individuals, workers, and events (stressful times or the worst times of an individual's life) Each department has a uniqueness focusing on type of care provided, systematic responses to events, and expectations of the consumers. I understood that the ED may be construed as a culture unto itself and further appreciated that ethnography could look at the traditional experiences and ED phenomenon but determined that ethnographic methodology did not fit the basic foundation of my research questions and theoretical framework. Ethnographic studies try to make sense of another world, culture, or phenomenon. Satisfaction and engagement within a healthcare organization is not another world, culture, or phenomenon. The final determination was that phenomenology would not provide adequate information for the research study.

**Grounded theory.** Grounded theory is a qualitative research approach developed to collect data, analyze the date, and then develop a theory that is grounded in the data. Grounded theory uses both inductive and deductive approach to theory development (Creswell, 2013; Yin, 2014). Theory generation becomes more important than theory testing. Grounded theory is an excellent method for understanding the processes that

occur in a phenomenon (Yin, 2014). Grounded theory aids in identifying concepts and making similar associations through literature analysis. The grounded theory looks to discover patterns in social life. Grounded theory develops throughout the process rather than testing hypotheses (Creswell, 2013; Yin, 2014).

***Rationale for decision.*** Grounded theory seeks to understand individual thoughts, ideas, and perceptions within an environment. The proposed research study focuses on an established environment, the ED, and to established elements influencing satisfaction and engagement. The grounded theory describes a methodology not acceptable or appropriate for the proposed research study.

**Historical studies.** Historical studies focus on the identification, location, evaluation, and synthesis of past data to examine the roots of the issues, concerns, or phenomenon (Creswell, 2013; Merriam, 2014). Historical data includes documents, relics, or artifacts described as primary or secondary sources (Yin, 2014). Primary sources provide firsthand or direct evidence of the history or historical event. Secondary sources provide information that has passed through a variety of sources and includes first-hand accounts recorded by an observer or in communication to another person. Primary sources include oral histories, written documents, diaries, eyewitness accounts, pictures, and physical evidence. Historical research data should be evaluated thoroughly for external criticism (concerned with the authenticity of the data and helps establishes reliability) and internal criticism (establishes the validity of the data). Historical qualitative research studies events from the past using an examination of previous experiences, interpretation of documents, artifacts, and prior information (Creswell,

2013; Guercini, 2014). The confidence in conclusions is limited since the analysis draws inferences from the past and conclusions about causation are suggestive and lack reliability, credibility, or validity.

***Rationale for decision.*** No relics, documents, or artifacts to review that would provide insight or relevant information about nurse satisfaction and engagement and this qualitative methodology was determined not to be suitable for the research.

**Descriptive research.** Descriptive research strives to explain a current status of an identified variable or phenomenon. Descriptive research does not generally begin with a hypothesis. The hypothesis generally develops after collection, analysis, and synthesis of data to prove the hypothesis. The hypothesis develops as the data is collected and analyzed and does not begin with a predetermined postulation (Creswell, 2013). This type of research relies on descriptive statistics, which in turn summarizes and gives an order to the measurements made. The goal becomes one of observing, describing, and documenting the phenomenon in the current state without manipulating variables (Creswell, 2013). Descriptive research frequently serves as a springboard to other forms of research methodology.

***Rationale for decision*.** The research questions focus on determining how and why ED RNs believe, perceive, or acknowledge factors influencing personal satisfaction and engagement. Descriptive quantitative research would describe these factors but would not provide the detailed, rich explanation, description, or narration of the information I seek to discover through the research study Descriptive research was determined not suitable for this study.

**Narrative.** The narrative qualitative methodology includes the text or discourse of stories told (Creswell, 2013; Merriam, 2014; Yin, 2014). The researcher pursues obtaining information about the lived experiences as told through re-storying seen in biographies, autobiographies, histories, or examinations of the lived phenomenon (Janesick, 2004). The narrative tells the story in the words of the speaker with emphasis placed on the research questions and the primary focus or purpose of the research study (Creswell, 2013; Yin, 2014). Narratives express experiences as written or spoken text accounting for the events through a connection or interaction of the varied aspects of the phenomenon. The analysis develops from interpretations of the written or recorded experiences of another developing a storyline that provides an interaction, continuity of the event, and describes the situation or event in terms that are understandable and relevant.

***Rationale for decision*.** The narrative methodology plays a secondary role in answering the research questions and provides valuable information for coding. Narrative is too self-limiting and too focused to gain a full appreciation of the factors influencing satisfaction and engagement. Narrative will not provide adequate saturation or quantity of information required to understand the complex phenomenon of satisfaction and engagement. Narrative will not provide the rich, thick descriptions being sought to understand satisfaction and engagement.

**Case studies.** Case studies are an in-depth examination of people or groups of individuals, institutions, events, or phenomenon and are rooted in society (Merriam, 2014; Pfeffer & Rogalin, 2012; Yin, 2014). Case studies strive to answer the questions of

how and what occurred within the confines of the bounded case (Yin, 2014). The researcher is interested in the meaning of the individuals themselves and how and what these individuals feel, observe, or sense as specific components of the studied phenomenon (Radley & Chamberlain, 2012; Sandelowski, 2011). Seeking meaning rather than generalizations becomes the main focus of case study research (Denzin & Lincoln, 2017). Case study provides opportunities to formalize knowledge related to what the individual voices or illustrates during the research (Benner, 2001). Questionnaires, interviews, observations, written accounts, or diaries are data sources. The content analysis provides the foundation of themes or patterns to express the comparison and relationship between subjects and materials provided to the researcher (Yin, 2014). Case study requires the researcher to select subjects who will respond truthfully and provide unbiased, diverse, and individualized information (Stake, 2001; Yin, 2014). Case studies are time-consuming and can be costly. Content analysis provides an examination of the communication messages obtained during the case studies.

***Rationale for decision.*** After examining the qualitative methodologies, case study fit my research focus and research questions. Case study provides opportunities to obtain thick, rich, in-depth information from multiple sources to establish credibility, reliability, and validity of what ED RNs believe, state, and perceive as factors influencing satisfaction and engagement. The multiple case study methodology provides opportunities to gain insight from multiple participants with varying degrees of expertise as a nurse, ED RNs, and within generational cohorts. This information provides a spectrum of views, opinions, and observations. This quality and quantity of data provides

ample opportunities to modify interview questions, expand the number of interviews, and reach saturation of data related to satisfaction and engagement.

Case study allows for the subjective assessment of the human creation of meaning (Yin, 2014). Yin (2014) described the creation within a social construct enabling individuals to tell a story. The underlying attributes of case study include a focus on studying how and why, the lack of subject behavior manipulation, the attention to contextual conditions, and understanding a lack of boundaries between the phenomenon and context (Stake, 2001; Yin, 2014). The use of case study allows me to bind the case by time and place, time and activity, or definition and context searching for reasonable results within this scope (Yin, 2014).

Yin (2014) described explanatory, exploratory, descriptive, and multiple case types of case studies. Explanatory case study seeks to explain the causal links in real life regarding a phenomenon considered too complex to understand through simple survey or questions. These real-life interventions are complex, and a survey or experiment would not provide adequate information or context to describe or explain the phenomenon. Exploratory case study seeks to explore a situation where an intervention has occurred and is searching to discover meaning or understanding of the phenomenon. Descriptive case studies describe an intervention or phenomenon within the existing real-life context. Yin (2014) also described multiple case studies. The multiple case study enables the exploration of differences within and between cases seeking to replicate findings across cases. Multiple case study requires careful choice of participants to ensure comparisons, similarities, and predict any contrasting results based on theory.

Stake (2001) outlined intrinsic, instrumental, and collective case studies as mechanisms to gain fuller, in-depth understanding of the phenomenon. An intrinsic case study requires a genuine interest by the researcher with an overall intent of better understanding the case and phenomenon. The case itself is the interest and is not related to other cases, particular attributes, or circumstances. Instrumental case study seeks to understand something other than a particular situation or phenomenon. The case becomes the instrument to refine a theory or secondary interest of the research. Instrumental case research requires an in-depth focus, scrutiny of contents, and detailed description of events, occurrences, or circumstances. Instrumental research allows the researcher to pursue the external interest of the case. Collective case study attributes are similar to multiple case study and allow meaningful comparisons, contrasts, and analysis of multiple cases using similar participants. Determining what research methodology would provide the most useful and relevant information to answer my research questions and to establish a connection with existing literature proved to be a meaningful personal experience. The information reviewed provided information from the review, analysis, and synthesis leading to the choice of multiple case study as the foundation for the research study.

## Summary and Conclusions

Satisfaction and engagement are broad, complex terms as evidenced by the literature review. The primary focus of my dissertation is to identify the key factors that influence ED RNs satisfaction and engagement in a healthcare environment that is in a state of disorder and confusion. Factors influencing individual satisfaction and

engagement include external elements such as an aging nursing workforce, generational differences, value-based purchasing, and increasing numbers of individuals seeking healthcare. Using the theoretical foundations of Herzberg, Vroom, Yetton, Maslow, Kahn, and Benner the literature was assessed focusing on the satisfaction elements of systems and leadership, resource, teamwork, direct management, and self, job, and organizational engagement. Unfortunately, no one theory contains all of the variables seen as essential for satisfaction and engagement. The literature analysis revealed a plethora of both subjective and objective elements viewed as essential for employee satisfaction and engagement. Herzberg determined that both objective and subjective variables influence employee satisfaction. Literature analysis also illustrated data that supported Vroom and Yetton's supposition that employees make specific choices that influence courses of action to maximize pleasure and minimize pain.

Positive elements required by employees included the need to grow and develop as a person and professional, the learning experience, and concepts of achievement, autonomy, and self-direction supported Maslow and Benner theories. The lack of autonomy leads to a less satisfied employee. Positive promoters of growth and development include input into decision-making, policy decisions, and frequent feedback. The sense of support coupled with the sense of autonomy promoted engagement not only of the individual but within teams and with the organizational mission, vision, and values. The literature reviewed also supported Kahn's premise that engagement required harnessing the organization's members to become cognitively, physically, and emotionally involved in the work performed. Successful production of engagement

requires a coupling between the employee and the organization. Employees require open lines of communication as well as an understanding of the expectations of the job performed. This coupling requires a cognitive awareness, a physical presence and usage, and an emotional tie with the job, team, and organization. The literature strongly supported open lines of communication, value congruence, organizational support, and organizational citizenship (Van Bogaert, Wouters, Willems, Mondelaers, & Clarke, 2013).

The use of the theory and concepts established for the literature review allowed personal control over the amount of literature reviewed focuses elements of satisfaction and engagement. A strong relationship exists between engagement and productivity. Without engagement, employees do not feel or sense the need to work harder because they have no value or benefit felt from work performed. The lack of engagement also limits the amount of organizational commitment or engagement seen in the employee. Disengaged employees do not work as individuals or in teams depending upon their interest, desire, or abilities. The more disengaged the employee becomes, the more they dread coming to work, do not do their jobs, disrupt work flow, or leave the job entirely. The commitment of the individual to the job, team, and organization is limited leading to decreased productivity and secondary dissatisfaction with the work performed.

The most distressing outcomes discovered in the literature review were the rampant depression, somatic illness, and absenteeism found with disengaged and dissatisfied employees. Similar messages, results, and findings supported strong communication, transformational leadership, input into decision-making, and autonomy

as essential to satisfaction and engagement. Through the review, I discovered that the physical, emotional, and psychological impact on individuals played a role in patient satisfaction and engagement. Normal or usual expressions of dissatisfaction and disengagement included compassion fatigue, compassion satisfaction, and burnout. Another negative outcome to employee work life balance included stress.

In a profession struggling to gain ground on the nursing shortage, opportunities to decrease stress through a variety of programs would be beneficial. If an organization's leaders can reduce stress, what impact would that have on retention and recruitment of new nurses and satisfaction and engagement of the existing nursing workforce? Additionally, how would stress reduction impact on productivity, improved engagement, and a sense of satisfaction? Coupled with stress are the physiologic outcomes of stress seen through depression, lack of ambition, and illness. The healthcare system is overcrowded, overworked, and stressed—another call-in, need to replace staff, and staff working with physical, mental, and cognitive issues could create detrimental outcomes and negative experiences for staff and patients.

Another key variable found throughout the literature review was the importance of an open, strong, and communicative superior-subordinate relationship. Employees have expectations of leaders. These expectations in many cases were simple and required no more than keeping employees informed of what is occurring within the department and organization. A fundamental component leading to increased engagement included how the leader approaches staff, work, and supports their staff. A primary component of engagement includes the need for trust. In general, when an employee does not trust a

leader, they will not fully engage for the leader thereby limiting the engagement on personal, team, or organizational levels.

The adage *produce or perish* is appropriate for the healthcare system. Today's healthcare system is competitive, fraught with opportunities for improvement, and reimbursement based on value-based purchasing. The literature illuminated that happy, engaged employees are more productive and customers have better outcomes when dealing with the engaged employee. The satisfied employees provide a positive pulse for the organization and tend to be more involved in the job, within teams, and illustrate a more cohesive employee-organizational fit (Lasater, Sloane, & Aiden, 2015). Productivity also provides happier customers, which in turn decreases complaints, disruptiveness, and employee morale.

Engaged employees play a more prominent role in the organization and become more involved as team members. Open lines of communication, feedback, support, and recognition all played a role in promoting this engagement (Lawrence, 2011). Teams worked for a common cause with employees feeling capable and free to discuss, communicate, and work when engaged. The leadership style promoting autonomy also allows this cohesiveness and freedom to exist adding a sense of accomplishment to the individuals' work. Autonomy plays a major role in how the employees viewed their involvement within the organization. If the employee felt empowered to work without being micromanaged or limited in their scope of practice, then the employee was more engaged and more productive. When given a more autonomous role the employee gained self-confidence and a sense of pride in the work performed.

Kahn's theory of engagement supports many of the elements analyzed as essential for employee engagement as an individual, within a team, and with the organization. Harnessing the employee's creativity, physical, cognitive, emotional, and physical abilities allow employees to become part of the work, team, and organization. The sense of belonging aids in providing a sense of security, positive work life balance, and opportunities to nurture and support personal and professional growth and development. The leader's ability to support, maintain trust, and provide timely, fair, and relevant communication also becomes imperative for employee engagement. When the employee is engaged, the role of work becomes positive. Engagement also promotes value congruence, fosters organizational support, and promotes organizational citizenship. Benner's theory of the stages of clinical competency also promotes engagement. If an employee cannot or does not have a sound foundation or frame of reference, then the employee will struggle to accomplish even basic work. The role of the leader in the development of the employee becomes imperative. To grow or foster engagement requires mentoring, leadership involvement, and support through communication, feedback, and education. Employees grow as they learn. The learning allows the employee to achieve successes but only if there is support, feedback, and communication.

The literature review of satisfaction was personally difficult to write. The word satisfaction had various meanings and connotations within the literature. The literature reviewed also used the word happiness interchangeably with satisfaction. Care was taken to differentiate the terms and understand that happiness does not reflect satisfaction or vice versa. After reviewing the literature, findings were divided into seven categories.

These included workplace culture, leadership, employee attitudes and feelings, burnout/compassion fatigue/compassion satisfaction, communication, training, and the nursing shortage. A strong connection exists between engagement, job performance, within the team, and at the organizational level. Teamwork, including open communication, freedom to express ideas, and autonomy fostered the engagement at all levels. The workplace culture also contributed strongly to the sense of engagement. Workplace culture requirements included a strong leadership staff and leaders willing to maintain inclusion, openness, trust, and communication. The communication aspect played a major role in the sense of satisfaction. Leaders who communicated directly, provided timely positive feedback, and gained as well as earned employee trust provided a sense of security or fit within the organization.

Leadership also included the leader's ability to direct without pressuring the employee, as well as '*sell*' the organizational goals, direction, and vision. If the leader was able to lead and not manage the employee, the outcomes were generally favorable to increase employee engagement. Leaders allowing for input into decision-making also provided ample opportunities for employees to become involved or engaged in the daily work, outcomes, and future of the organization. A leader who did not provide communication, was untrustworthy, did not provide support or feedback, and did not provide employee support fostered a negative environment leading to disengagement and limited employee participation.

Engagement and satisfaction are not a constant for each employee. Specific variables influence how an employee becomes or remains engaged and satisfied. For

example, a negative work life experience may challenge an engaged employee to remain engaged. Staff personalities and the mesh of those personalities influence employee engagement. Being left out of the conversation about a project, not being included in the decision-making, and losing trust or desire to participate also impact the employee's satisfaction. Work relationships are also challenging in a workplace environment. Negative relationships have negative outcomes on productivity and satisfaction and engagement (Keyko, 2014). A change in organizational structure, leadership, or processes can also negatively sway employee engagement or satisfaction. Leaders who are untrustworthy, poor communicators, uninvolved, provide a lack of structure, or as disconnected foster disengagement (Westphal et al., 2015). A clear connection occurs between leadership and employee engagement.

Burnout, compassion fatigue, and compassion satisfaction are serious factors influencing employee engagement, especially in the healthcare profession (Hooper, Craig, Janvrin, Wetsel, & Reimels, 2010). Kahn, Maslach, Saks, and Harter's theories outlined the foundation for the disengagement among employees. The stressors cause a prolonged and exaggerated response by the body leading to a multitude of somatic and other illnesses, symptoms, and problems. When employees are unable to deal with the stressors they are unable to become involved or engaged. The individual uses their responses to care for him/herself. The stressors outlined illustrated the need for leaders to provide feedback, understand the stress employees work within, and develop programs to destress, defuse, and decrease work place stress. The inability of individuals to care for patients effectively while dealing with stress presents a problem in the current healthcare

environment. Recognized problems included increased acuity, lack of staff, and limited leader support.

Another key factor influencing satisfaction and engagement is communication. The communication must occur between the subordinate and supervisor as well as between the team and the leader. When communication fails, employees share a sense of disengagement without a clear picture or plan for the work performed. How the organizational leaders define the mission of the organization, the expected outcomes, the proposed and accepted values, and the vision for the future also foster engagement. Ethical concerns also play a major role in engagement and satisfaction (Huang, You, & Tsai, 2012). Huang et al. (2012) also emphasized the importance of employee knowledge of what is currently happening within the organization and plans of the work, team, and organization.

A method to improve employee engagement and satisfaction is training. Employees require an understanding of what to do, how to perform duties, and how/when/where to ask questions and gain knowledge. Employee expectations are for clear direction, open communication, and support from leaders. Employee expectations also include expectations of training and job advancement to meet personal/job needs. As leaders foster individual growth and development, the sense of engagement also increases. Mentoring, training, and recognition required leadership input, individualized support, and monetary input to provide a valuable, relevant system of increasing professional development.

Both satisfaction and engagement require input from leaders and shared responsibility between leaders and employees. The organizational management team must support employees and recognize the needs, desires, and expectations of the workers. Leaders must also be transformational, interactive, and supportive. Another common theme is productivity and outcomes. If the culture does not support organizational citizenship, a positive organizational culture, and autonomy then satisfaction and engagement will be difficult to attain.

The environment, autonomy, staffing, outcomes, culture, attitudes, compassion fatigue, stress, violence, overcrowding, communication, coping, and supervisor-subordinate problems were key factors influencing ED RNs satisfaction and engagement. ED literature outlined a system of overcrowding, short staffing, and fatigued/exhausted staff. Violence directly impacts nurse satisfaction and engagement. ED design includes a set number of beds and space. The influx of uninsured, underinsured, newly retired Baby Boomers, and newly insured have compromised ED capability and capacity. Added to this lack of capacity is a lack of staff. Through the literature assessment and synthesis, information analyzed outlined tired staff, overcrowding, and violence leading to poorer outcomes and loss of staff. The research outlined the importance of developing new coping strategies to ensure the mental health of the nursing staff.

Chapter two includes an overview of current literature describing employee, healthcare, and ED staff satisfaction and engagement. The literature review tied the conceptual framework, theoretical foundation, and research questions to determine relevant information about factors influencing satisfaction and engagement. Keywords

were used to limit and define specific components of satisfaction and engagement. These keywords provided valuable information regarding challenges faced in today's healthcare system related to the nursing shortage, overcrowding, violence, and personal afflictions related to stress, compassion fatigue, and burnout. The literature review illustrated that there was limited qualitative data to explain, define, postulate, or expand upon the factors influencing ED RNs satisfaction and engagement. From this assessment, multiple case study qualitative research methodology was determined to provide the most appropriate method to determine how and why ED RNs believe, view, and interpret factors influencing satisfaction and engagement. Chapter three contains information outlining the research study design and methodology, population and sample, pilot study, data collection methods including interviews and describes the link between research questions and interview questions. Chapter three information defines the ethical considerations, professional and personal relationship between the researcher and participants, validity, reliability, and triangulation of research data.

# Chapter 3: Research Method

The research questions and current literature provided a foundation for this research study. The selection of the correct research method led to opportunities to tie the research questions with the current literature and establish the most appropriate methods to obtain meaningful data. The selection of the most appropriate research methodology provided opportunities to design the research plan and ensure completeness, credibility, reliability, and transferability of the data obtained during the research study (Athon, 2013). The focus of this research study was to listen to, synthesize, and better understand the beliefs, perceptions, and experiences of how and why specific factors influence personal satisfaction and engagement of ED RNs. The knowledge gained afforded valuable information to facilitate social change through system improvement and influence personal satisfaction and engagement of nurses and healthcare leaders (Copeland & Agosto, 2012; Kossivi, Xu, & Kalgora, 2016).

Healthcare leaders face multiple challenges to maintain adequate staffing and provide optimal, safe, cost effective, and consistent patient care (Agency for Healthcare Research and Quality, 2011). As the societal and institutional needs for healthcare services increase, the importance of safe staffing and ultimately safe patient care become paramount. Understanding and interpreting what nurses articulate as factors causing dissatisfaction or disengagement provides valuable information. The simple act of listening to employees is not a new concept in the field of management (Yin, 2014). Early theorists examined both hard and soft elements influencing an individual's satisfaction and engagement (Benner, 2001; Herzberg, 1966, 1976; Kahn, 1990; Maslow,

1999; Vroom, 1964, 1970; Vroom & Yetton, 1973). How these hard and soft elements influence employees and leaders plays a key role in satisfaction and engagement in the work place. These elements carry over into the relationship expectations between employee and employer as well as consumer and service provider.

Determining and understanding what influences nurses, who are consumers within the work environment, requires further investigation. Influencers include input into decision-making (consumer choices), teamwork (functionality within groups and individually), direct communication (from peers, leaders, and customers), respect (caring about the individual as a customer, provider, or combination of both), and organizational commitment seen as a sense of belonging, engagement, and interest (American Association of Critical Care Nurses, 2010). These principles will influence how organizational leadership communicates the institutional messages to staff and to the community, seeks to gain trust, and employs tools to influence how society or consumers view goods, services, and products (Janzen, Mitchell, Renton, Currie, & Nordstrom, 2015).

In January 2002, Verizon (2015) launched the now infamous *Can you hear me now?* advertising campaign. Verizon leaders understood the important role Verizon played and could continue to play in the new, rising market of telecommunications. Verizon had established a company with documented reliable and dependable coverage with a keen awareness that competition could easily change the company's advantage (Verizon, 2015). The leaders recognized the importance of maintaining the current market share as well as branding Verizon as the *'go to'* company. Verizon looked to

brand the company as a premium service provider and decrease the complexity of differentiating between brands of phones, cellular service, and telecommunication short- and long-term coverage plans.

Paul Marcarelli portrayed the technician wearing black horn-rimmed glasses and appeared in a variety of locations and situations speaking into his cell phone and asking the simple question *Can you hear me now?* The simplicity of the question and the underlying focus of the message was to ask consumers how satisfied and engaged they were with Verizon as a cell provider and to ensure individuals that Verizon heard and listened to the consumer. The simple acts of asking questions, seeking clarification, and observing reactions provided valuable insight for Verizon to modify, enhance, and upgrade systems to meet consumer demand. By using this simple marketing tool, Verizon decreased crossover turnover to other companies and rocketed the company into a leading manufacturer, service provider, and innovator in the telecommunications field. During the first year of the *Can you hear me now?* campaign, Verizon sales increased 10% with an increase from 37.5 million subscribers at the start of the campaign to 43.8 million within the kickoff year (Verizon, 2015).

Similarly, listening to, observing, and investigating how and why nurses feel, believe, or perceive satisfaction and engagement provides valuable information for healthcare leaders (Agar, 1980; Brady, 2011; Brinkman & Kvasle, 2015). Personal challenges included choosing the correct research methodology to obtain thorough, in-depth, relevant, and rich data about ED RNs satisfaction and engagement. The choice required investigation of methodologies and determining which methodology best

explored, described, and clarified the perceptions, observations, and beliefs of ED RNs on how and why specific factors influence satisfaction and engagement.

In Chapter 1, I provided an overview of the problems facing healthcare leaders specifically pertaining to the nursing shortage. Current elements influencing the nursing shortage include an aging nursing workforce, value-based purchasing, generational differences, and expanded use of healthcare resources (Atchison, 2014; Cogin, 2012; Dotson et al., 2013; Hussain et al., 2012). The nursing shortage has created challenges to leaders seeking to provide adequate, safe staffing to care for patients. Hospital leaders are challenged to motivate, satisfy, and engage nurses while maintaining fiscal solvency and customer satisfaction. They are striving to retain and recruit nurses to meet the demand for healthcare services (McGlynn et al., 2012; Kooker & Kamikawa, 2011). Determining and focusing on what satisfies and engages nurses becomes essential to improve current working environments, promote opportunities to increase satisfaction and engagement with current working nurses, and to foster an environment to entice individuals to join the nursing profession.

In an effort to answer the research questions, determining the most suitable and appropriate methodology to obtain a full, broad, and in-depth understanding of ED RNs satisfaction and engagement was essential. This chapter includes the rationale for study methodology selection, the study design, methods of data collection, and data analysis plan to ensure adequate collection and scrutiny of data in order to answer the research questions and establish study validity. The purpose of the study was to concentrate on

determining how and why nurses perceive, believe, and feel specific factors that influence personal satisfaction and engagement.

## Research Design and Rationale

Qualitative case study was selected to address the research questions. The subjects of study for this project were ED RNs. The qualitative case study approach allowed for questioning to obtain a holistic view of ED RNs views, beliefs, and perceptions of factors influencing job satisfaction and engagement. This design provided time to ask questions of RNs about their work environments, to probe for insight into why RNs perceive specific factors as influencing satisfaction and engagement, and to obtain data saturation after assessment, interpretation, and analysis. A qualitative case study design provided opportunities to collect data from ED RNs in their natural work environments. Qualitative case study requires dedicated time and effort to the labor intensive and time-consuming enterprise of interviewing and observing individuals. Qualitative case study also provided large amounts of information requiring categorization and theme development. Relationships and patterns aided in identifying specific aspects of the case in a holistic, interpretive, and empirical manner.

The underlying attributes of case study include a focus on studying *how* and *why*, an absence of subject behavior manipulation, attention to contextual conditions, and understanding a lack of boundaries between the phenomenon and context (Yin, 2014; Stake, 2001). Case study provides a mechanism to bind the case by time and place, time and activity, or definition and context in a search for reasonable results within this study

scope (Yin, 2014). Focusing on ED RNs provided me a bonded case within a specific scope of practice.

The rationale for selecting a qualitative case study was to describe the concepts of satisfaction and engagement in broad philosophical terms (Creswell, 2013; Yin, 2014). The concepts of satisfaction and engagement are abstract and encompass personal descriptors of an individuals' perceptions, beliefs, and attitudes toward their environment and role within that environment. Each perception or belief defines the individuals' sense of how they are treated, perceive a connection, feel included, or lack input into decision-making. The case study approach provided opportunities to ask questions specific to the individuals' perceived level or degree of satisfaction and engagement. The case study approach provided for direct information on the lived experience of the ED RN. The focus was on individuals and how the individuals sensed their role within the system.

## Role of the Researcher

The researcher is the primary research tool in qualitative research (Merriam, 2014; Yin, 2014). Case study provides opportunities to conduct individual interviews. The researcher assumes an active role as the interviewer. Secondary to my background in nursing and primary role as an ED RN, I anticipated challenges to the interview process requiring concentrated efforts to prevent bias or misinterpretation of information. These efforts included a focus on listening, observing, and sensing the environment without making judgments, comparisons, interpretations, or assumptions based on prior experiences (Adler & Adler, 1987; Agar, 1980; Seidman, 2012). This conscious personal shift toward an unbiased assessment of the interview experience enhanced my abilities to

more clearly understand and interpret what motivates and influences personal satisfaction and engagement (Barth & Thomas, 2012; DeWalt & DeWalt, 2002). This focus afforded opportunities to ask questions within the real-world ED environment.

Observation during the interview process provided a useful tool to describe the ED RNs reactions, facial expressions, and nonverbal information during interview questioning. Observation, when coupled with narrative assessment and analysis, added to the holistic overview of the ED RN. Merriam (2014) called the participation "schizophrenic activity" (p.103) because the researcher participates to a point where observation and analyzing can be done without altering the true meaning of the event or observation. The quality of observations was dependent upon personal skills, limitations, and abilities to listen, understand, interpret, and analyze the observations (Creswell, 2013; Janesick, 2004; Kisely & Kendall, 2011). The primary goal was to create accurate observation without imposing preconceived ideas and allow information to emerge through careful listening, attention to detail, and validation of data.

The role of the researcher is also important in the interview process. As the primary data collection tool, researchers use their senses, skills, knowledge, expertise, background, and abilities to guide the interview process, assist the participant in answering open-ended questions, and delve into the thoughts, ideas, perceptions, and beliefs of the individual (Rosengren, 2018). The ability to formulate questions, garner answers, lead the individual to a fuller awareness, weave the communication together with theory and research questions, and formulate an in-depth analysis of the written, spoken, or visualized word became the primary focus of a skilled interviewer (Janesick,

2004). During the interviews, a safe, quiet, comfortable environment was provided to ease any concerns or fears of the participant. Active and reflective listening techniques allowed initial questioning, clarification, maintaining open lines of communication, and delving deeper into questions.

## Methodology

The methodology included a pilot study (using three RNs) and interviews of 21 ED RNs. The pilot study provided opportunities for enhancement and refinement edification of the interview questions. The interviews provided a method to obtain and discuss specific data related to factors influencing personal and professional satisfaction and engagement (Hancock & Algozzine, 2011). The interviews required an environment conducive to asking subjective and objective questions in order to obtain thick, rich, quality information from participants. Yin (2014) described the importance of asking questions, using pilot studies, and clarifying participant responses.

The interview offered an opportunity to observe the RN during the interviews, test the research questions to ensure that the data obtained during the interviews was thorough, clear, and concise. The relationship between the researcher and participant also is often less formal in qualitative than quantitative research and provides opportunities for the answers to be more elaborate and in greater detail than those found from tailor-made or quantitative questions (Creswell, 2013; Merriam, 2014; Patton, 1990; Yin, 2014). This openness allows participants to answer in their own words, rather than forcing a choice to fixed responses (Hancock & Algozzine, 2011). This openness also allows opportunities to respond in meaningful and culturally relevant ways, which are rich and explanatory in

nature, requiring careful listening and engagement to probe the deeper meaning of responses (Janesick, 2004; Merriam, 2014; Yin, 2014).

Interviewing afforded chances to obtain relevant information specific to the RNs beliefs, perceptions, and thoughts regarding satisfaction and engagement for three distinct generational cohorts. These cohorts included Baby Boomer, Generation X, and Millennial RNs. The data collected provided opportunities to compare and contrast differences in generational cohort needs, expectations, and influencers of satisfaction and engagement. The collection of data related to tenure as a RN and as an ED RN offered glimpses of differences or sameness in factors influencing satisfaction and engagement.

## Participant Selection Logic

The research methodology employed interviewing as the main means of collecting information about ED RNs satisfaction and engagement. Interview data was collected using purposive sampling (Gelshorn, 2012). The interview candidates were chosen from three hospitals. The initial sample size was 24 RNs with three of the 24 individuals serving as the pilot study participants. Data was reviewed, and a constant comparative analysis was made throughout the data collection. Each interview used a semi-structured interview format. ED RN selection centered on similarity of work environments, patient exposures, and work performed. The selected participants included a cross section of ED RNs with varying degrees of nursing and ED experience and within three generational cohorts. Work cohorts included RNs with minimal (less than 2 years), moderate (3-5 years), and maximum (6 years or greater) experience as an RN and within the ED. The generational cohorts included Baby Boomer (1946-1964), Generation X

(1965-1980), and Millennials (1977-1994) (Twenge et al., 2012). The information obtained provided a wider range of insight from individuals with varying degrees of experience and tenure. Participants were chosen based on personal interpretation and analysis of the ability of the RNs to be open, honest, and candid about their experiences in the ED.

The 21 participants for the study represented three generational cohorts and degrees of nursing and Emergency Nurse experience. To gather information from a wide frame of reference I interviewed

- Five ED RNs Millennials with less than 2 years of ED experience with two RNs from the critical care access hospital, two RNs from the mid-size regional medical center, and three RNs from the teaching hospital,
- Eight ED RNs Generation X with three to five years of ED experience with two RNs from the critical care access hospital, two RNs from the mid-size regional medical center, and three RNs from the teaching hospital, and
- Eight ED RNs Baby Boomers with greater than six years of ED experience with from two RNs the critical care access hospital, two RNs from the mid-size regional medical center, and three RNs from the teaching hospital.

## Pilot Study

A pilot study including three ED RNs was conducted to finalize the interview questions. The pilot study aided in clarifying, defining, and framing the interview questions to obtain clear, concise, and relevant data from the interviews. The pilot study process included:

- development of a pilot study operations plan;
- selection of three ED RNs (one Baby Boomer, one Generation X, and one Millennial RN);
- providing interview questions;
- scheduling of interviews;
- providing research study information fact sheet;
- participating in the one-on-one interview process asking, probing, and determining methods to improve, clarify, and establish interview questions which further define satisfaction and engagement;
- recording interviews;
- taking detailed pilot study interview notes;
- transcribing interview data;
- member checking interview data;
- modifying interview questions;
- telephone follow-up interview;
- reschedule of interviews with pilot study participants; and
- finalization of interview question for use with remaining 21 participants.

Required resources included the interviewer, pilot study interview participants, interview questions, recorder, consent form, written transcripts, member checks, and finalized research questions for the remaining interviews.

## Procedures for Recruitment, Participation, and Data Collection

The study's source of data collection, interviews, offered a complimentary perspective on satisfaction and engagement among ED RNs. Interviews provided a primary data source asking questions to help define, refine, and establish consistency, reflection, and appropriateness of participant responses. The interview approach coupled with member checking assisted to maximize available information, establish trustworthiness, and form the basis to triangulate the data. The combination of data sources aided to remove single source disadvantages of lack of clarity, information, bias, and other factors influencing reliability, validity, and confidence in the research data obtained. The data when used in combination provided opportunities to gain different perspectives from individuals and discover themes, patterns, and inferences related to theory. All interviews occurred outside of healthcare facilities.

Partnering hospitals included three hospitals within the Hospital U healthcare network and included the flagship University teaching hospital (Hospital U), Hospital C, a mid-sized healthcare facility, and Hospital E, a critical access hospital.

### Hospital U

The Hospital U is a 419-bed tertiary care referral center, Level I trauma center, and provides oversight of a five-hospital network to provide coordinated, quality, cost effective, and efficient care. Hospital U functions within a larger organization with 30 patient care sites, 100 outreach clinics, and four campuses providing services to over 1 million residents of Vermont and New York. Hospital U serves as the regional tertiary care referral center for children (the Children's Hospital), cancer treatment, and

institutional research activities through the Hospital U College of Medicine and Surgery department. Hospital U Medical Center ED treats 65,000 patients annually in a 45-bed ED

**Hospital C**

Hospital C has 341 beds and serves as a regional referral center for four counties in New York. Hospital C provides services to over 150,000 residents of 3 supporting counties as a full-service provider of critical care, medical, surgical, pediatric, oncology, and other specialty services. Critically ill and injured patients are referred to the tertiary care center at Hospital U including all open-heart patients, pediatric critical care patients, and other patients requiring specialized care from the regional referral university hospital. The 26-bed ED has an annual volume of 50,000 patients.

**Hospital E**

Hospital E is a critical access hospital serving as a stabilization hospital for critically ill and injured patients. Hospital E operates 25 beds used for medical, surgical, swing bed patients, and patients awaiting nursing home or long-term placement. To maintain critical access status, the hospital must provide 24-hour emergency services, have less than 25 licensed beds, be a part of the state rural healthcare network, and be located greater than 25 miles from a tertiary referral or larger hospital able to provide advanced patient care. The Hospital U health network provides basic and intermediate care and provides services to transport ill and injured patients to either Hospital C or Hospital U. The ED at Hospital E has approximately 5000 visits annually in an established six-bed unit.

## Personal and Professional Relationships with Participants

Participants included 24 ED RNs from three hospitals of varying sizes including generational cohorts of the Baby Boomer, Generation X, and Millennial age groups. Personal relationships with the ED RNs include a prior staff working relationship at Hospital C, a current staff position at Hospital U, and no relationship with Hospital E. No supervisory or seniority roles exist. No power or coercive relationships exist in these relationships. Inclusion criteria included

- licensed ED RN,
- greater than one-year ED RN experience,
- voluntary participant, and
- free to withdraw from participation at any time during the research study.

Exclusion criteria included:

- managerial or supervisory role,
- ED RN less than one-year experience, and
- involuntary participation.

A prestudy meeting provided opportunities to discuss with the nurse manager of each ED and explain the research, garner support for the research, address, questions and concerns, and to develop an action plan if potential issues or problems occurred during the research. The plan included open communication channels to address problems, and action plan to address any problems. The plan included a discussion with the nurse manager to address issues, follow-up with the IRB if protocol deviation occurred, and direct discussion with Walden IRB and Dissertation Committee members. The ethics of

undertaking a research study in an environment in which the researcher works or has worked required care to ensure confidentiality, the identification of conflicts of interest, power issues, and credibility. These efforts ensured a safe and secure method to observe and interview, and care to ensure that participants remain anonymous using de-identifiers (Seidman, 2012).

## Interviews

The overarching goal of the interview was to provide a well-constructed, well-organized collaboration between the researcher and participant(s) to obtain relevant, rich, in-depth information on a specific topic, belief, event, or phenomenon (Creswell, 2013; Merriam, 2014; Patton, 1990; Yin, 2014). Interview times ranged from 26 to 46 min. Planning included preparation for the interview, constructing effective, relevant interview questions, and the implementation of the interview process (Janesick, 2004; Patton, 1990; Webb, 2015; Yin, 2014). Two interview methods were used. The first choice was face-to-face interviews. Due to travel logistics and scheduling conflicts telephone interviews were also conducted. McNamara (2009) applied eight principles in preparing for a successful interview. The steps included:

- choosing a setting with little distraction;
- explaining the purpose of the interview,
- addressing the terms of confidentiality;
- explaining the format of the interview;
- indicating how long the interview usually takes;
- telling the participant how to get in touch with the interviewer;

- asking if the participant has any questions prior to the beginning of the interview; and
- using tools to write, record, or document the interview and not relying on memory to obtain credible, valid, and correct interview information.

The refined, clarified, and defined interview questions prepared after the pilot study provided opportunities for the study RNs to answer questions tied to the conceptual and theoretical framework of the study while providing thick, rich information regarding their beliefs, expectations, and feelings about ED RNs satisfaction and engagement. The process included:

- developing an interview operations plan;
- selection, contact, and consent of 21 ED RNs (mixture of Baby Boomers, Generation X, and Millennial RNs);
- scheduling of RNs interviews;
- interviewing of 21 RNs;
- recording of interviews;
- transcription of interview tapes;
- member checking of interview data;
- formalized completion of interview notes and data collection;
- hand coding;
- data entry into NVivo software;
- data analysis of interview data;
- comparison of interview and pilot study information; and

- evaluate for data saturation from data obtained in interviews.

Required resources for the interview phase of the research included the interviewer, RNs participants, research questions, recording of interview conversations and discussion, consent of individuals, written transcripts, member checks, data entry, analysis, and comparison of interview information.

**Demographic Data**

Collection of demographic data provided information regarding nursing and ED RNs experiences, level of education achieved, and generational cohort. Each interviewee was asked:

- last name
- first name
- hospital
- year of birth
- length of time as an RN
- length of time working in the ED
- education level (RN)
- generational Cohort (determined by age)
- interview date

Each interview was identified by initial of number, generational cohort, and hospital initial. For example, 3BBC or number 3, Baby Boomer, Hospital C.

The rationale for inclusion of this data was to provide broad categories of information for hand coding and entry into NVivo to assist in the development of pattern

identification and to visualize patterns from generational groups as well as obtain hospital specific information. For example, generational cohort information was separated and assessed for common themes or differences among the three generations. The demographics also provided opportunities to see differences/sameness within hospitals, ED work tenure, and nursing tenure.

## Link Between Research Questions and Interview Questions

Establishing a link between the theories, research questions, and interview questions was imperative. This relationship ensured that the framework (theory), research methodology (interviews), and research questions (information/inquiry) were cohesive and aligned with the interview questions. The horizontal axis represents the research questions while the vertical axis represents the interview questions and provided evidence of the connection between the overarching research questions, connection to theory components, and interview questions seeking to determine specific factors influencing employee satisfaction and engagement. Table 6 provides a vertical and horizontal axis outlining the link between research questions and interview questions. For the horizontal axis are the RQs.

Overarching RQ: How do ED RNs describe satisfaction, satisfiers, engagement, and disengagement in the professional work environment?

RQ1: What are the satisfiers and dissatisfiers identified by ED RNs as contributors to personal and professional satisfaction?

RQ2: What factors contribute to ED RN engagement at the personal, department, and organizational levels?

RQ3: How do hard and soft work elements such as direct management, teamwork, leaders, and resources influence nurse satisfaction and engagement?

RQ4: What emotional and psychological connections do nurses describe as making them feel engaged in individual, team, job, and organizational work and performance, or as providing a feeling of accomplishment and use of personal skills?

RQ5: What themes, perceptions, impressions, barriers, frustrations, and opportunities to improve satisfaction and engagement emerge related to the influence of direct management, teamwork, systems, leaders, and resources?

For the vertical axis are the satisfaction interview questions and engagement questions. The satisfaction questions were:

1. Tell me about your work. What is it like to work in your ER?
2. Do you feel satisfied in the work you perform in your ER? Describe why you are satisfied or dissatisfied in the work you perform?
3. If I asked you to describe a perfect and satisfying work environment, how would you describe that environment? What things would you say make for the perfect work place?
4. What are the top three actors that you consider essential for your satisfaction in your job?
5. Let's talk about staffing because resources are essential to doing your job. Tell me about the resources you have available in your job.
    a. Staff

   b. Equipment and supplies
   c. Education and continuing education
6. What happens when you don't have enough resources—Management, coworkers' responses?
7. Communication occurs at many levels. Let's talk about what's good, what's bad, and what works in your ER.
   a. Between staff
   b. To and from leaders
   c. Frequency
   d. Is your voice heard? Why or why not?
   e. What would make communication better?
   f. How important is communication to your satisfaction?
8. How involved are you in decision-making? Does your input into decision-making or lack of influence your satisfaction? Why or why not?
9. Do you feel you have autonomy in your job? Why or why not?
   a. Is workplace autonomy important to you?
10. Are you recognized in your job? How are you recognized? How does recognition influence your satisfaction?
11. Tell me about your opportunities for improvement? Courses, education, continuing education

   a. Are you encouraged to go the extra mile and do more? Do you feel that you are provided encouragement and services to improve yourself in your job?
   b. Does anyone talk to you about your career pathway? How important are these conversations to your satisfaction?

12. Teamwork is an important aspect of ER nursing. We work as one. Tell me about your working relationships as a team? Does the team work cross into leadership? How important is teamwork to your satisfaction? How do your coworkers' interaction and how do people work together?
13. We work very closely as ER staff. ER relationships are very important. Times can be tense, fun, and just a regular day. Tell me about your relationship with coworkers and how important those relationships are? Do you feel a group cohesiveness or do people just do what they want? Explain. Does the physical layout influence or impact teamwork and workplace relationships?
14. Coaching, mentoring, and orientation are important in nursing. What types of coaching, mentoring, and orientation occurs in your department? Why or why not is this effective?
   a. Were you coached or mentored in your job when you started? Are new employees given these opportunities?
   b. How important are coaching and mentoring to your satisfaction? Do you feel that new employees receive adequate coaching, mentoring,

and orientation in your department—why or why not? Impact on your satisfaction?

c. Do you feel that your role is important as a staff RNs? Why or why not?

15. How is education provided to you? What types of offerings are provided? Does education or continuing education provided influence your satisfaction? Do you feel you are provided ample educational opportunities?
16. Stress is a big factor in ER nursing. Tell me about ER stress in your department. What ongoing stressor influence your satisfaction? Are measures in place to help you decrease your stress? What are those measures? What do you do to de-stress?
    a. Do you talk to each other about stress? What do you do to help each other when you are stressed?
17. Compassion fatigue and burn out are two concerns for nurses.
    a. How does your compassion fatigue impact your satisfaction and how you care for patients?
    b. Do you believe that compassion fatigue impacts your patient outcomes? Explain
    c. What do you know when you have reached the breaking point? What do you do to get yourself back on track?
    d. Do you think we do enough to decrease compassion fatigue or do we just expect that it's part of the job?

e. Do nurses talk about fatigue and burnout with each other?

f. What do you think causes compassion fatigue?

18. Violence—ER RNs are exposed to violence on an almost daily basis.

    a. Describe the violence in your department?

    b. Is violence a problem and does it impact your satisfaction?

    c. Do you fear for yourself when working? Why or why not?

    d. Do you feel safe? If not, what makes you not feel safe?

    e. How do you prepare for ER violence?

    f. Is leadership understanding and doing anything about the violence?

19. Sense of accomplishment—what make you feel like you accomplished something when working? Describe how you get things accomplished? What impact does a sense of accomplishment have on your satisfaction?

20. Overcrowding—ER are overcrowded. How does overcrowding impact your work and your satisfaction? Does anyone seem to care that the ER is overcrowded?

21. What is it about being an ER RNs that keeps you coming back day after day? Tell me the reasons

22. What is the most pleasurable aspect of your job?

23. What is the most unpleasant aspect of your job?

24. What are the top three things you would do to make your job more satisfying?

The engagement interview questions were:

25. Engagement occurs at three levels—job performed, work, and at the organizational level and occurs at a physical, cognitive, and emotional level.
26. Do you feel engaged in the job you perform? Tell me why you are engaged. What aspects of what you do make you feel engaged?
27. Do you feel engaged in your work? What aspects of your work make you want to be engaged? Do you feel you can trust the people you work with? Explain.
28. Do you feel engaged on the organizational level? Do you know your organization's mission, vision, and values? Why or why not are you engaged with the organization?
29. Is it OK to not be engaged? Why or why not?
30. How engaged to you feel in your job, your work, and with the organization?

Table 6

*Research Questions (RQ) Correlation with Interview Questions (IQ)*

| IQ | RQ 1 | RQ2 | RQ3 | RQ4 | RQ5 |
|---|---|---|---|---|---|
| 1 | X | | | | X |
| 2 | X | | | X | |
| 3 | X | | X | X | |
| 4 | X | | X | | |
| 5 | X | | X | | |
| 6 | X | | X | | X |
| 7 | X | | X | | |
| - | X | | X | X | |
| 9 | X | | X | | |
| 10 | X | | X | X | |
| 11 | X | | X | X | X |
| 12 | X | | X | X | |
| 13 | X | | X | X | |
| 14 | X | | X | X | |
| 15 | X | | X | | X |
| 16 | X | | X | X | |
| 17 | X | | X | X | X |
| 18 | X | | X | X | |
| 19 | X | | X | X | X |
| 20 | X | | X | X | |
| 21 | X | | X | X | |
| 22 | X | | X | X | |
| 23 | X | | | | X |
| 24 | X | | | X | |
| 25 | | X | | X | |
| 26 | | X | | X | |
| 27 | | X | | | X |
| 28 | | X | | | X |
| 29 | | X | | X | |
| 30 | | X | | X | |

*Note.* Horizontal axis: research questions. Vertical axis, interview questions (satisfaction interview questions, 1-24; engagement interview questions, 25-30).

## Data Analysis Plan

The data collection and analysis used an iterative process (Creswell, 2013; Merriam, 2014; Yin, 2014). Yin (2014) outlined two essential requirements for data analysis. The first requirement necessitated the use of an analytic strategy seeking results relying on theoretical propositions. The second essential requirement required the development of case description for the study framework. Favored coding and pattern matching of data points were used to identify key information during the analysis. Yin (2014) outlined four principles including an analysis based on relevant evidence, interpretation of the potential rival theory, addressing the significant aspects of the case study, and using my prior, expert knowledge to analyze data. Data was hand coded to reduce the quantity of information and produced a manageable amount of and significant accumulation of materials obtained from interviews (Saldaña, 2013). The data were synthesized, ongoing comparative analysis assessed, and member checked to obtain accurate information from interviews (Barth & Thomas, 2012).

A constant comparative method of qualitative data analysis was used to compare incidents (cases), integrate properties and data, and compare cases or incidents with previous incidents to ensure reliable and consistent coding (Glaser, 1965). Each incident provided a stepping stone to the next incident to build upon and to generalize ideas and relationships between the concepts. The constant comparative process ensured code consistency and the generation of new codes from gathered information. The end product of the constant comparative method was the development of theoretical propositions.

Initial coding was open, and subsequent coding was axial or interconnecting coding and ended with selective coding providing the story of the units of the case.

Patton (1990) described the coding process as a grouping of answers to common questions leading to the analysis of different perspectives on different issues to determine what is significant and what is insignificant from the interviews. Lincoln and Guba (1985) described four factors for accurate constant comparative coding which included comparing incidents, integrating categories, delimiting the theory, and writing the theory. The inductive analysis as described by Patton (1990, p. 390) allowed the researcher to "visualize patterns, themes, and categories emerging from the data rather than having the ideas or outcomes imposed on them". Dey (1993) described constant comparative analysis as a mechanism to determine bits of data and how these bits become patterns. Through the separation of bits into smaller more defined bits with patterns emerging allowed for distinctions to be made as conceptual rather empirical information. Dey (1993) described these bits as jigsaw puzzle parts or kaleidoscope in nature.

The constant comparative analysis process was a systematic process framed in inquiry seeking to find the meaning of concepts, ideas, words, actions, and observations. The constant comparative process grouped incidents, units, or events into meaningful pieces of data for analysis and provided a foundation to determine the relationships between categories or ideas. As analysis continued, the data was reconstructed to conceptualize the experiences. The constant comparison and analysis provided ongoing assessment, evaluation, and review of words which told a story about the event.

Data management presented two challenges. The first challenge was how to manage the vast amount of data and a second challenge was how to analyze this data in a meaningful, unbiased manner. In qualitative research, data is the primary tool since no pre-existing or pre-defined hypotheses exists (Hahn, 2008). An inductive process was used to determine categories, themes, and patterns to develop a working hypothesis of why and how events or phenomenon are occurring within a defined time or location (Hahn, 2008). Coding aided in examining the data for similarities, regularities, and words, topics, or phrases to represent the investigated phenomenon (Patton, 1990).

Hahn (2008) described four levels of coding. Level 1 coding describes initial coding where large amounts of raw data are grouped into large categories of information. Level 2 coding focuses on coding and category development with a re-examination of Level 1 data and further focuses on the initial level 1 pass through of information. Level 3 or axial/thematic coding examines the previous coding and refines categories, themes, or concepts. The final level of coding develops theoretical concepts or the emergence of data from saturated categories and themes.

All interview data, field notes, and observation impressions required clarification, validation, and validation using member checks. Interview tapes provided information which was transcribed. In most cases the transcripts were transcribed verbatim while excluding superfluous information as described by Loftland as “every word, exclamation, or pause that occurs in the interview…. You do not need a verbatim transcription of everything the interviewee said…” (Lofland, Snow, Anderson, & Lofland, 1995, p. 88). The transcriptions provided direct quotes and specific pertinent information and with the

removal of insignificant verbiage such as conversations not specific to interview questions (Lofland et al., 1995; Merriam, 2014; Yin, 2014). Coding included a combination of open coding (reading line by line and identifying code concepts) and selective coding (focusing on main ideas, developing a story, and aligning the information). Selected transcript and coded information were entered into the NVivo software program from Excel spreadsheets. Themes and key phrases identified were analyzed, categorized, and sub-categorized into elements related to satisfaction and engagement (Saldaña, 2013). Ongoing data analysis occurred to determine commonalities or differences from the interviews (Saldaña, 2013).

## Issues of Trustworthiness

A fundamental concern with any research study is to ensure that mechanisms are in place to ensure quality and credibility of the data and findings. Study validity creates connections between findings and theoretical ideas or concepts (Patton, 1990; Yin, 2014). Internal validity demonstrates sound concepts between research findings and observations to the theoretical concepts developed. External validity defines the amount of generalization of the findings. Cumulative validity focuses findings and the support of these findings by other studies. Validity creates credibility and makes the findings believable. The research study validity also provides an accurate representation of the phenomenon, conclusion integrity, and the correlations between data and conclusions. Validity represents quality, rigor, and trustworthiness.

Reliability requires input from more than one observation or interview to agree upon observations, conversations, or experiences (Creswell, 2013; Yin, 2014). Reliability

ensures dependability and consistency in the data obtained during the research study (Bekhet & Zauszniewski, 2012). Data was member checked to ensure dependability, reliability, and transferability. This effort increased the reliability and validity of the data by evaluating and analyzing data for consistency, accuracy, and quality. These efforts provided opportunities to ask for clarification and follow-up questions related to the observations, interviews, and experiences.

Triangulation is a process of verification that increases validity by incorporating three different viewpoints or methods thereby viewing the phenomenon from three perspectives (Creswell, 2013; Bekhet & Zauszniewski, 2012; Gelshorn, 2012; Yin, 2014). This triangulation allowed for cross-checking information to ensure non-bias, optimal saturation, and correction of inaccuracies or misinterpretations. Data was triangulated using multiple sources to obtain the required information, and mechanisms were developed to obtain data saturation to establish trustworthiness, internal credibility, and reliability.

Reflexivity was an important consideration to the qualitative research study. Reflexivity emphasizes the importance of self-awareness in the research study to be attentive to and conscious of issues potentially impacting the research. The qualitative researcher without reflexivity can present skewed, biased, or incomplete data. Establishing credibility depends on the extent, skill, competence, and rigor in which questions formation, participant selection, and data analysis and interpretation.

Credibility is a process that assists in demonstrating the merit of the study. Credibility was described by Stake (2001) as information interpreted and member

checked assisting in aligning the theories, concepts, and questions in a logical, sequential, and understandable manner. Credibility assures truth and value in the study findings. These findings aid in explaining a complex phenomenon using holistic rich description. Transferability refers to the ability to transfer study results to other persons in similar situations or conditions. Stake (2001) further described transferability as the reader's ability to decide if and how the study results apply to their individual situation or condition. Lincoln and Guba (1985, pp. 79-80) described transferability as the "applicability of the study and study findings as idiopathic (particular to the study) rather than nomothetic (law-like generalizations)".

Dependability ensures that results are consistent, repeatable, and valid (Yin, 2014). Dependability ensures that sources are factual with inferences or personal bias removed. Dependability identifies the methods and methodology as relevant and specific for the study of the phenomenon (Bekhet & Zauszniewski, 2012; Bleijenberg, Korzilius, & Vershuren, 2011). Remaining neutral and non-biased is essential to ensure trustworthiness (Creswell, 2013; Yin, 2014). Confirmability is the objectivity of qualitative research and requires that the researcher have complete oversight of the research process (Yin, 2014). This oversight necessitates careful examination and management of the process in entirety. Being objective during this research process was exhaustive and enlightening. A detailed research plan, comprehensive research data collection system, and use of field notes, memos, and interview participant observations aided in confirming the data.

## Ethical Considerations

The primary consideration in any research study is to conduct the research process in an ethical, open, and well-documented manner. Opportunities were provided to explain, explore, and answer questions about the interview and research study. Another ethical responsibility was to preserve the anonymity of the participants in the final report, field notes, and interviews. Participants were de-identified using a series of letters and numbers to describe the person(s) interviewed. All information was member checked by participants and changes made as required. All records were maintained in a secured, locked location and no copies of the interviews or notes were made. Continuous efforts were made to be cognizant of bias, stereotypes, or misinterpretations during the interview process. The non-biased approach provided sensitivity, privacy, and respect to participants.

The subjects received assurances of record privacy and confidentiality of all study materials. The recorded interviews were held in private locations or via telephone conversation. Informed consent was obtained prior to the interviews and after IRB approval. No power or coercion to enroll the participants were used in recruitment or enrollment of participants. All information was stored in a locked, secure location and was not shared. Personal behaviors, mannerisms, and language (both verbal and non-verbal) were personally monitored during the interviews. Becoming over-involved and under-involved was a potential ethical concern. To prevent over or under-involvement direct, open-ended questions were used seeking to gain information from the participant and no words, phrases, or body language to sway or lead answers from the participants

occurred. Any personal behaviors potentially lead, direct or encourage answers that may alter the individual's exact, real, or true feelings, beliefs, or perceptions were avoided.

Institutional Review Board approval were obtained prior to the initiation of any study research interview or observation. All participants were provided informed consent, research information, and the opportunity to opt out of the research at any time without consequence or problem.

## Summary

The purpose of this research study was to determine factors that influence ED RNs satisfaction and engagement. The research design of qualitative case study provided opportunities to obtain thick, rich data within bounded interviews. The pilot study provided opportunities to streamline and clarify interview questions seeking how and why factors influence an ED RNs satisfaction and engagement. Gaining insight from ED RNs from different age groups as well as from ED RNs working at healthcare facilities offering varied types and opportunities furnishes quality information directly from front-line workers regarding specific factors influencing personal and professional satisfaction and engagement in the workplace. Interweaving the codes, themes, and data related to satisfaction and engagement obtained through qualitative case study methodology affords valuable information to use in the retention or recruitment of nurses into the workforce. Understanding the elements that satisfy, dissatisfy, engage, or disengage nurses offers valuable insight from leaders to design, develop, implement, and evaluate new, improved methods to improve working conditions for nurses.

The qualitative case study of factors influencing ED RNs satisfaction and engagement offered specific information to support the literature reviewed. The study results are provided in Chapter 4 outlining specific elements deemed as essential for ED RNs satisfaction and engagement. Satisfaction and engagement elements are defined, described, and analyzed providing valuable information to support challenges faced by nurses and leaders to improve working conditions, support staff, and improve morale. How and why nurses describe, define, or explain satisfaction and engagement requirements illustrates valuable personal and professional needs, expectations, and demands in the chaotic healthcare environment of the ED.

# Chapter 4: Results

## Introduction

Challenges to recruit, satisfy, retain, and engage nurses are ever-present in today's healthcare environment. Specific dynamics include a dissatisfied workforce, a surge in patient volume with the aging Baby Boomer population, an aging nursing workforce, fee-for-service reimbursement, and an ongoing nursing shortage with no projected changes to these trends over the next decade. Nurses are a vital element in healthcare provided, patient satisfaction, and patient outcomes. How leaders respond to the ongoing nursing shortage will determine the number of nurses practicing in ED. Understanding what satisfies and engages ED RNs is imperative as nursing shortages continue, the volume and acuity of patients increases, patient satisfaction decreases, and nurses make conscious choices to leave the chaos of the ED. This chapter includes a brief overview of the study purpose and research questions, information about the pilot and study participants, and any unusual circumstances influencing data collection. The data analysis included inductive processes to define elements or units from which to develop themes and categories by hospital and generational cohort responses. Data analysis included clarification of codes and patterns as they link to the research questions. The data interpretation provided context to the conceptual framework and supported evidence of trustworthiness.

## Pilot Study

Three RNs participated in the pilot study and included one nurse from the Baby Boomer, Generation X, and Millennial cohort. Table 7 provides pilot study participant information, nursing and ED tenure, educational degree, and interview dates.

Table 7

*Pilot Study Participants*

| Generation | Hospital | RN yr. | EDRN | Degree | #1 interview | Phone | # 2 interview |
|---|---|---|---|---|---|---|---|
| BB | U | 26 | 16 | BSN | 11/16/17 | 11/19/17 | 12/2/17 |
| Gen X | U | 16 | 10 | AAS | 11/18/17 | 11/21/17 | 12/2/17 |
| Millennial | U | 3 | 1 | BSN | 11/16/17 | 11/19/17 | 12/2/17 |

Each pilot study interviewee participated in three sessions, an initial interview of 45 minutes, a follow-up phone interview (10 minutes), and a final interview (35 minutes) totaling approximately 90 minutes. Respondents voiced concerns over the broadness of the initial interview questions and felt that more specific questions should be used during the interviews to create a more balanced and fair assessment of factors influencing satisfaction and engagement. Responses included:

- "I think you have good questions but don't ask specifics about things like communication, teamwork, and things that impact every EDRN" (BB).
- "You aren't capturing the day-to-day things we do as an RN. It's not just about resources or how I feel about satisfaction. I think you need to delve

deeper into critical elements such as teamwork, our relationships with leaders, and how we treat our patients" (Gen X).

- "You're an ER RN, and you know that if you ask such a broad question you're going to get an answer about what the RN is upset about or thinking about at the very time. You've got to be more specific if you want to know what drives us to be satisfied" (Millennial).

Appendix A contains a list of the initial interview questions with Appendix B providing the revised interview questions developed from Pilot Study participant responses.

## Research Setting

At the time of the interviews, both Hospital U and Hospital C were experiencing staffing shortages in the ED. Hospital U supported their staff through the use of traveling agency RN staffing to cover staff shortages. Hospital C provided minimal agency staffing, and wide gaps continued in the number of staff available to cover ED staffing needs. Hospital E provided care with reduced (par level) staffing and favorably supported increasing par levels to maintain safe care. These shortages potentially influenced the responses from nurses at Hospitals C and U. Another issue that potentially shaped participant response included the current flu epidemic, which occurred during the study period and which directly impacted patient volumes and acuity in the ED.

Participant responses ranged from satisfied and engaged to negative and untrusting. An overall tone at Hospital C interviews expressed a sense of negativity and hopelessness. Conversely, the nurses at Hospital E provided affirmative responses

describing factors viewed as conducive to safe care and content nurses. Hospital U nurses described a mixed degree of satisfaction and provided information in a positive, educational, and proactive manner supporting management yet questioning specific methods or factors impacting satisfaction. All interviews were conducted outside of working hours and in a neutral setting allowing the nurses to feel less stress in a safe, comfortable, open environment in which to express their thoughts.

## Demographics

Participant selection included ED RNs at three hospitals in upstate New York and Vermont. Twenty-one ED RNs participated in the research study and represented Baby Boomer, Generation X, and Millennial staff. I excluded managers, non-nursing staff, and ancillary staff from the research study. I used a purposeful sampling strategy for the selection of participants. Each Hospital afforded distinct services with varying capabilities and capacities. Hospital U offered tertiary care, Hospital C delivered midlevel care, and Hospital E provided supportive care in a critical care access facility. Hospital U nurses possessed a variety of nursing experiences outside of the facility while Hospital C and Hospital E ED RNs included predominately locally born and raised RNs who had obtained a local nursing education with no or limited RN experiences outside of their respective healthcare facility. The research study participants represented both hospital and generational alignment with the current issues facing healthcare leaders and ED RNs staff.

## Amendments to Proposal

The initial proposal for this research study included one observation at each of the participating hospitals. IRB approval for the observations at Hospital C and Hospital U required consent from patients and from those whom I encountered and with whom I conversed during the observation. After careful consideration and discussion with my dissertation chair, I decided not to do observations as part of my research study due to the time required to obtain patient consent, the issues involved in the process of consenting, and the amount of pertinent information likely to be gained from observations.

Nurse availability and response to recruitment necessitated amending the number of interviews from seven at each facility to ensure data saturation. Amendments included the addition of three interviews at Hospital U due to a lack of available staff at Hospital E and unwillingness to participate at Hospital C. Hospital E, a small critical access hospital, operated with a seven ED RNs. Five of the seven Hospital E ED RNs agreed to participate in the research study. The current staffing at Hospital C was below par levels, and only six RNs consented to participate in the interviews. The number of interviews at Hospital U was increased to ensure data saturation.

## Data Collection

Data collection occurred using ED RNs from three hospitals located in New York and Vermont. The study excluded the names of the hospitals to ensure confidentiality, protect the organization's reputation, and to prevent any negative impacts to the organization based on comments made by participants during the interview process. Data collection included the name (defined identifier), the hospital code, the number of years

as an ED RNs, the number of hospital RNs experiences, the highest nursing degree, the interview date, and the length of the interview as outlined in Table 8. Nurse identification included an interview number, generational cohort, and hospital identifier. For example, Nurse Jane Smith, a Baby Boomer from Hospital C identified as 4BBC (number 4, Baby Boomer, Hospital C).

Interviews occurred from December 2017 to February 2018 using the modified interview questions in one-on-one sessions. I maintained privacy, recorded and transcribed interviews, and member checked all data for accuracy, need for revision, or edification. Unusual circumstances included the logistics of completing the interviews face-to-face secondary to the geographic location (45-minutes to 1-hour drive from my home), participant work schedule, and my work schedule. Face-to-face dialogues provided opportunities to view participants during the interview process and included 16 one-on-one interviews. Logistic issues necessitated the use of telephone interviews of five participants with subsequent comparison to face-to-face interviews with no discernable differences in quantity or quality of interview data found. Confidentiality methods included locking all interview materials, field notes, transcriptions, and study data in a secured locked environment to protect participant confidentiality and privacy. Table 8 contains demographic data for the 21 ED RNs. Figure 1 provides information related to each study participant's years of nursing and ED nursing experience. The highest nursing education level is displayed in Figure 2.

Table 8

*Study Participants*

| Identifier | Cohort | Hospital | RN years | ED RN | Degree | Interview date | Time |
|---|---|---|---|---|---|---|---|
| 1BBU | BB | U | 22 | 18 | BSN | 2/7/18 | 43 min |
| 2BBU | BB | U | 36 | 35 | AAS | 1/16/18 | 40 min |
| 3BBU | BB | U | 28 | 26 | BSN | 1/6/18 | 46 min |
| 4GU | GX | U | 14 | 7 | MSN | 1/3/18 | 40 min |
| 5GU | GX | U | 20 | 19 | BSN | 2/1/18 | 38 min |
| 6GU | GX | U | 19 | 18 | BSN | 1/18/18 | 48 min |
| 7GU | GX | U | 18 | 14 | BSN | 1/16/18 | 39 min |
| 8MU | M | U | 3 | 3 | BSN | 2/7/18 | 36 min |
| 9MU | M | U | 6 | 2 | MSN | 2/3/18 | 35 min |
| 10MU | M | U | 5 | 3 | BSN | 1/16/18 | 40 min |
| 11BBC | BB | C | 11 | 11 | BSN | 2/15/18 | 36 min |
| 12BBC | BB | C | 26 | 10 | AAS | 2/9/18 | 47 min |
| 13GC | GX | C | 16 | 6 | BSN | 1/16/18 | 35 min |
| 14GC | GX | C | 12 | 5 | AAS | 1/4/18 | 26 min |
| 15MC | M | C | 6 | 5 | AAS | 1/15/18 | 30 min |
| 16MC | M | C | 7 | 5 | AAS | 1/12/18 | 26 min |
| 17BBE | BB | E | 21 | 16 | AAS | 2/19/18 | 34 min |
| 18BBE | BB | E | 24 | 16 | AAS | 2/1/18 | 36 min |
| 19BBE | BB | E | 33 | 10 | BSN | 1/19/18 | 35 min |
| 20GE | GX | E | 21 | 21 | BSN | 2/16/18 | 30 min |
| 21GE | GX | E | 10 | 10 | BSN | 1/20/18 | 29 min |

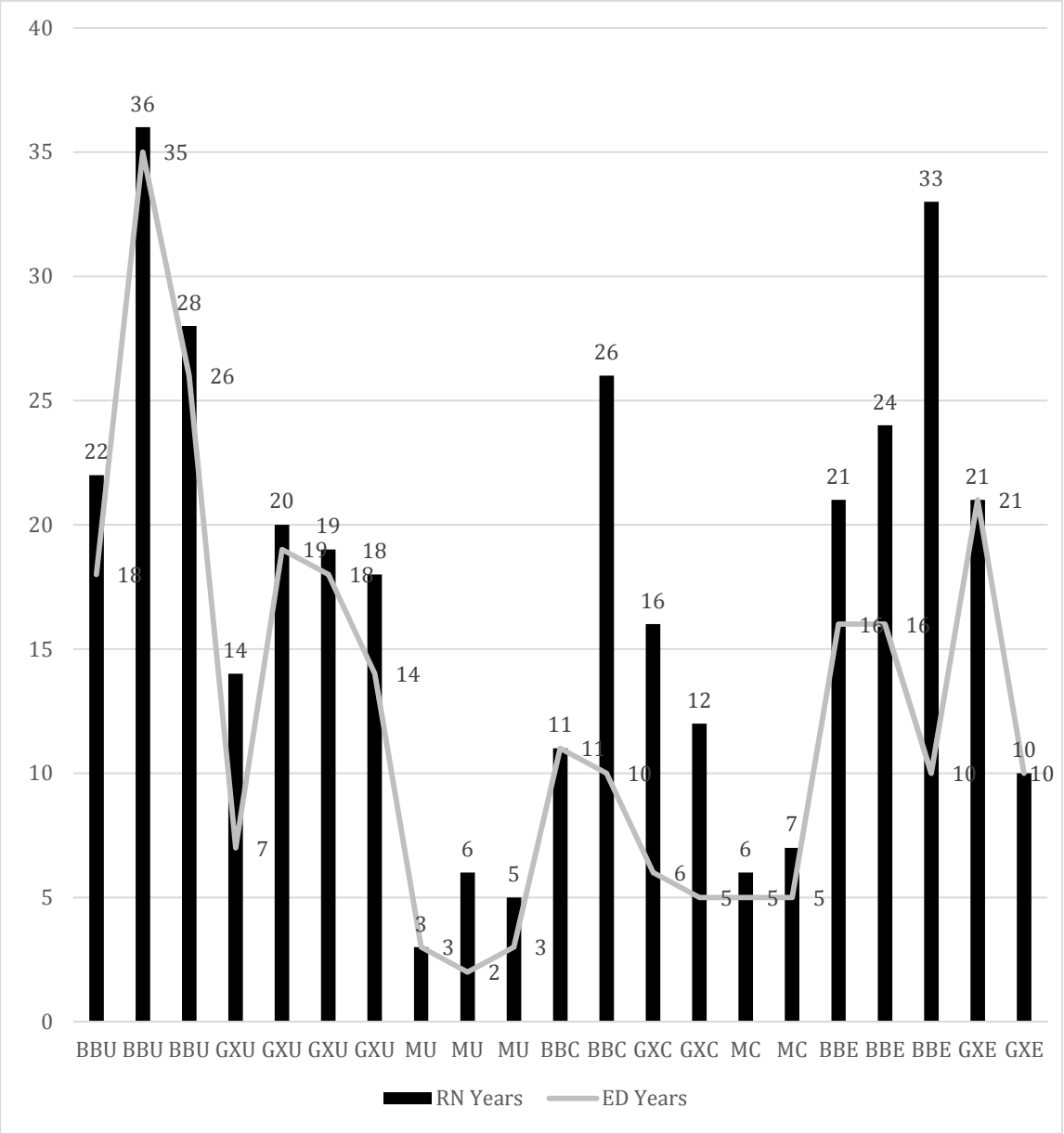


*Figure 1.* Study participants years of nursing experience and ED tenure.

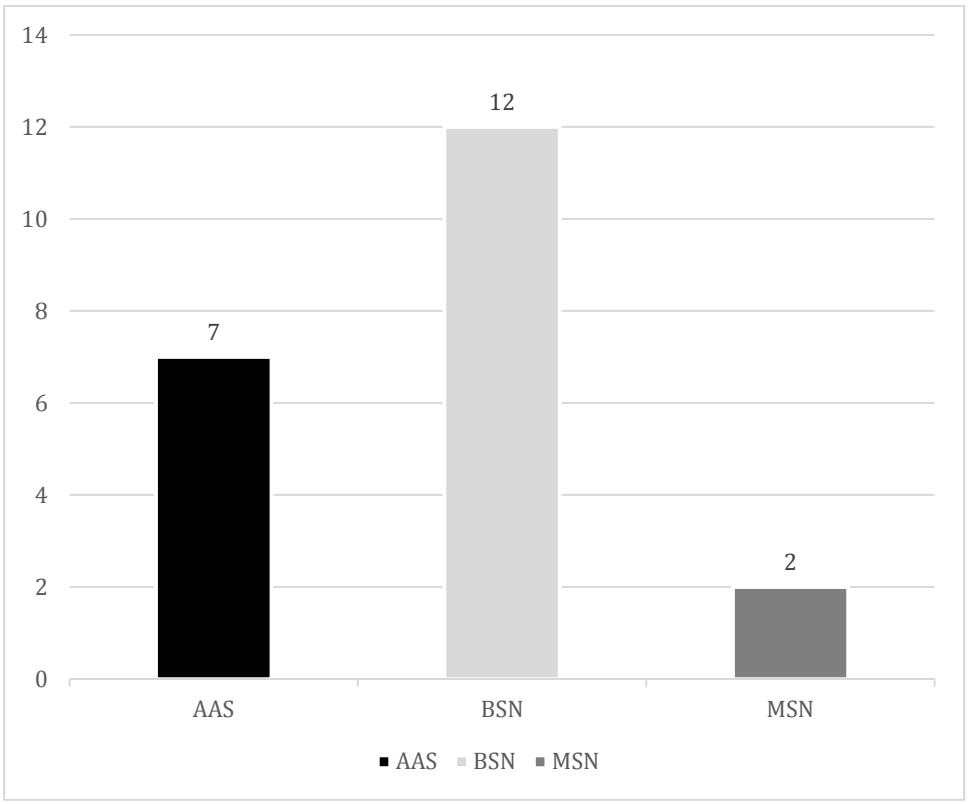


*Figure 2*. Study participants highest nursing education level.

## Data Analysis

Data analysis occurred through a series of planned steps. During the interviews, a diligent effort was made to provide objective, non-biased, and validated information. The steps provided a foundation to assess, member check, validate, code, develop themes and subthemes, and establish patterns from interviews.

- step 1: Data collection included transcripts of recorded interviews, memos, and member checks. A concurrent analysis offered opportunities to assess transcriptions, interview information, and member checked data. Notes and memos were transcribed immediately following an interview. Audio recordings transcriptions occurred within 24 hours of interviews and included

word-for-word transcription of notes, the interview discussions, and observations made during the interview process.

- step 2: In step 2, all labeled and archived data was entered into an Excel folder to ensure easy access to the location and contents of the encounter. Labeling included the name, the date, the location of the interview, the time of the interview, and the interview transcripts. Participant identification included a unique identifier.
- step 3: Concurrent review of data aided in maintaining alignment with the purpose, research questions, and reasons for conducting the research. This concurrent review provided opportunities to '*same time*' analyze information and to make modifications as needed.
- step 4: Preliminary coding included careful read-throughs of all transcripts (initial read and transcriptions completed within 24 hours of an interview), memos, and notes (made in the margins of transcripts).
- step 5: The preliminary coding occurred after four transcript reviews (read-throughs) with all identified key and sub-themes from transcriptions and memos entered into an Excel spreadsheet.
- step 6: Initial coding included a process of analysis, determining what the data was saying, and establishing relationships and patterns within the data which included the identification of broad and specific themes.

- step 7: Data themes and pattern identification from hand coding provided the code or central words entered into NVivo software to assist in determining patterns, repetition, and themes throughout the data.
- step 8: Data interpretation used hand coding, participant responses, conceptual framework, and NVivo pattern recognition. The interpretation extended beyond descriptions and words and developed stories, explanations, and quality of participant responses aiding in understanding significant elements of ED RN satisfaction and engagement. Through pattern recognition, major topics and elements of satisfaction and engagement were identified and substantiated by quotes adding richness to the major themes.

The satisfaction and engagement quotes obtained from the interviews aided in formulating patterns and themes. The direct quotes assisted in the development of major and sub-themes identified in Table 9. Data specific to Hospital U (Appendix C), Hospital C (Appendix D), and Hospital E (Appendix E) provides quotes and related information regarding ED RNs beliefs, perceptions, and descriptions of satisfaction and engagement factors. The information contained in the appendices aided in deriving themes and patterns.

Table 9

*Categories and Themes*

| Major theme | Quotes aiding in deriving themes |
|---|---|
| Satisfaction elements | |
| Resources | "We never have enough staff" "It's hit or miss. Sometimes we have enough and other times, not enough." "No one seems to care if we have enough staff or not." "We work short, and when we do have the staff, we don't have time to take good care of our patients". "I wish someone would realize how important staff is to the hospital." "It's scary when you know you don't have enough people to care for the patients." |
| Communication | "I think our voices are heard." "Sometimes the communication doesn't filter down to the staff level." "We have a good system in place, but sometimes things get missed." "We're supposed to follow policies and sometimes we don't know about things." "I think our manager keeps us up to date on what is going on." "Leaders don't communicate well at any level." |
| Decision-making | "We are included in decision-making on some levels and not on others." "I think we are included. I'm not sure how much more I need to be included." "Leaders make the decisions." "I think decisions are made that even our managers have no control over." |
| Autonomy | "You have to be autonomous to do this job." "I feel that I am autonomous and have control over my job." "It depends on the physicians you work with. As a nurse, I feel I'm fairly autonomous in what I do." "We have standing orders that help with the autonomy." "I feel that you can't be a good ER nurse if you can't do things on your own." "Unfortunately, the new hires are inexperienced and don't know what they don't know." |
| Recognition | "A thank you once in a while would be nice." "The patients thank us more than our leaders." "I didn't go into this profession for the recognition but thank you once in a while would be nice to hear." "Our managers always recognize us. We have staff meetings; they provide lunches." A lot of recognition comes from our peers." "It's nice to have someone |

| Major theme | Quotes aiding in deriving themes |
|---|---|
| | recognize you. Our peers are wonderful at saying job well done. Sometimes I think managers forget what it's like to work out there." "Our managers never say thank you. They usually have negative feedback to us. Saying something positive would be great." |
| Stress | "ER are stressful places." "I know when I'm really stressed and find myself not picking up extra shifts." "sometimes when we are stressed we snap at each other." "I get really bitchy when I'm stressed." "Sometimes I don't realize how stressed I am until I yell at my child." "Stress, what's that…we work in an ER, it's going to be stressed". |
| Opportunities for improvement | "The hospital provides many educational opportunities for me." "We get nothing above the annual things. We have an educator who does nothing." "There are so many ways things could be done better. Education is key for me, and I think the unit is severely lacking in quality and education at all levels." "I wish more time could be spent on education. It seems like it's hit or miss." "I'm not sure we get education as clearly or timely as we need to be getting it. Sometimes I hear about things after the fact and wonder why our educator hasn't posted something or I haven't heard about the information before." |
| Teamwork | "Teamwork is essential." "This job would not function without teamwork." "Teamwork depends on who you are working with and the providers who are working that day." "There are too many distractions by some people to work as a team. The younger group of workers like to play rather than work." "I usually know who the team players are. I tend to ignore those who don't play well with others." |
| ER relationships | "I don't associate with my coworkers outside of work." "Being part of the ED team is important to me". "I want to be included". "I don't think you have to be friends with the people you work with but who knows?" "We do things outside of work, and I think that makes us a better team." "I like the people I work with and trust them." |
| Compassion fatigue | "I get tired of the same faces and people who we treat." |

| Major theme | Quotes aiding in deriving themes |
|---|---|
| | "Sometimes I don't think people realize how draining this job can be." "I would say that compassion fatigue is real. I don't think people realize how tired they are of providing care until one day they snap at a patient or a co-worker." "I wish we had programs to help staff to destress and talk about those days when it's hell to work in the ER." "I think compassion fatigue is real, but I don't think ER nurses understand what it does. We're of the mentality of 'suck it up' and get the job done. You can't do that day after day without it taking a toll on some part of your life." |
| Coaching/Mentoring | "Mentoring programs do not exist in my ER." "We miss out on many opportunities by not having a formalized orientation process with consistency." "I wish we would get up to speed and get an orientation program what works." "We're hiring new grads or nurses with less than six months experience. We need to provide new staff resources. We are not providing them enough experiences, orientation or resources to succeed." "orientation can make or break a nurse—old or young. We have to be conscious of providing a formal process for education and for orientation." |
| Education | "We miss out on many opportunities." "seems we are always too busy to get our education programs together." "we don't get anything beyond annuals. It's a shame. We never get to attend a conference or class because we're too short staff." "I would love to see a more formal program for our education." "We can attend conferences and are encouraged to go to the conferences. It's great because we need the exposure to things we do not see." |
| Violence | "It's a horrible environment in ER now. There are so many psych patients, holds, and patients with drug problems." "Our ER is violence." "There are patients who don't receive long-term care like the drug addicts. They end up in the ER, and they are many times violence." "ER have become dumping grounds for violence and drugs. It's a very scary environment. Thank goodness we have security." "I'm the only RN in the department. Yes, it's out there, but we're lucky that we have not had violent episodes frequently." |

| Major theme | Quotes aiding in deriving themes |
|---|---|
| Safety | "The population coming into the ER has changed. I feel safe but am cautious of my environment." "No, it's not safe with all of the drugs in the area and the drug traffic. It's easy to see what may happen if things don't change." "The police are a phone call away." "We have panic buttons all over the place." |
| Overcrowding | "We have not experienced overcrowding." "It's an everyday event. We open up the halls. It's degrading to the patients." "There are patients everywhere in the ER. The time in the lobby is crazy. People are upset having to wait." "It's a never-ending cycle. We are short staffed, overcrowded, and always running. Not a fun way to work." "If we could figure out something to fix our psych holding problem that would certainly help in the overcrowding problems." |
| Sense of accomplishment | "I love what I do." "The joy is meeting a patient when they are really sick and seeing them get better." "I feel that I don't have enough time to do all that I need to do for my patients." "I love having someone say thank you to me. It means I have done something right that day." "I know I make a difference. Sometimes I don't feel like it, but when I see a sick patient get better, it makes it all worthwhile." |
| Engagement elements | |
| Skill utilization | "I get to use my skills all of the time." "I wish I could do more, but we see a limited number of patients, so I love being able to use my skills when asked." "We're a full-service ER, so I'm always prepared to use my skills." "Being an ER nurse is always being prepared for what is coming through the door. You'd better have your skills ready for use." |
| Trust | "I trust my coworkers." "I have full trust in the people I work with. You can't work in an ER without trusting your staff." "It's an unwritten eye contact that means you trust that the person you are with will get up, help, and do things without being asked." "You have to trust your coworkers." "I know that my fellow workers trust me, trust my judgment, and will help me like I would them." |
| Organizational mission | "I know what the organization is planning, but I'm removed." "I don't want to be involved at the organizational level." "My |

| Major theme | Quotes aiding in deriving themes |
|---|---|
| | family comes first, so the organization takes a back seat for sure." "I don't feel connected with the organization." "I feel that we are connected as a team in the ER with the organization and community." |
| Connection with coworkers | "I love my coworkers.". "My fellow workers can be good or bad depending on who you are working with." "we're so short staffed that we don't have a connection. All we do is work, keep our heads down, and go home." "We have a strong connection, and we work well together." |

Alignment with the research questions provided a connection with specific factors described as directly influencing satisfaction and engagement expressed during the interviews. A relationship exists between the research study's main themes, sub-categories, and alignment to research questions (Table 10).

Table 10

*Major Themes, Sub-Categories, and Alignment to Research Questions*

| Main theme | Subcategory | Research question alignment |
|---|---|---|
| Satisfaction elements | | |
| Resources | Adequate staffing<br>Communication<br>Equipment and supplies | RQ 1, RQ 3 |
| Communication | Bidirectional communication flow<br>Need to be heard<br>Trust in leadership | RQ 1, RQ 3 |
| Decision-making | Input into decisions<br>Awareness of decisions<br>Communication flow | RQ 1 RQ 3 |
| Autonomy | Need for freedom | RQ1 RQ 3 |

| Main theme | Subcategory | Research question alignment |
|---|---|---|
| | Standing orders<br>Communication flow | |
| Recognition | Incentives<br>Confidence<br>Acceptance<br>Reward | RQ1, RQ2, RQ4 |
| Stress | Destress activities<br>Recognition of stress<br>Workflow and throughput | RQ1, RQ 3 |
| Opportunity for improvement | Education<br>Vacation and time off<br>Development plans | RQ3 |
| Teamwork | Reward/recognition<br>Throughput<br>Orientation/mentoring<br>Coaching<br>Relationships with leaders | RQ1, RQ3 RQ4 |
| ER relationships | Stress reduction<br>Communication<br>Recognition<br>Time off | RQ1, RQ3 |
| Compassion fatigue | Recognition of stress<br>Team functioning<br>Flow of communication<br>Recognition<br>Time off | RQ3 |
| Coaching/Mentoring | Formal Process<br>Standard Program<br>Assignment of preceptors<br>The similarity of programs and process for orientation | RQ1, RQ3 |
| Education | Improved communication<br>Coordinated system<br>Input from staff | RQ1 |

| Main theme | Subcategory | Research question alignment |
|---|---|---|
| | Make a priority for the department | |
| Violence | Methods to decrease<br>Identify measures to improve safety<br>Forums to address with staff input | RQ3 |
| Safety | Make safety a unit priority<br>Safety team leaders | RQ3 |
| Overcrowding | Identify measures to change throughput<br>Increase staff<br>Standards of care<br>Autonomy | RQ3 |
| Sense of accomplishment | Recognition for job<br>Rewards<br>Thank you from management | RQ2, RQ4 |
| Engagement elements | | |
| Skill utilization | Skill acquisition<br>Education<br>Skill assessment | RQ2, RQ4 |
| Trust | Relationships<br>Communication<br>Teamwork | RQ2, RQ4 |
| Organizational mission | Mission vision, values<br>Alignment between staff, management, and community | RQ2, RQ4 |
| Connection with coworkers | Trust<br>Communication<br>Teamwork | RQ2 RQ 4 |

| Main theme | Subcategory | Research question alignment |
|---|---|---|
| Connection with job | Trust<br>Communication<br>Teamwork | RQ2 RQ 4 |
| Connection with organization | Emotions<br>Trust<br>Energy<br>Loyalty<br>Mission, vision, and values | RQ 2 RQ 4 |

An explicit relationship existed between patterns and themes and components of the theories of Herzberg, Vroom and Yetton, Maslow, Benner, and Kahn. For example, specific themes and patterns '*fit*' the elements described in the theories (Appendix F).

## Evidence of Trustworthiness

### Credibility

Credibility is a process that demonstrates the merit of the research study. Credibility is also known as construct validity in the quantitative research process (Merriam, 2014). Stake (2001) described credibility as interpreted, information checked by the participant, and recorded in a systematic, logical manner with alignment to theories, concepts, and research questions. For this study, all data was memo checked to ensure accuracy. Each transcript was re-read four times before initial coding to gain new insight, conceptualize the topics discussed, and determine generalizations about the patterns, codes, and themes which emerged. The literature review provided facts and information for a comparative review and to link the review, conceptual framework, and the theories of Herzberg, Vroom, Yetton, Maslow, Benner, and Kahn.

**Transferability**

Transferability is known as external validity in quantitative studies (Stake, 2001). Transferability refers to the study findings being transferable to other people in similar situations (Stake, 2001). Stake (2001) described the most practical form of transferability in the case study as the reader's ability to decide if and how the study findings apply to their situation. The rich, thick, and descriptive analysis of the data provided information related to context, setting, demographics, and specific elements related to satisfaction and engagement easily transferable to other healthcare providers. The information described provided in this study includes the methodology, demographics, and design.

**Dependability**

Dependability, known as reliability in quantitative research, ensures that all research results are consistent, repeatable, and valid (Yin, 214). Yin (2014) described the importance of not making inferences from data. Yin outlined the requirements to examine external sources such as interviews, memos, and field notes to ensuring that factual sources negate inferences. During the interview and data collection process, notes were made related to the interview process, questions, observations, and clarifications. An analytical assessment of notes, observations, and interview data aided in providing and substantiating that the evidence was factual, inferences removed or validated, and accurate results. Member checks provided a level of dependability to ensure factual and valid information.

### Confirmability

Confirmability is the objectivity of qualitative research and requires that the researcher have complete oversight of the research process (Yin, 2014). This oversight necessitates careful examination and management of the process in entirety. Being objective during this research process was exhaustive and enlightening. Being an RN required looking objectively at the data, asking questions, not making inferences, and making careful, purposeful notes, and taking adequate time to carefully and critically analyze the role of the researcher. A detailed research plan, comprehensive research data collection system, and use of field notes, memos, and interview participant observations aided in confirming the data. At the start of each interview, RNs received explanations of potential biases and asked to '*pretend*' that the interviewer did not know the ED, allowing for frank, unbiased, and open discussion.

## Study Results

Five research questions formed the foundation for this research study. The research questions focused on elements influencing ED RNs satisfaction and engagement. Twenty-four ED RNs participated in the research study with three of the 24 participating in the Pilot Study. Approximately 250 pages of interview data, field notes, or memos were reviewed to obtain the rich, thick data for this research study. Data summaries included coded hospital and generational cohort information.

## Hospital Summaries

Hospital U interviewees included ten nurses with ages ranging from 25-63 and a mean of 42.4 years. Seventy percent (7/10) of ER RNs participants were bachelors

prepared, 10% had received an associate's degree (1/10), and 20% (2/10) were master's prepared. Four ED RNs had worked solely at Hospital U and had never worked at another healthcare facility or in another healthcare unit or department. Nursing experience and ED experience for Hospital U nurses is displayed in Figure 3. Highest nursing education attained by participating ED RNs at Hospital U is displayed in Figure 4.

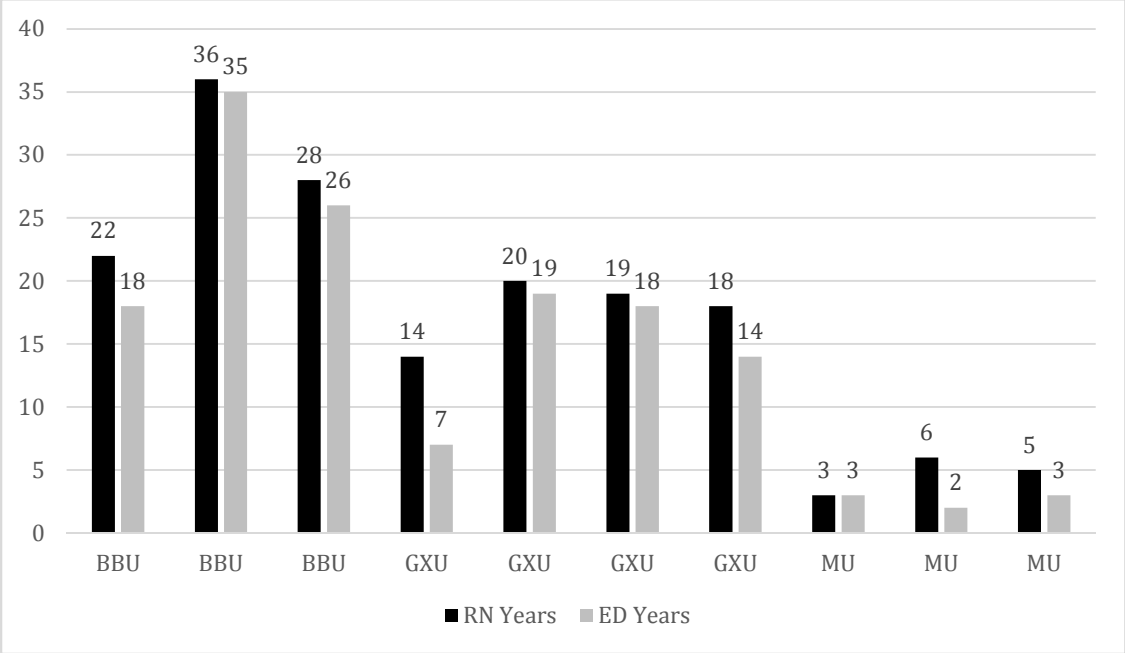


*Figure 3*. Hospital U years of nursing and ED experience.

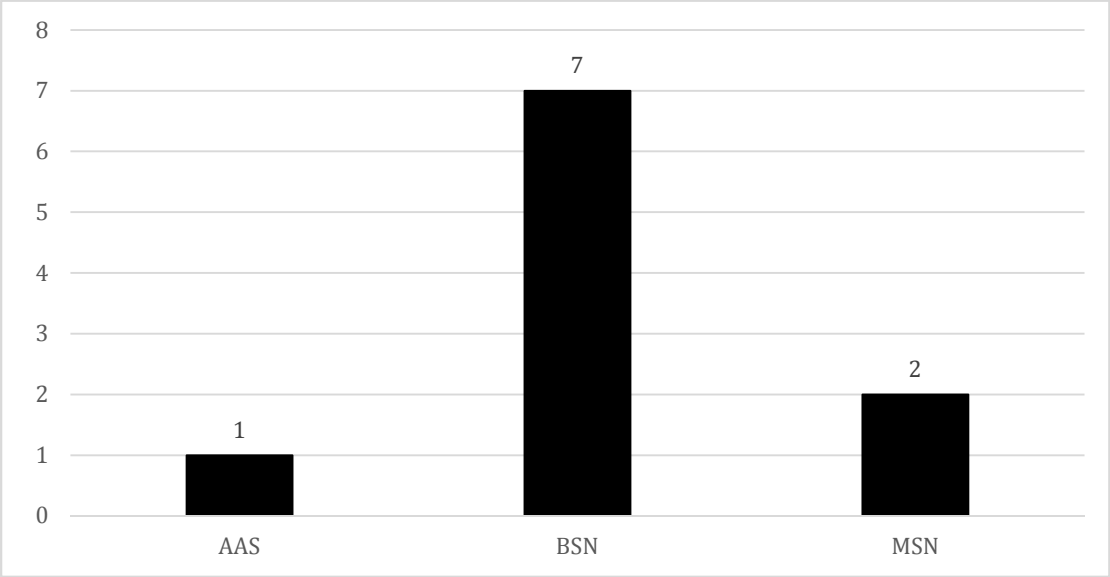


*Figure 4.* Hospital U highest RNs education level.

Hospital C interviews included six RNs with ages ranging from 29 to 54 with the mean age of 24.9 and 33% with BSN and 66% AAS preparation. Four of the six ED RNs had never worked for another healthcare system. All had worked in other departments before working in the Hospital C ED. Nursing experience and ED tenure is provided in Figure 5 and the highest RN educational level attained is displayed in Figure 6.

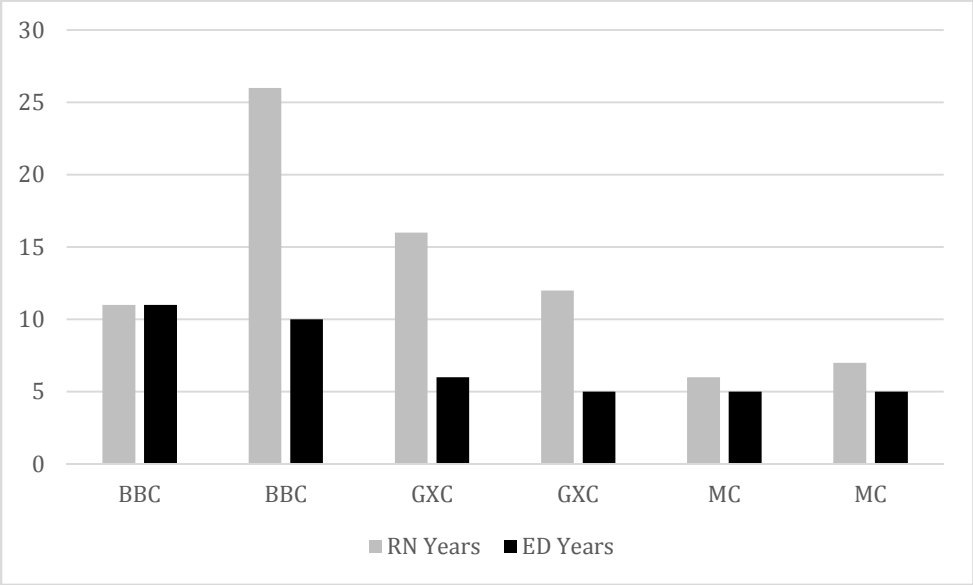


*Figure 5.* Hospital C years of nursing and ED experience.

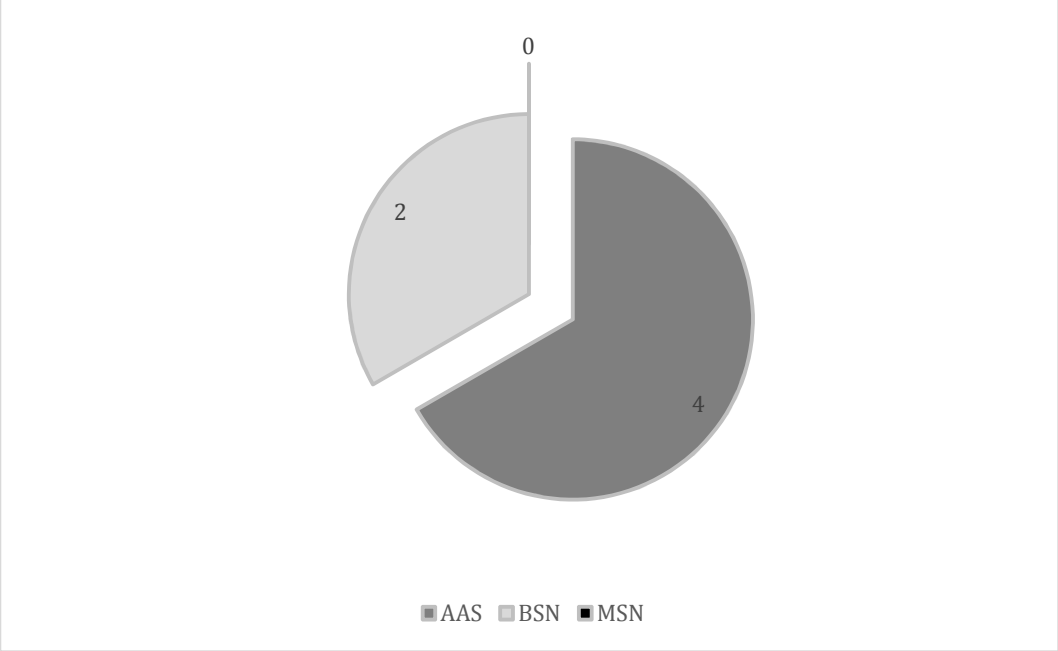


*Figure 6.* Hospital C highest RN education level.

Hospital E interviews included five participants with ages ranging from 44 to 51 years of age with a mean age of 47.6 Two with (40%) of RNs attained an AAS and 60% BSN prepared. All of the ED RNs from Hospital E had worked in other departments before working as an ED RN. Four of the five RNs had worked in other healthcare facilities with one ED RN having worked solely for Hospital E since graduation from nursing school. Information relating to nursing and ED years of experience is displayed in Table 7 and highest RN education level is illustrated in Table 8.

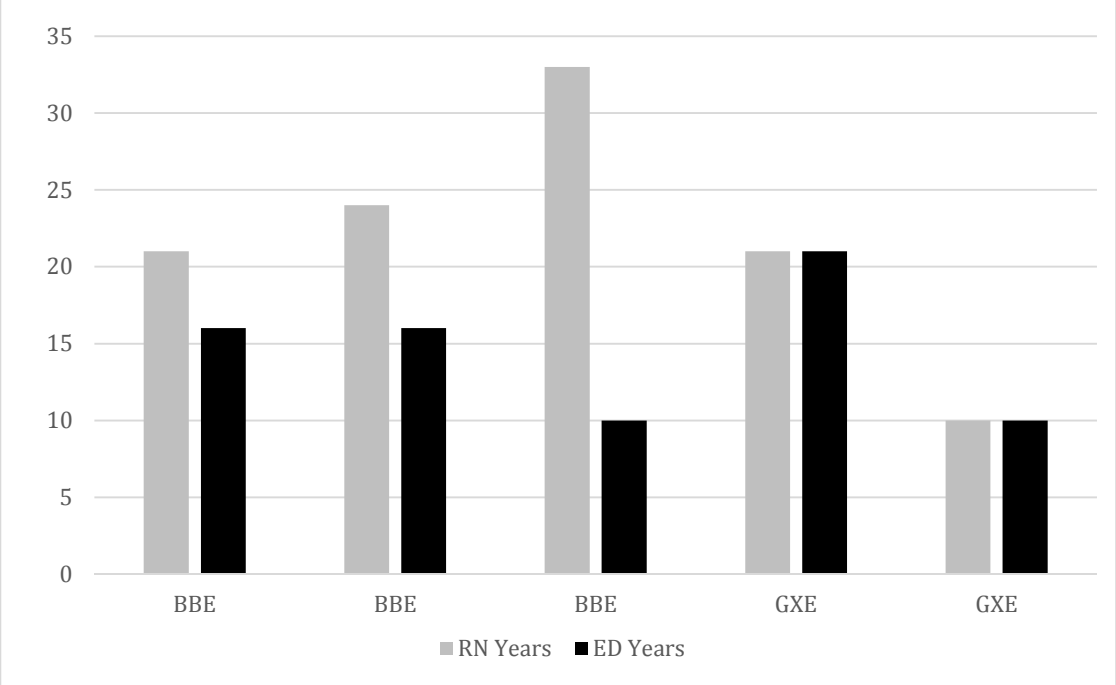


*Figure 7.* Hospital E years of nursing and ED experience.

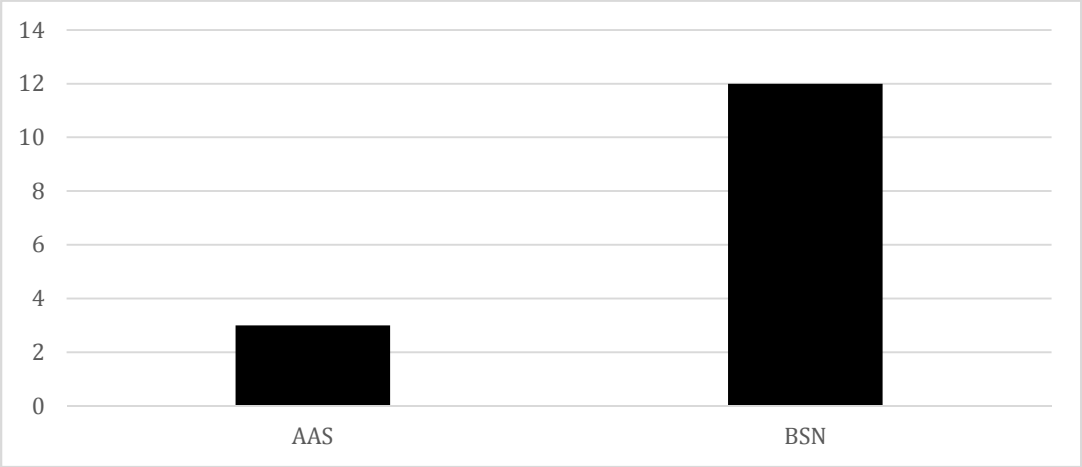


*Figure 8.* Hospital E highest RN education level.

The lead-in (icebreaker) questions provided valuable information. Introductory responses by participants set the tone of the interviews. The tone demanded a focused, concurrent, and ongoing command of the interview process to ensure completion of the interview questions. Initial questions focused on broader components asking the RNs to describe the current work environment, sense of work satisfaction, description of the perfect work and environment, and top three factors viewed as essential for optimal work satisfaction.

For example, Hospital U RNs described the work environment as busy, staffing as stretched, and a proudness of the capabilities of the ED (for example, Level I Trauma Center). The interview opener responses provided a far different tone for the Hospital C RN. The mood was negative, filled with frustration, and focused on mistrust. For example, an RN described the ER as *insane*, another as *no one cares about us*, and a third as *short staffed*. An amended interview technique was used for Hospital C RNs and re-focused discussions back to the interview questions and from '*stories*' of problems.

Conversely, Hospital E RNs interviews were positive, friendly, and open interviews filled with positive information and responses.

Hospital U RNs described issues and concerns in logical, educated manners voicing concern over specific issues, but, in general, describing an environment providing autonomous, safe, and productive care. Hospital C RNs described frustrating, immobilized, and chronic, dysfunctional institutional issues. The staff expressed anger, frustrations, and a sense of paralysis and viewing satisfaction regarding staffing and poor communication and interactions with managers. Conversely, the Hospital E RNs voiced a positive sense of satisfaction and engagement at multiple levels including support for managers and with the organizational mission and vision for the organization and community. The major concerns expressed by all participants was the lack of staff, nurse-to-patient ratios, and communication/interactions with managers.

Each of the satisfaction and engagement themes as described by the participants provided valuable information into the key aspects that directly influence ED RNs. Major themes emerged, and the elements grouped into four categories.

- Group one contained factors related to resources and included staffing, equipment, and supplies (tangible, objective factors).
- The second group described subjective elements including open lines of communication between staff and from leaders, input into decision-making, autonomy, recognition, opportunities for improvement, teamwork, relationships, coaching, mentoring, education, and a sense of accomplishment. (Subjective, intangible)

- The third group contained elements impacting the nurse either directly or indirectly and included stress and stress reduction, compassion fatigue, violence, safety, and overcrowding.
- The final group outlined engagement themes and includes skill utilization, trust, connection with coworkers, the job, the work, and the organization.

**Group One Satisfaction Factors**

Group one contains elements related to resources. The Hospital U ED RNs described staffing issues, inconsistent managerial communication, and RN-to-patient ratios as key factors influencing satisfaction. The lack of resources impacted the RNs in a variety of ways. Without adequate staff, the RN experienced stress, frustration, and worked outside a comfort zone. Nurses described safe staffing as a satisfier to ensure secure, productive, efficient, and effective care. EDs can sometimes be chaotic so having a staffing ratio provided a sense of comfort, control, and safety for the RN to work within. Hospital U used temporary or agency nurses to assist with staffing issues. The ED provided an on-call and call-in system providing for additional staff as needed during high peak volume times and a management team response to staff needs.

Hospital C described a consistency of being short staffed and viewed this issue as directly impacting patient safety, with unsupportive managerial staff and poor communication described as major sources of dissatisfaction. The staffing issues proved to be the central issue discussed during each interview. The nurses depicted a sense of helplessness, poor quality and patient outcomes, and a sense of non-caring about the staffing issues plaguing the ED staff. Hospital C ED RNs provided information to support

frustrations and appeared discouraged and overwhelmed when describing conditions within the department. The ED management team provided no on-call, prearranged or scheduled plan to increase staff numbers, and inconsistent managerial responses during shortages or high acuity. ED RNs interviews illustrated a staff frustration with the lack of managerial support during busy, critical short staffing times, insignificant communication, and a lack managerial support as key dissatisfiers.

Hospital E ED RNs provided information on staffing within their facility and described the need to increase staffing levels for '*off shifts*' such as nights when only one RN and PA are available to provide service within the ED. ED RNs voiced satisfaction with the on-call system and described a peer response to high volume as supportive and '*expected*' secondary to the working relationships of the ED staff. Hospital E ED staff recognized the need to increase staff to ensure staff and patient safety during off shifts and voiced managerial commitment to increasing staff within the next six months.

The ED RNs at all hospitals described staffing and communication as a key indicator of satisfaction. Without staffing, the nurses felt that patient care suffered, nurse satisfaction decreased, and outcomes deteriorated. Nurses described the lack of equipment and supplies as important but not a key element that influenced satisfaction or engagement. The staff interviews provided the valuable information described in Appendices C, D, and E regarding the importance of major factors influencing satisfaction and engagement. These appendices provide participants statements and field notes used for coding.

**Group Two Satisfaction Factors**

The second group described subjective elements including open lines of communication between staff and from leaders, input into decision-making, autonomy, recognition, opportunities for improvement, teamwork, relationships, coaching, mentoring, education, and a sense of accomplishment (Subjective, intangible).

**Communication with leaders.** ED RNs at all hospitals described open lines of communication between staff as an essential factor influencing their ongoing satisfaction. Participant responses focused on the importance of these open lines of communication. Staff provided examples of how patient care suffers (things not being completed), staff feeling of isolation (no back-up to assist when needed), and a sense of working in a vacuum when communication is not open, fluid, and honest. The ED RNs discussed how open dialogue aids them in knowing what needs to be done, the status of the patients, and a sense of how well the team is working as a unit.

Open communication from leaders provided a wide range of discussion. Nurses at Hospital E described open exchange with managers and discussed how this openness allows them autonomy and a sense of connection. Nurses at Hospital C provided detailed information regarding the lack of communication with managers and how this deficiency impacted their daily work. Hospital C nurses outlined the importance of managers listening, hearing, responding, and being emphatic as essential to ED RNs satisfaction. These key needs were described by all participants at Hospital C. ED RNs at Hospital U outlined opportunities for managers to become more involved in communication with staff and stressed the importance of this communication. Nurses described a sense of

isolation, a lack of response, and initiatives undertaken to improve communication. From the interviews, open lines of communication, both upstream and downstream from managers, was described as essential for ED RNs satisfaction.

**Input into decision-making**. ED RNs at all hospitals discussed the importance of input in decision-making. None of the ED RNs stated that involvement into decision-making specifically influenced their satisfaction either positively or negatively yet discussed frustrations when not included. The responses to input into decision-making were difficult to analyze secondary to inconsistency in responses to initial and follow-up questions. Nurses wanted to be included in the decision-making process but did not describe the need as essential to their satisfaction. The nurses described frustrations in feedback and methods of providing information to staff. RNs stated that input frequently occurs as an afterthought and acknowledged that decisions occur at higher levels with minimal input from mid-level managers. The participants from each hospital provided information on committees and opportunities for nurses to become included in the decision-making process and described a lack of input many times due to apathy, lack of connection, or a sense of futility in making change happen within the department. The final analysis was that nurses voiced the need to be included, had opportunities, and had no specific manner, method, or trend in becoming involved beyond wanting feedback.

**Autonomy.** Nurses viewed autonomy as essential to satisfaction. Nurses described the importance of working within guidelines and developing a sense of trust with providers as important to patient outcomes, a sense of accomplishment, and initiation of care. Hospital E nurses outlined the limited resources and requirements to be

autonomous, or a patient might die or have a bad outcome. Nurses at Hospital C communicated a direct connection between the level of autonomy and provider trust. With the increased use of temporary physicians, the nurses described an environment where care providers do not know capabilities of one another as a key factor influencing the degree of autonomy the ED RN takes on when caring for patients. Nurses at Hospital U described a high sense of autonomy and stated the importance of trust, providers, and patient outcomes as leading factors impacting the importance of autonomy.

ED RNs viewed autonomy as expected and necessary describing times when the ED RNs cannot wait for an order to provide care. Delays would negatively influence patient outcomes. The ED RN is expected and required to assess, implement, and evaluate care they provide. The implementation of care takes many forms when practicing as an ED RN. The ED RNs recognized the importance of starting care, implementing care, and coordinating care with providers. All ED RNs interviewed stated that autonomy is essential to ED practice.

**Recognition.** All ED RNs interviewed stressed the need for recognition. The types of recognition varied and ranged from a simple thank you to recognition at a higher level for going above and beyond in the care provided. Hospital E outlined a variety of recognition initiatives provided by managers. Hospital U described recognition at annual reviews and between peers with minimal recognition provided by leaders. The RNs stated that a few types of recognition are in place, but a formal process does not exist in the Hospital U ED. Recognition does occur but usually when the census is high, and the nurses have not had a break. This recognition frequently is pizza or food for the staff.

Unfortunately, the nurses did not view this as recognition as much as management's attempt to make them feel better about the acuity, and lack of breaks. Hospital C nurses described an environment with a limited degree of recognition by managers, negative recognition, and a minimal amount of peer-to-peer recognition attributed to a lack of communication due to the staffing shortages. Nurses at Hospital E described a positive, welcoming environment where nurses and staff are recognized as individuals and as a whole. The nurses talked about luncheons, staff satisfaction recognition parties, and other ways the managers and administration recognized the staff.

All RNs described the importance of recognition extending beyond peers and leaders. The acknowledgment occurred from patients and provided positive reinforcement for the work performed by the RNs. The RNs voiced the need to have someone say thank you, to be told they did a good job, or to hear praise for working in overworked, stressed, and many times violent circumstances. RNs expressed this as an essential need and expressed concerns regarding a lack of effort and support by managers in providing positive rather than negative recognition. Respect and appreciation provided a strong sense of satisfaction to the RN.

**Opportunities for improvement.** Each hospital provided opportunities for improvement on different, distinct levels. Hospital U offered Nurse III and Nurse IV opportunities for RNs to participate in classes, quality activities, and committees to develop leadership, managerial, and educational expertise with specific requirements outlining each process step. Hospital C provided limited opportunities beyond advancement to mid-level management, and Hospital E promoted an environment

fostering nurses to attend conferences, receive advanced certification, and attend college courses. Nurses described opportunities as important for satisfaction with only Hospital C RNs discussing the negative impact of the lack of these opportunities on personal fulfillment. The RNs at Hospital U and Hospital E stated that opportunities were available, and the RNs had to try to use the resources. Hospital C RNs stated that opportunities were available, but short staffing made attendance impossible because the nurse was not allowed days off to attend the offerings.

**Teamwork.** ED RNs considered teamwork as an essential element driving satisfaction. Participants viewed teamwork as the central factor in success or failure in patient care. Nurses at Hospital U described a strong sense of team including physicians, EMT, and ancillary staff. The nurses viewed teamwork as communication, trust, and dedication to the job. Nurses at Hospital C described teamwork as important but stated frustrations related to the lack of team due to nursing shortages. The nurses expressed times of isolation, patient safety concerns, and poor outcomes as issues within the work environment. Hospital E nurses lauded a strong sense of team and the importance of open communication, trust, and autonomy as significant factors in satisfaction within their department. Nurses discussed the importance of knowing your coworkers and how the unspoken communication between team members is essential when caring for ED patients. All nurses stated that teamwork, the development of teams, support of teams by managers, and the team philosophy as fundamental factors essential to ED RNs. satisfaction.

**Relationships.** The ED RNs interviewed discussed the connection of teamwork with the success of relationships. Nurses described the importance of knowing the capabilities of coworkers, understanding strengths and weaknesses of workers, and using skills as essential to providing safe nursing care. Hospital E nurses outlined strong internal and external relationships between coworkers. The nurses described how well they functioned as a team and the importance of knowing your partner. Hospital U nurses described strong work relationships as well as a close-knit family atmosphere among the nursing, physician, and ancillary staffs. The nurses described a family working relationship with open communication, trust, and sense of accomplishment. The Hospital U nurses discussed the importance of relationships on both good and bad working days. The nurses described the importance of the support provided by these relationships. Nurses at Hospital C described good working relationships in a stressed, understaffed environment. These nurses outlined the importance of these relationships to their satisfaction when at work. The nurses described these relationships as emotional, psychological, and physical assistance to complete work.

**Coaching/Mentoring.** Nurses from all hospital and generational cohorts described coaching and mentoring as important but not as important as the orientation process. Hospital U, C, and E lacked formal mentoring or coaching programs and described standard orientation processes lasting upwards of six months. Participants discussed frustrations with orientation programs and the lack of follow-up, follow-through, or ongoing mentoring of new employees as a factor influencing staff satisfaction. Nurses at Hospital U voiced concern that nurses receiving a less than

adequate orientation would be less engaged or satisfied in the ED work environment. Hospital C nurses described the importance of a structured orientation process secondary to new staff currently working coming to the ED with limited ED or nursing experience or expertise. A formal orientation would provide a safety net to ensure current employees at Hospital C that new nurses have the basic knowledge to provide care. The Hospital C nurses expressed deep concern for the nurse and patient safety with the novice RN coming to work in the ED. Hospital E RNs praised managers for developing a mentoring program for floor nurses, and one RN stated that she is involved in developing a mentoring program for the ED staff. Nurses outlined formal orientation processes and ongoing mentoring as factors influencing ED RNs satisfaction.

**Education.** Nurses communicated the importance of education. Nurses described ED nursing as ever-changing, chaotic, and evolving. Hospital E nurses portrayed managers as supportive participants in education. Leaders provided opportunities for nurses to attend conferences, practice/maintain high priority/low volume skills, and obtain advanced certification or ongoing college education. Hospital U nurses defined education as predominately internal with multiple areas for improvement. Hospital U nurses explained that two nurse educators were currently developing educational programs. The nurses described current in-house education as sporadic, redundant, poorly planned and executed, and inconsistent. Nurses depicted education as essential to maintaining skills and improving patient care. Hospital C nurses expressed concerns over the lack of quality education, poorly timed educational opportunities, and current methods used to provide educational events. Hospital C nurses communicated that due to

a lack of staffing they were unable to attend outside educational opportunities. All nurses stated that education is essential for ED RNs satisfaction for a multitude of reasons including safe care, improved patient outcomes, and personal and patient safety.

**Sense of accomplishment.** Nurses at all hospitals and within each generational cohort described the need to feel a sense of accomplishment. ED nurses provide care across a continuum of ages and move from death to birth in an instant. Nurses at Hospital E voiced the importance of patient outcomes and how the outcomes directly impact the personal sense of accomplishment. Nurses from Hospital U expressed the importance of the simple act of seeing a patient get better as influencing their sense of accomplishment. Recognition from peers or managers provided another layer to this sense of accomplishment. Hospital C nurses depicted a group of nurses struggling to feel a sense of accomplishment in an environment of poor communication and managerial support coupled with short staffing, increased acuity, and higher patient volumes. Nurses stated that a simple thank you or smile sometimes provided a sense of accomplishment.

All nurses voiced concerns that the managers lack of empathy directly impacted the RNs sense of accomplishment. Staff stated that when acuity and stress are high, the sense of accomplishment decreased, care lessened, quality suffered, and outcomes deteriorated. All interviewed RNs expressed a sense of accomplishment as essential to personal well-being, professional fulfillment, and quality patient care.

**Group Three Satisfaction Factors**

The third group contained elements impacting the nurse either directly or indirectly and included stress and stress reduction, compassion fatigue, violence, safety,

and overcrowding. These factors are many times uncontrollable. Even in an uncontrolled environment, the impact on the ED RNs can be tremendous. Understanding the impact of these factors provides insight into satisfaction and engagement.

**Stress.** Every RN described the ED as a stressful environment. The degree of stress varied in interview responses with no differences between hospital or generational cohort RNs. Multiple nurses described stress as anticipated in the chaos of ED nursing. Sentiments at Hospital U echoed RN staff sensing that managers expected the nurses to '*suck it up*' and inconsistency in managerial visibility contributing to increased stress. Five ED RNs at Hospital C used the phrase '*suck it up*' when describing stress while at work. All ED RNs at Hospital C voiced concerns over the lack of compassion from managers related to the day-to-day stress and work environment.

Hospital E ED RNs viewed stress as expected and stated that managers recognized staff stress with actions supporting methods to decrease stress and workload. The nurses at Hospital U described a stressful work environment laced with strong relationships, teamwork, and commitment to providing excellent care. None of the hospitals provided stress reduction programs, departmental discussion regarding stress, or stress recognition education. Nurses identified stress reduction as essential to creating burnout and recognized the need to create programs or opportunities to decrease stress. No ED RN discussed call-outs, stress-related illnesses, or staff related problems during the interviews. The nurses' words describing stress as normal, expected, and anticipated evoked my concern for the nurses' well-being, work life balance, and physical, mental, psychological, and emotional health.

**Compassion fatigue.** The term compassion fatigue created misunderstanding from ED RNs during the interview process. The interview responses focused on nurse fatigue and rarely on the ability to provide compassionate care. The responses focused on nurse frustrations with specific patient populations such as patients seen frequently, drug seekers, and chronic ED abusers. An attempt to re-focus the discussion to broader issues of compassion fatigue or burn-out yielded a minimal change in participants responses. Seventeen of the 21 ED RNs stated that they did not believe that compassion fatigue directly impacted work satisfaction and held that the term frustration provided a more suitable description of the issues causing stress. Baby Boomers and Generation X RNs voiced concerns related to younger Millennial RNs not understanding their capabilities and how this lack of insight could potentially negatively influence how long the Millennials remained as nurses.

**Violence.** Hospital U nurses voiced concerns about the increased violence seen in the ED especially with limited psychiatric resources, increased opiate addiction/misuse, and increased societal violence. Hospital U nurses described an environment of verbal and physical abuse with a strong security presence and law enforcement support system in place. Hospital U required in-house training on the management of violent patients. Nurses at Hospital C described an increased level of violence occurring in the ED related to increased psychiatric admissions, compounded by opiate seekers and abusers, limited security personnel, and inadequate staff training in the management of violent patients. Hospital C nurses sensed an increased the level of verbal and physical abuse over the last few years. Nurses at Hospital E had experienced one physical confrontation over the last

two years. The nurses described verbal abuse as limited and adequate training in the care of violent patients.

**Safety**. The literature review provided information on the physical and violent nature of the ED environment. Hospital E nurses expressed a general sense of safety while at work yet were quick to offer that being isolated and small also presented other safety concerns. Hospital E provided panic buttons throughout the ED. Nurses expressed concern over the increasing opiate epidemic and the closeness to the interstate and border as concerning issues. The limited capabilities of the police related to the large service area provided concerns for Hospital E nurses.

Hospital U nurses articulated a sense of safety secondary to the in-department security presence, Code 8 (out of control patient) response team, management of aggressive patient training, and rapid response from law enforcement as factors supporting a sense of safety. The Hospital U nurses voiced concerns over the increased number of out-of-control patients, added number of violent psychiatric patients, and increased verbal and physical abuse as concerns for individual, staff, and patient safety within the department.

Hospital C RNs echoed the concerns of Hospital U nurses while stressing the inadequate staff training in the management of violent patients in their facility. The Hospital U nurses sensed an increase in violent behaviors and drug seeking as concerns for individual safety. Hospital C RNs stated that violence has increased over the last few years and they did not feel that management was aware of the threat the nurses faced on a

day-to-day basis. Nurses at Hospital C felt that a bad situation would happen before anyone from administration moved to make the department safer.

**Overcrowding.** For many ED RNs, ED overcrowding has become a normal way of life as a care provider. Hospital C nurses stated that overcrowding is a daily event with a poor quality of care, delays, and potential poor patient outcomes. Hospital C nurses viewed overcrowding as expected and stressed the importance of managerial support, assistance, and understanding of increased acuity and volume. Hospital U nurses stressed the impact overcrowding has on the nurse, patient, and family. As volume increased, Hospital U nurses sensed an increase in stress, less control, and increased opportunity for mistakes, poor outcomes, and patient dissatisfaction. Nurses described concerns over the quality of care, patient confidentiality, and respect for patients placed in hallways for care. One nurse at Hospital U stated she believed patient care in hallways was disrespectful, unrewarding for the nurse and patient, and viewed this care as subpar. Hospital E nurses stated they rarely had issues with overcrowding and if needed hall beds would be opened to accommodate increased volume. All respondents detailed concerns related to overcrowding and the potential poor outcomes, satisfaction, and confidentiality issues when the ED is at maximum capacity.

**Group Four Engagement Factors**

The final group assessed engagement themes and included skill utilization, trust, connection with coworkers, work, and the organization.

**Skill utilization.** All ED RN respondents verbalized that their skills were maximally used or tested as an RN. The RNs stated the importance of being up-to-date on

skills, acknowledged the need for competency in high risk, low volume skills, and recognized the importance of education, knowledge, and acquisition of competency with new skills, equipment, or supplies. The competency, skill, or comfort level designated the physical, emotional, and cognitive aspects of engagement as outlined by Kahn.

**Trust.** Nurses at Hospitals U and E expressed a strong sense of trust between coworkers while nurses at Hospital C described trust based on comfort levels with specific staff working together or as a team. Nurses at Hospital E expressed a strong sense of trust between staff and managers while Hospital U nurses described concerns with managerial visibility, communication, and follow-through as direct influencers of trust. Hospital C nurses expressed minimal trust in leaders expressing discontentment at a variety of levels including communication, respect, and leadership. All nurses viewed trust as essential to becoming engaged and supported open lines of communication, discussion, and respect as key contributors to individual engagement at the work and organizational levels.

**Connection with coworkers.** All ED RNs interviewed accredited the strong sense of connection with coworkers as an essential component of ED nursing. Without a sense of connection with coworkers, ED RNs described opportunities for mistakes, miscommunication, delays in patient care, and potential poor outcomes. Nurses at the three hospitals described the connection with coworkers as a bond to improved care, essential to emotional health, and improved work experience. Nurses described strong engagement with coworkers.

**Connection with the work**. The connection with work is defined as the work performed in the organization and not solely as an RN. The Hospital C ED RNs described a low. These nurses voiced discontentment with leaders at the highest and lowest level of the organization as non-caring, non-supportive, and not committed to nurse satisfaction. The nurses stated that these negative attributes lead directly to a poor connection with the work secondary to the general hospital attitude and atmosphere. A strong sense of connection with work was described by the nurses from Hospital E. Nurses from hospital E voiced the connection between the work, the job, the organization, and the community. The responses provided positive attributes to support this connection. Nurses alluded to administrators speaking directly to the nurses, awareness of expectations, and a close unity between the work and quality of care.

The nurses interviewed at Hospital U had mixed reviews of the connection to work. The nurses voiced a strong sense of connection secondary to the role the hospital plays in the region, the lead role taken as an academic center, and as a Level I trauma center. The connection had limitations due to a lack of unity or connection between the staff and unit leaders. A disconnect was felt and the nurses interviewed described a lack of caring (or sense of) as a major factor in the lack of connection with the work performed. These nurses sensed a strong connection with being a nurse yet felt a disconnect with working for the medical center secondary to a lack of caring from leaders.

**Connection with the job.** The connection with the job identifies the job as duties performed by the RNs in the role of a nurse. The respondent RNs described the

connection with the job as low at Hospital C, moderate at Hospital U, and high at Hospital E. Hospital C RNs outlined frustrations with low staffing, high nurse-to-patient ratios, poor communication from managers, and lack of recognition as key variables influencing job engagement. The Hospital C nurses stated difficulties in becoming engaged when survival to complete the basics was a priority. Hospital U nurses provided mixed feelings related to a connection to job. Five of the ten respondents voiced a high connection to the job while 33% sensed a limited connection to work based on communication from leaders and overcrowding, acuity, and volume of psychiatric holding patients. All ten voiced their love of nursing and stated that even with the concerns expressed would always enjoy the job of being a nurse. Hospital U RNs recognized the importance of the job they performed at the hospital and acknowledged a strong sense of connection to the work performed, the patients served, and the community requirements. Hospital E nurses expressed a strong sense of connection with the job. Each nurse discussed the love of the job, the joy of being a nurse, and the satisfaction he or he attained from being a nurse.

**Connection with the organization.** The nurses at Hospital E collectively acknowledged a strong sense of community, pride, and expectations to and from the organization. The nurses expressed pleasure in working at the hospital, in serving the patients, community, and for being part of the organizational mission, vision, and values. Nurses at Hospital U felt a minimal connection with the organization and expressed reservations related to the organizational strategic planning and vision for the organization. One RN voiced her concerns regarding the exclusion of the nursing

shortage as a key aspect of the Hospital U five-year strategic plan. Hospital C nurses conceded that organizational connection was lacking on many levels and described a senior leadership team as distant, unapproachable, and uncaring. No Hospital C nurses viewed a connection with the organization.

## Generation Cohort Assessment

The literature reviewed illustrated differences in expectations, demands, and requirements for various generations. The generation cohort assessment revealed minimal relevant data to describe or define differences in satisfaction and engagement between Baby Boomers, Generation Xers, or Millennials. Baby Boomers identified concerns about the Millennial generation's lack of knowledge and skills with potential impact on patient outcomes. Only three (14%) voiced this concern. Two (9%) of the Baby Boomers voiced concern over disrespect and use of resources by the Millennials as concerns. Generation X participants voiced concern over the changes that are occurring in the provision of care, work ethics, and timeliness (14%). One Millennial (5%) expressed concern over the Baby Boomer's ability to provide efficient, timely, and productive care.

The development of patterns and themes provided valuable information used in determining positive (+), negative (-), or neutral (+/-) elements influencing ED RNs satisfaction and engagement. Information provided in Table 11 outlines themes and elements viewed as essential (positive) or non-essential (-) to ED RNs satisfaction and engagement.

Table 11

*Positive and Negative Influences on Satisfaction and Engagement*

| Themes | Hosp U | Hosp C | Hosp E |
|---|---|---|---|
| Staffing | + | + | + |
| Equipment/Supplies | - | - | - |
| Staff communication | + | + | + |
| Leader communication | + | + | + |
| Decision-making | +/- | +/- | +/- |
| Autonomy | + | + | + |
| Recognition | + | + | + |
| Opportunities | +/- | +/- | +/- |
| Teamwork | + | + | + |
| Relationships | + | + | + |
| Coaching | + | + | + |
| Education | + | + | + |
| Accomplishment | + | + | + |
| Stress | + | + | + |
| Compassion fatigue | + | + | + |
| Violence | + | + | +/- |
| Safety | + | + | +/- |
| Overcrowding | + | + | +/- |
| Skill Use | +/- | +/- | +/- |
| Trust | + | + | + |
| Connection coworkers | + | + | + |
| Connection job | + | + | + |
| Connection work | +/- | +/- | + |
| Connection hospital | +/- | +/- | + |

## Relationship with Research Questions

The relationship between study results and research questions established a bond analyzing interview responses and developing themes and patterns describing the beliefs, perceptions, and ideas of factors influencing satisfaction and engagement. The thick, rich interview data provided valuable evidence outlining themes and patterns of elements influencing satisfaction and engagement. The relationship between the research data, conceptual framework, literature review, and research question established a connection linking elements of satisfaction and engagement.

Overarching RQ: How do ED RNs describe satisfaction, satisfiers, engagement, and disengagement in the professional work environment?

Specific themes and factors influencing satisfaction and engagement included

- resources: Staffing
- resources: Equipment and supplies
- communication between staff
- communication with management
- decision-making
- autonomy
- recognition
- opportunities for improvement
- teamwork
- relationships
- coaching and mentoring

- education
- compassion fatigue
- violence
- stress
- overcrowding
- connection with coworkers
- skill utilization
- trust
- connection with job
- connection with work
- connection with organization

RQ1: What are the satisfiers and dissatisfiers identified by ED RNs as contributors to personal and professional satisfaction?

After data analysis, established themes viewed as essential for ED RN satisfaction included,

- adequate staffing
- defined nurse-to-patient ratios
- open communication with managers
- positive relationships with managers
- input into decision-making
- autonomy
- recognition

- opportunities for improvement as a professional
- quality, frequent, and timely education
- teamwork
- formalized coaching/mentoring/orientation
- identification of compassion fatigue and programs to assist RNs
- identify violence and develop plans to protect staff and improve patient care
- provide an environment fostering nurses to achieve a sense of accomplishment
- identify measures to decrease overcrowding with back-up plans
- foster trust by improving relations with managers

RQ2: What factors contribute to ED RNs engagement at the personal, department, and organizational levels?

All engagement interview responses were reviewed, analyzed, and coded. The questions focused on connection with coworkers, trust, skill utilization, connection with the job, work, and the organization. These questions related to Kahn's (1990) cognitive, physical, emotional, and psychological engagement needs. The results illustrated that all RNs felt a connection with coworkers at some level. RNs viewed skill utilization as a minor contributor to engagement with trust and connection to job viewed as essential components. Nurses discussed varying factors influencing connection to work with only 33% (7/21) stating a sense of connection to work.

RQ3: How do hard and soft work elements such as direct management, teamwork, leaders, and resources influence nurse satisfaction and engagement?

Specific hard elements included pay (2/21 or 7%), education, adequate staffing (100%), and opportunities for improvement (100%). Soft elements included communication both upward and downward, decision-making, autonomy, recognition, teamwork, relationships, coaching and mentoring, awareness of compassion fatigue, violence, stress, sense of accomplishment, overcrowding, connection with coworkers, trust, and connection with job and work.

RQ4: What emotional and psychological connections do nurses describe as making him or her feel engaged in individual, team, job, and organizational work and performance, or as providing a feeling of accomplishment and use of personal skills?

The emotional and psychological connections found after analysis and coding included autonomy, recognition, relationships, teamwork, compassion fatigue, stress, sense of accomplishment, trust, and a connection with the job, work, coworkers, and the organization. Kahn described the need for emotional, cognitive, physical, and psychological connections for an employee to experience engagement. The ED RNs described emotional disengagement related to a variety of factors as well as psychological factors such as respect, recognition, and input as essential to engagement beyond the job level. Nurses expressed the importance of the cognitive aspects of engagement such as clear, open communication, understanding of requirements, and input into decision-making.

RQ5: What themes, perceptions, impressions, barriers, frustrations, and opportunities to improve satisfaction and engagement emerge related to the influence of direct management, teamwork, systems, leaders, and resources?

Key themes and impressions included resources, communication, and recognition. Nurses described barriers to satisfaction and engagement as poor communication, lack of recognition, staffing, nurse-to-patient ratios, violence, and overcrowding. Nurses at Hospital U outlined opportunities to improve communication as essential to improving individual satisfaction. Staff provided suggestions to improve safety (more education to make staff safe), education (planned, formal educational opportunities), staffing (assistance from managers), and decision-making (include staff in the discussion).

## Summary

Multiple case study provided opportunities to obtain rich, thick data on factors influencing ED RNs satisfaction and engagement. The interviews provided valuable information on specific elements impacting care, outcomes, and fulfillment for the nurse and patient. The assessment and analysis included the development of themes and sub-themes specifically linking the literature review, conceptual framework, research questions, and study results. As a novice researcher, care was taken to proceed cautiously to ensure credibility, trustworthiness, and a non-biased approach to the interview process, data collection, analysis, and coding. Gaining insight into factors affecting ED RNs staff required analysis of the interview information to understand how and why specific components influence satisfaction and engagement. The research results provided information focusing on the importance of safe staffing, communication with leaders and

autonomy. Interviews also provided additional supporting information regarding recognition, teamwork, relationships, coaching, education, violence, safety, and overcrowding. Factors related to engagement centered on trust, connection with coworkers, and connection with the job as elements. The information provided in Chapter 5 expands on the study results and provides information relating to study limitations, recommendations, implications, and implications for social change.

# Chapter 5: Discussion, Conclusions, and Recommendations

## Introduction

The purpose of this qualitative case study was to determine factors influencing ED RNs satisfaction and engagement using semi structured interviews of three generational cohort ED RNs working in three hospitals of varying sizes and capabilities. I used coded interview data to develop themes and patterns outlining objective and subjective factors, directly and indirectly, influencing the ED RNs beliefs, descriptions, and elements of work satisfaction and engagement. Satisfaction elements included objective and subjective components as well as factors outside of the ED RNs control such as overcrowding and violence. The participants' responses provided evidence to support the need for adequate staffing, appropriate nurse-to-patient ratios, and open lines of communication. Participants valued input into decision-making, autonomy, recognition, opportunities for improvement, teamwork, relationships, coaching, education, and a sense of accomplishment as factors influencing personal and professional satisfaction. Engagement elements included skill use, trust with leaders and between staff, and a connection with work, the job, and with the organization.

## Interpretation of Findings

Analysis of the research data provided valuable information related to satisfaction and engagement. The literature review supported a connection with study results. Both satisfaction and engagement are multifaceted and diverse. The study interpretations support confirmation, disconfirmation, and extend knowledge of that analyzed in the literature review. The findings provided show consistencies in factors described by ED

RNs participating in this study with current peer-reviewed literature. The study participants provided examples of elements that satisfy, dissatisfy, engage, and disengage an RN and directly impact personal and professional fulfillment. The literature review supported the analysis and focused on the importance of the results and the link to current peer reviewed literature.

## Engagement: Positive State of Work Mindfulness

The psychological, cognitive, emotional, and physical attributes of engagement illustrated the direct impact of personal and professional factors on the employee's degree of engagement. Bargagliotti (2012) described engagement as a positive state of work mindfulness. The engagement required trust between coworkers, as well as with managers, and included teamwork, autonomy, and communication. Responses from ED RNs at Hospital E described the work environment as positive, autonomous, and supporting open communication between workers and managers. Conversely, the responses provided by ED RNs from Hospital C outlined a negative environment with minimal engagement between workers, less with the job, and a negative connection between the RNs and the organization. The Hospital U ED RNs described strong engagement at the work and job level while outlining a limited connection with the organization's mission, vision, and values.

Nurses described trust and the connection with the job as factors influencing engagement. All interviewees stressed the need for trust and a strong connection with the job as essential for feeling engaged in work performed. Wollard and Shuck (2011) outlined the problems in supervisor-subordinate relationships as directly leading to issues

of retention, poor patient outcomes, and lessened individual nurse involvement with their work. The negative relationships described by a Hospital C RNs illuminated feelings of isolation, psychological strain, and a sense of personal persecution. The ED RNs at Hospital U emphasized the importance of trust and a connection with coworkers similar to those described as satisfaction requirements in the literature such as respect, sense of accomplishment, autonomy, and recognition. Rivera et al. (2011) determined that the greatest contributor to employee retention was management action or inaction.

Aspects of engagement linked directly to a sense of comfort (Valentine et al., 2015). Nurses highlighted the importance of teamwork to intrinsically motivate employees leading to an increase in an engagement at the work, job, and organizational levels (Bøgeskov, Rasmussen, & Weinreich, 2017). The data analysis provided information to support the need for teamwork, relationships, and a connection between staff and managers as key factors guiding employees toward engagement. Participants expressed workload as a direct influencer of engagement.

All participants stressed the importance of safe staffing levels, as well as the impact of the nursing shortage, staffing concerns, and overcrowding on engagement and satisfaction. For example, the critical access hospital ED RNs described open lines of communication, feeling valued, and a high degree of trust coupled with an engagement at the job, work, and organizational level. Conversely, the Hospital C ED RNs voiced low levels of trust, limited communication, and a sense of devaluation. One employee described the devaluation leading to a subsequent lack of involvement, not caring about work, and the urge to change job location and go to another department.

Pfaff et al. (2014) also outlined specific factors viewed as essential to employee engagement. These factors focused on teamwork, mentoring, proximity to education, supportive leadership, and time. ED RNs identified with a strong sense of team, work relationships, and autonomy (Mone & London, 2017). The participants described the need for mentoring, education, and a sense of accomplishment. Experiencing a sense of accomplishment required support from coworkers and managers, patient satisfaction and input, and time to complete tasks. Nurses expressed the need for autonomy, feedback, support, and positive customer perception to develop and maintain personal and professional satisfaction and engagement. Nurses, front-line care providers, discussed the importance of freedom to provide care, gain insight into outcomes, and manager recognition of nursing care provided. Safe staffing, communication, collaboration, responsibility, morale, meaningfulness, and recognition directly influenced satisfaction and engagement (Ulrich et al., 2014).

The engagement occurred at four levels. These levels include the psychological, cognitive, emotional, and physical levels as described by Kahn (1990). The psychological levels outlined in the research analysis included a sense of meaningfulness, autonomy, fairness, trust, support for compassion fatigue, and integrity (communication, support, and feedback) of supervisors. The psychological components demonstrated the importance of a positive psychological climate; they included adequate resources, safety, and input into decision-making (Adriaenessens & Maes, 2015). Cognitive factors acknowledged the importance of professional and personal development, communication, leadership skills, and connection with staff, work, and the organization. The emotional

level of engagement promoted a sense of accomplishment, innovation, input into decision-making, safety, and compassion fatigue while the physical characteristics outlined the importance of resources, adequate staffing, outcomes, work life balance, workload, and time (Knight, Patterson, Dawson, & Brown, 2017).

The data analysis supported the importance of these variables influencing staff engagement at the job, with the work, and at organizational levels. ED RNs expressed the importance of autonomy, fairness, support for compassion fatigue, communication, and trust and their direct relationship to staff engagement. ED RNs at all hospitals and within all generational cohorts stressed the importance of relationships to improve teamwork and enhance a sense of accomplishment. Emotional engagement factors prompting disengagement included a lack of open lines of communication, a lack of managerial trust, a lack of empathy toward employees, and a sense of isolation (Alharbi, 2017). Participants communicated the importance of the relationship between emotional mistrust and a lack of connection at the work and organizational levels.

The interpretation of the engagement components of the interviews provided clear information outlining specific factors on employee engagement. Key components included staffing, staffing shortages, unsafe nurse-to-patient ratios, communication, autonomy, sense of accomplishment, recognition, opportunities for improvement, trust, and connection with coworkers, the job, the work, and the organization. Participants discussed the managers' role in controlling work conditions such as safe staffing levels, visibility of managers at crisis times, and emotional support for staff. The analysis showed a sense of engagement with the job by all participants and expressed fundamental

needs including safe staffing, open communication, trust, and connection with coworkers as essential needs.

**Trust**

The ED RNs described the need for trust between one another as well as with and from managers. The trust between peers focuses on an established relationship, open communication, teamwork, and autonomy. The ED RNs does not work in a vacuum and expressed an understanding of the need to trust. The ED RNs described trust as verbal, through actions, and nonverbal, which was seen as anticipation, unspoken communication, and the sense of trust in how and what the coworker provides to assist the RN (Roussel, Thomas, & Harris, 2016). The ED RNs also expressed the importance of trust with leaders, and the leader's trust with the staff, RNs, and the work performed. ED RNs described the need for trust to be bidirectional, open, truthful, and direct (Kaiser, 2017). The RNs outlined the importance of the visibility of leaders to staff. The visibility provided a sense of acknowledgment, caring, and involvement. This acknowledgment, caring, and involvement provided a foundation of trust that leaders listened, cared, and respected staff.

**Interpretation**. Trust is fundamental for an ED RNs. Trust is essential between staff and with managers. A direct relationship included open, understandable communication, verbal and nonverbal dialogue, teamwork, autonomy, respect, and positive interactions (Morisani, Bagnasco, & Sasso, 2017). Nurses have a strong sense of reliance on each other and value the importance of how, what, and why others assist in providing care. Trust links directly with positive, productive patient outcomes. A nurse

cannot provide care without the assistance of others. The lack of trust produces a nurse unwilling to ask for assistance, a coworker unable or reluctant to aid a fellow RNs, or fear that assistance will result in significant unfortunate outcomes.

The lack of trust with and from leaders produces an atmosphere of mistrust, isolation, resulting in unreliable, questionable communication (Gopee & Gallowary, 2017). Nurses demand and require trust with and from managers. The trust must be reciprocal. Nurses must also be trustworthy if demanding trust from leaders. Nurses deal with life and death situations, provide highly skilled, professional patient care, and make snap decisions. Trust allows the nurse the opportunity to use these skills to provide services in an atmosphere free from self-doubt, the fear of persecution, and apprehension about doing something wrong (Bradd, Travaglia, & Hayen, 2017). Mistakes happen, and support and trust that managers can and will be thorough in investigating, interpreting, and discussing errors, outcomes, and care is important to all RNs providing patient care.

**Skill Utilization**

Skills and skill sets are essential to the work ED RNs perform. Skills range from routine to high risk, low volume skills. Whether routine or high risk, the ED RNs requires education, training, and evaluation in skill utilization. Skills determine a level of competency. Competency includes the ability to perform the skill (physical), the knowledge to perform the skill (cognitive), and a sense of comfort in skill performance (emotional). The interviewed ED RNs voiced the importance of skill utilization and the need for education, training, and monitoring of new skills. The ED RNs stated that skill utilization and competency directly impacted patient outcomes. If a nurse cannot perform

a skill, does not understand the skill, or feels discomfort when performing the skill, the RNs provides suboptimal care. Competency requires input from educators, methods to ensure competency, and ongoing education.

**Interpretation.** The inability to perform skills impacts patient care. An example is when the ED RNs might improperly place defibrillator pads when a patient requires conversion from a life-threatening heart rhythm. Skill utilization is a basic, fundamental element of ED RNs care. Some skills, such as placing an IV or putting a patient on a cardiac monitor, are routine. Less frequently used skills include high-risk, low-volume activities. These skill sets require an RNs to be competent, cognizant, and unafraid of the set-up, completion, and follow-up required for the procedure. Many of the high-risk, low-volume skills are needed emergently or at a time when the RNs needs to be ready to perform, able to complete, or competent to assist in the procedure.

A direct tie exists between skill utilization and education. ED RN require ongoing, continuous education secondary to the variety of patients treated in the ED, the evolving needs of patients, and the critical nature of the work. Management must ensure that ED RNs have regularly scheduled, ongoing, and adequate education to maintain skill sets and train new employees so the nurses feel comfortable, competent, and able to perform the skills. Competent skill practice impacts patient outcomes.

**Connection with Coworkers**

ED RNs discussed the importance of a connection with coworkers. This connection included elements of engagement and satisfaction. ED RNs described a sense of comfort, safety, and improved outcomes when a strong connection was felt,

established, or maintained with coworkers. This connection reinforced emotional and psychological health during times of stress, with difficult patients, and promoted positive relationships, patient outcomes, and work environments (Bruyneel, Thoelen, & Sermeus, 2017). The positive connection with coworkers also promoted constructive group behaviors, thoughts, and interactions. The positive, constructive group behaviors advancing optimism at work (Ciocco, 2018). Environments filled with negativity, deficient communication, and mistrust promoted a disconnect between workers and a sense of isolation (Boaman & Laschinger, 2015).

Maslow described the importance of meeting basic physiological and safety needs before moving to higher psychological or cognitive levels. The perception of connection provides a safe and comfortable work environment promoting trust. Impact occurs at many levels when teamwork, patient care and workers do not function with a direction, purpose, and shared values. A lone individual professional cannot provide the required multi-layered and multi-faceted levels of ED care. Care extends beyond a band-aid and includes assessment, interventions, re-assessment, and multiple levels of decision-making to ensure safety, efficiency, and cost-effectiveness.

**Interpretation**. A connection must occur between the ED RNs and peers (Cho & Kim, 2014). The coworkers extend beyond RNs and include physicians, aides, ancillary service providers, and other individuals involved in patient care. A positive connection between workers provides safety, comfort, and trust (Sinclair et al., 2015). The connection occurs at many levels including assisting with care, spoken and unspoken communication, the anticipation of needs, support at a variety of levels including

emotional, spiritual, and psychological, as well as coordination of care (Bellagamba, Gionta, Senergue, Bèque, & Lehucher-Michel, 2015). Nurses acting as primary care providers deliver care, compassion, and support to patients, families, and other care providers. The connection with coworkers is an expected, anticipated, and many times never discussed between peers. The expectations exceed the need to discuss. Nurses require assistance and a strong connection provides support, teamwork, positive relationships, and aids in providing a sense of accomplishment, completion of tasks, and producing satisfaction for the nurse, patient, and families.

**Connection With the Job**

A connection with the job describes the work of being a nurse including caring, skills, and compassion. ED RNs possesses unique skills, provide care, and interact with patients uniquely. Nurses working in different units and in different roles provide basic care to patients while also delivering specialized care through a variety of methods. For example, nurses on a medical-surgical unit may not start intravenous lines while the ED RN are expected to start all intravenous lines across the age continuum. The connection with the job is distinctive in the ED. The ED RNs experience patients of a variety of ages, medical illnesses, trauma, surgical requirements, or wellness examinations. The ED RN is unique, specialized, and enjoy the adrenaline rush of the emergency situations provided in the environment of the unknown.

ED RNs expressed a strong connection with the job of being an RN. The RNs voiced the love of the job, the experiences and excitement of the unknown, and the pleasure of making a difference in the patient's life. The nurses described the stimulation

of the '*save*', the thrill of seeing positive outcomes, and an eagerness to provide quality care. The RNs expressed concerns related to the overcrowding, violence, drug issues, and psychiatric patients are factors influencing job satisfaction. While expressing these complicating factors, the RNs expressed the importance of the ED RNs job, the essential role they played in the outcomes of patients, and the devotion to providing safe, effective, and efficient care (Basu, Qayyum, & Mason, 2016). The phrase *Once an ED RN, always an ED RN* echoed loudly throughout the interviews. Benner's stages of clinical competency support the connection with the job as seen through advancement in a nurse's tenure.

**Interpretation.** While ER RNs struggle with increased acuity and volume, the RNs described a sense of satisfaction and connection as essential in keeping them engaged, satisfied, and involved in the job. The RNs discussed the importance of the nurse role, the distinctiveness of the provided services, and the motivation to provide excellent care. While the ED RNs describe frustration with their institution, the RNs remains focused on the simple act of providing care. The connection with peers, communication, and relationships aid in strengthening the connection with the job of nursing (Ke & Hung, 2017). ED RNs, while stressed, remain dedicated to providing nursing care without questioning the need for the care, the importance of the patient, and quality of the anticipated outcomes.

**Connection With the Work**

The definition of connection with work included the physical work environment, the workplace culture, and social, psychological, emotional, cultural, and cognitive

elements in and with which the ED RNs participate as an RN. Hospital E nurses voiced a strong connection with work as well as a positive description of the work environment. Hospital E ED RNs described an optimistic, constructive work environment including managerial support, appropriate educational opportunities, and an environment supporting a positive work life balance. Conversely, ED RNs from Hospital C outlined a minimal connection with work (Rasmussen et al., 2014). The limited connection included negative elements such as limited staff, inadequate communication, a lack of managerial support, and disapproving, downbeat organizational culture. Hospital U ED RNs acknowledged a healthy work environment interlaced with communication, leader visibility, managerial support, and overcrowding issues. The nurses, while voicing frustration, characterized the barriers, identified specific challenges, recognized improvement process changes, and focused on improving outcomes.

**Interpretation**. A connection to work requires both subjective and objective factors. Herzberg described these elements as essential to satisfaction. These same elements are easily transferrable to Kahn's descriptors of elements influencing engagement. Factors that directly impact the psychological, emotional, cognitive, or physical nature of the work performed, influence the employee's sense of connection with the work. When the work environment is physically, emotionally, or psychologically unsafe, unstable, or unfit, the employee does not connect with the work. An ED RN labors in close quarters, working with sick patients in a stressful environment of too many patients and too few staff. Developing or fostering an environment supporting the psychological, emotional, cognitive, and physical needs of the RNs aids in promoting a

healthy connection with work. The secondary impacts include a happier, satisfied, less stressed, healthier, and improved work life balanced healthcare provider who wants to come to work, do a great job, and feel a sense of accomplishment in the job performed.

**Connection With Organization**

ED RNs interviewed from Hospital E described a close-knit workforce, engaged, connected, and involved as providers, peers, and at the organizational and community level. The RN described an interwoven relationship between nursing, organization, and community. This relationship supported interpersonal relationships, communication, safety, comfort, and a sense of brotherhood. The ED RNs from Hospital C described a culture of negative, non-caring, and unsupportive staff experiencing a minimal connection with the organization, laced with distrust, poor communication, and dysfunctional managerial staff. Hospital U RNs voiced pride in the institution, a strong sense of commitment to providing safe care, and an awareness of a disconnect between upper management and staff. Nurses described this disconnect as a separation between the workers and the leaders, a divide between the reality of patient care and expectations, and a limited knowledge of how staff functioned day-to-day.

**Interpretation.** The connection with the organization is not essential for the worker. A worker can be happy, satisfied, and engaged at other levels without developing a connection with or toward the organization. What factors cause an employee to develop a strong connection with the organization? If satisfied workers produce happy customers, do hospitals need to produce happy workers to develop a strong connection to the organization? Hospitals strive to produce happy customers to obtain a market share of the

healthcare dollar. To combat the nursing shortage, to promote retention, and foster recruitment requires hospitals to develop programs, opportunities, and systems to improve engagement (Graban, 2016). Supporting a positive environment to engage the RNs promotes engagement. Promoting engagement fosters constructive elements to support trust, maintain relationships with peers, support emotional health, and build optimistic work environments.

**Satisfaction**

Satisfaction is also a multi-faceted and complex phenomenon influenced by various factors (Allan, Dexter, Kinsey, & Parker, 2016). Responses and analysis identified adequate staffing, open lines of communication, autonomy, recognition, and respect for and from managers as the key factors influencing satisfaction. The interviews provided information to support, confirm, and extend knowledge identified in the literature review. Brunges & Foley-Brinza (2014) discussed the importance of building an organizational and workplace culture fostering nurse satisfaction, safety, and quality outcomes. The ED RNs interviewed expressed the need for a positive workplace culture that recognized the RNs and fostered teamwork and positive relationships. This satisfaction also fostered the incentive to remain with the organization rather than explore other nursing career options (Sageer et al., 2012).

The interviewed RNs described the essential need for recognition and reward. Asiedu (2015) described the need for professional development and methods to value employees as assets as important attributes of satisfaction. The study analysis outlined the need for ongoing continuing education and opportunities for improvement as satisfiers.

Cicolini et al. (2014) also stressed the requirements of a positive environment for the nurse to perform their duties as an influencer in day-to-day satisfaction. Throughout the interviews, the respondents expressed a strong need for open lines of communication from leaders, support from leaders, and the need for inclusion. Fedock et al. (2013) outlined the significance of transformational leadership and staff satisfaction.

The RNs interviewed voiced the desire for the leader to listen, to respond, and to care about the communication rather than ignore, block, and stifle their voices. Ahmad et al. (2013) outlined the importance of the connection between leader and worker as essential to connect with the job, work, and outcomes. ED RNs emphasized issues of acuity and overcrowding as dissatisfiers. The participants described the importance of the simple act of taking a meal break, having opportunities to '*take a break*,' or avoiding violence as key contributors to satisfaction (Amiresmali & Moosazadeh, 2013; Tahghighi, Rees, Brown, Breen, & Hegney, 2017)). Coupled with the need for breaks and downtime, the nurses described the central need for autonomy, central support, and control of professional practice (Brunges & Foley-Brinza, 2014).

ED RNs expressed the important need for autonomy. Autonomy is a means to gain control and confidence while providing care (Wu et al., 2014). The Baby Boomer and Generation X ED RNs articulated concerns regarding the autonomy of the Millennial RN related to the lack of experience, knowledge, and expertise in decision-making, clinical judgment, and patient care. Both Baby Boomer and Generation X ED RNs cautioned that autonomy without clinical experience supported unsafe care. Conversely, the Millennials interviewed voiced concern with the Baby Boomer ED RNs as controlling

and unwilling to change patterns leading to repetitive behaviors mired in pessimism, negativity, and an unwillingness to change. The Millennials described the Baby Boomers as stuck in the past, unwilling to change, and focused on the problem and not the solution.

Nurses viewed a quality in work life balance as essential for personal and professional satisfaction. Nurses discussed the importance of taking a vacation, attending continuing educational opportunities, and psychological, physical, and emotional regrouping. Zhang et al. (2013) asserted that a work life balance as essential to nurse satisfaction in both the acute and non-acute care settings. Unfortunately, ED RNs described the inability to take vacations, days off, or attend educational programs directly related to insufficient resources such as a lack of staff. The ongoing nursing shortage contributes to these difficulties (Singh, 2013).

Nurses sensed inadequate resources directly influence burnout, compassion fatigue, and satisfaction (Lee et al., 2017). Hegney et al. (2014) discussed the depletion of energy related to the lack of resources and the result of fatigue, depletion of energy, decreased caring, and a lack of coping skills. ED RNs related negative work environments to poor coping, an inability to maintain positive perspectives, and peer-to-peer or nurse-to-patient hostility (Rosales et al., 2013).

Themes and patterns outlined a physical, psychological, emotional, and cognitive connection between factors influencing satisfaction and nurse professional/personal satisfaction. The link to satisfaction occurred at many levels. The physical connection described the relationship between the nurse, adequacy of resources, and free-flowing

communication. A psychological connection promoting satisfaction included communication between staff and with leaders, input into decision-making, autonomy, recognition, relationships, coaching and mentoring, and a sense of accomplishment (Price & Reichert, 2017). A cognitive connection occurred with the establishment of autonomy, the input into decision-making, the sense of accomplishment, and trust leading to individual satisfaction. The emotional connection transpires through trust, relationships, teamwork, connection with the job, the work, and the organization, safety from violence, and an environment with low stress (Orgambidez-Ramos & de Almeida, 2017). The physical, psychological, cognitive, and emotional connections provided important information viewed as essential to ED RNs satisfaction, correlating directly with existing peer review literature, the proposed conceptual framework, and research questions.

**Resources**

Resources included staffing, equipment, and supplies. ED RNs identified staffing as a contributor to satisfaction with dissatisfaction expressed when staffing exceeded safe nurse-to-patient ratios, and no back-up system in place to assist RNs when critical staffing levels occur. Equipment and supplies were identified as important to day-to-day operations and provided limited dissatisfaction when limited, out of stock, or missing from the work environment. Resources are described by Herzberg as a hygiene factor, by Maslow as a physical level requirement, by Vroom as an expectancy element, and by Kahn as required for cognitive, physical, psychological, and emotional engagement.

**Interpretation.** The ED RNs described staffing as a key factor influencing individual satisfaction (Wolf, Perhats, Delao, Clark, & Moon, 2017). From personal

observation as an ED RNs, other factors influence the number of ED RNs required to care for patients. These include availability of hospital beds for admission, type of patients and level of acuity, patient throughput issues such as speed of physician care, ancillary services, or admission processes. Other factors influencing throughput include the number of ambulances arriving, the number of patients being held, and patient disposition (for example, nursing home patients requiring disposition using ambulance or wheelchair services). Is the problem the adequate number of individuals, the nursing shortage, or additional issues, such as extraneous issues influencing patient flow? Since most ED are short-staffed, many of these questions remain unanswered because no matter how full, how busy, or how stressed, ED patients keep arriving and ED RNs continue to care for the arrivals not matter the circumstances.

Staffing concerns require leaders to address the issues with input from nursing staff (Griffith, Ball, & Murrells, 2016). Nurses, working on the front lines, understand the needs and expectations of the day-to-day care provided to patients. Decision-making cannot be made solely on fiscal concerns, by individuals not directly involved in care, or based on numbers. ED managers frequently publish daily census numbers. While these numbers provide information about the amount of volume, the numbers do not reflect the acuity of the patients, the peak volumes, or backlogs, delays, or barriers to patient movement (throughput concerns). A comprehensive assessment of staffing requires a comprehensive review, including staff, managers, patients, and ancillary departments. Staffing numbers, patient flow, and many other factors require validation and appraisal to

ensure that safe care is provided even in times when the supply of nurses does not meet the demand.

**Communication**

Communication is essential at all levels, requires input, follow-through, caring, and demands respect (Louch, O'Hara, Gardner, & O'Connor, 2016). ED RNs described communication as the second factor required for satisfaction. Nurses communicate through a variety of methods including verbal, non-verbal, using language lines, written discharge instructions, and the communication requires careful thought, preparation, and assessment of the needs, expectations, and demands of the receiver (Rong, Hong, Jianxin, & Liyao, 2017). Communication without listening is not communication. Communication requires a message, a means of delivery, comprehension of the message, interpretation of the message, listening, and responding. Communication is not an easy task, especially in a busy ED. The nurse listens to why the patient is presenting to the ED, develops and communicates the work plan, communicates with peers, and provides services.

Communication extends beyond contact with patients, families, or peers. Essential communication also includes communication to and from managers. This communication must be bi-directional, respectful, meaningful, and relevant. Most of all the communication requires listening, being non-judgmental, and responding in a direct, meaningful, timely manner. Nurses described communication from managers as inconsistent, hurtful, non-empathetic, and sensed that messages were unheard, unacknowledged, and meaningless to managers.

**Interpretation.** Communication is crucial to RNs satisfaction. Nurses maintain open lines of communication while providing care. This openness occurs as patients move through the care continuum and decisions are made to disposition the patient out of the ED. Communication is personal and requires a personal touch to ensure that the message is conveyed, received, acknowledged, and responded to by the communicators. The communication cannot be one-way or non-productive. Communication requires all participants to listen to the message and to return communication constructively, directly, and on point.

**Input Into Decision-Making**

Decision-making occurs at a variety of levels in a hospital or healthcare setting. These levels include the patient care level, departmental level, divisional, and organizational levels. Nurses may or may not have input into decision-making at all levels and even without direct input nurses require a working knowledge of the decisions, the process, the anticipated outcomes, and the personal or professional impact of the decisions on the RNs. Nurses are directly and indirectly involved with decision-making at the patient care level. This level of decision-making requires active participation by the ED RNs. Changes require input from ED RNs working with peers, physicians, ancillary staff, administrators, and others providing a mechanism of open communication. Nurses make conscious decisions to become involved in decision-making at the departmental level. This input frequently occurs through active participation on committees, ad hoc work groups, or discussion groups. The involvement at the departmental level requires a conscious effort and decision to participate.

Decision-making at the divisional or organizational level occurs through planned, acute, or gradual processes. Decisions impacting ED care at '*higher levels*' necessitate input from staff ED RNs. The middle manager provides a pivotal role in bi-directional communication and in obtaining input from their staff. The communication-feedback loop allows the manager to keep staff up-to-date and elicit feedback to the communication. ED RNs are acutely aware that input into decisions cannot occur with every change made within an organization. Open lines of communication provide feedback, knowledge, and information to staff to keep them informed, aware, and cognizant of the change process.

**Interpretation.** A simple mantra for managers might include *always keep your staff informed, do not surprise them, and allow them to vent about change.* Change is a difficult process for individuals, upsetting the norm, challenging the individual to cope with the unexpected, and removing individuals from a comfort zone (Wright et al., 2015). Providing opportunities for staff to provide input into the decision-making process allows staff to have a say in the process, sense involvement, and make a conscious, proactive decision to participate (Chang et al., 2015). Unfortunately, the onus lies with the RNs and their decision to become involved or to stand idly by and wait for the change to occur. Participation obliges RNs to take an active role in the job, the work, and patient care.

**Autonomy**

ED RNs requires the freedom to move from task-to-task, critical situation-to-situation, and to provide care in the ebb and flow ED environment. Autonomy is crucial for an ED RNs. Autonomy requires self-confidence, trust between care providers,

standards of care, and communication (Vera, Martin, Lorente, & Chambel, 2016). Autonomy allows the ED RN to function as a team member providing care through established standards, using skills, knowledge, and communication in an environment of teamwork, trust, and a connection to the work, the job, and the patient. Autonomy requires the nurse to be aware of their limitations as described by Benner's stages of clinical competency and to be comfortable as outlined in Maslow's cognition, esteem, and belonging levels. ED RNs expectancies include autonomy as described by Vroom and Yetton with the clear understandings outlined as instrumentality.

**Interpretation.** Autonomous behaviors are expected and welcomed by ED RNs. Autonomy requires self-direction, self-assurance, and trust in decision-making, care provisions, and a sense of accomplishment (Amini, Negarandeh, Ramezani-Badr, Moosaeifard, & Fallah, 2015). Trust between providers allows the ED RNs to provide care, function within standards, and treat patients immediately to ensure improved outcomes, timeliness, and efficiency of care. Nurses who are not autonomous would experience difficulty in the ED setting. Waiting is many times not an option for patients secondary to the severity of the illness or injury, physician availability, or availability of resources. ED RNs makes an across the room assessment, initiate a dialogue with the patient to determine the reason for ED admission, and proceed with care using their skills, knowledge, background, expertise, or '*gut*' to deliver needed care. Autonomy is essential to ED RNs satisfaction.

**Recognition**

Individuals seek recognition. Humans seek and crave interactions, acceptance, and acknowledgement throughout life. ED work is difficult, many times not pretty or happy, and requires a dedicated, special person to perform tasks, provide compassionate care, and provide care to ill and injured patients. In general, the ED RNs do not seek the limelight or expect accolades for the job they perform. Sometimes, a simple thank you would be enough after a long and difficult shift. Recognition comes from a variety of sources. ED RN described recognition from peers as important for emotional and psychological health.

Beyond peer recognition is the need for recognition from managers, organizational leaders, and patients (Habib, Khalil, Manzoor, & Jamal, 2017). ED RN stressed the importance of receiving positive feedback such as recognition versus only hearing when a problem exists. Manager and leader recognition require a focus on the acknowledgment of the hard work, dedication, and demands of being an ED RNs (Johansen & Cadmus, 2016). The focus necessitates managers and leaders to recognize the importance of nursing to the patient, the profession, and to the organization's reputation, mission, vision, and values within the community (Rondeau & Wagar, 2016).

**Interpretation.** Peers describe ED RNs as thick-skinned. These nurses deal with stress, death, dying, anger, violence, overcrowding, and many other situations and continue to provide safe and efficient care. Even thick-skinned ED RNs have expectations which include recognition. This recognition does not necessarily require more than a thank you from a manager, patient, or peer. Recognition many times occurs

when a patient gets better and a family smiles and, tells you how important you were in that change.

Maslow outlined the importance of successful accomplishment at levels. Accomplishment drives individuals to increase efforts and be inspired to do more for the organization. Recognition requires that individuals be recognized based on specific results and behaviors. Organizations frequently recognize employees based on company tenure. Celebrations occur when the employee reaches a milestone such as a 10th anniversary. Recognizing the employee more frequently for the important work performed every day would provide ongoing recognition and directly influence the employee's sense of self-worth. Recognition improvements require peer-to-peer programs, focusing on recognition stories, making recognition easy and fulfilling, and linking recognition to the organization's values and goals.

**Opportunities for Improvement and Education**

Imaging a nursing environment where nurses are not seeking, demanding, or asking for education, input, or ways to improve their practice is unimaginable in today's rapidly changing healthcare environment. New equipment, supplies, standards, medications, and procedures are routine in the ED. Simply '*keeping up-to-date*' requires reading peer-reviewed journals, maintaining certifications, learning from peers, and attending continuing education opportunities. Participating study nurses articulated the importance of providing opportunities for improvement. These opportunities are not limited solely to education but extend to professional growth and development occasions to become involved in committees, policy development, mentoring, and moving to leader

roles. The central idea becomes one of focusing energies into not fighting the old but building on the new. Opportunities for improvement aid in building on the new.

**Interpretation.** The ED RNs is expected to move with the times which includes remaining informed about new skills, education, and procedures. The inclusion of staff nurses remains essential to identify required needs, demands, and issues for the ED staff RNs. Communication to and from managers provides dialect to inform nurses of available opportunities and requests from the staff. Internal and external opportunities exist for quality improvement. For example, hospitals provide quality improvement activities and list multiple opportunities for improvement impacting social, physical, fiscal, or professional spheres within the organization.

External opportunities may include the implementation of an electronic medical record to link physician offices with the hospital record. Internal opportunities for staff improvement could include coaching for performance programs, mentoring programs, or leadership development programs to internally '*grow*' leaders rather than hire from outside. Opportunities for improvement focus on prioritizing proactive change and staff development. Whatever method chosen, staff require, demand, and expect to experience personal and professional growth offered through organizational opportunities for improvement.

**Teamwork**

ED nursing is teamwork driven. Teams understand goals, have unique members, have conscious and unconscious interactions, and focus on goals based on a mission, vision, and needs. Teamwork requires open, honest, and respectful communication and a

strong sense of belonging to the team (Prapanjamensin, Patrician, & Vance, 2017). ED nurses are members of a unique team, are creative, innovative, and offer different viewpoints in an environment requiring constant examination of the situation, environment, and care. The ED RNs functions with agreed upon processes to orderly analyze, initiate, and resolve issues. ED RNs participating in this study provided examples outlining the importance of the team, and the direct or indirect role peers play as a team member. ED RN stressed the importance of trust, communication, and input in the productive functioning of an ED team. ED RNs stated that teamwork is essential to safe, timely, and functional ED care.

**Interpretation.** Building a team requires more than simply placing individuals together to complete a task, develop a plan, or initiate actions. While ED nursing is a team activity, many opportunities exist to expand the idea a team to encompass team building, problem identification, quality improvement activities, and focusing outcomes toward safe, efficient, and effective patient care. Throughout the interview portion of this study, ED RNs discussed the importance of working as a team. This teamwork many times flows without interruption based on matching skill sets, cohesiveness and connection between workers, and task completion. Member requirements include facilitators, followers, workers, and individuals involved at a variety of levels, experience, and engagement.

Building teams require identification of common goals. These common goals may extend beyond the patient level and incorporate unit, divisional, or organizational components. The selection or inclusion of specific team members necessitates selection

of individuals seeking participation, focused on problem solving, and willing to participate to complete tasks, make improvement, and move toward common goals (Deravin, Francis, Nielsen, & Anderson, 2017). Teams require a strong sense of belonging and open, honest, and respectful communication. The opportunities to develop team-building exercises, facilitate team meetings and identify quality improvement activities exist and require leaders, nurses, and managers to work collaboratively for inclusion, process improvement, education, learning, and development of teams (Bakker, 2017). The team building process aids in providing opportunities to improve teamwork at the patient care level, to improve the quality of care provided, and to facilitate change.

**Relationships**

Relationships within the ED consist of multiple elements directly or indirectly influencing relationships, relationship building, and trust. Relationships within the ED exist among staff, physicians, ancillary services, patients, families, and any individual the nurse contacts during the delivery of care. Relationships aid in the development of teamwork which provides creative, innovative and different viewpoints from individuals (Yalabik, Rayton, & Rapti, 2017). Open communication assists in building strong positive work relationships. ED RNs identified the importance of relationships outside of the work environment. Nurses carry the relationships outside of the workplace and share emotions and stores, provide support, and afford psychological safety for the RN. Maslow identified the importance of relationships as a sense of belonging to the work culture.

Similar to teamwork, ED RN expressed the need for reward and recognition. Reward and recognition occur from peers in work relationships. At times, this recognition occurs through the close relationships formed while caring for patients. Relationship building focuses on communication, trust, recognition, and understanding the work climate, stressors, and methods to reduce stress. ED RNs offer support through the relationships and develop a strong bond in patient care and for the individual needs of the nurse including time off, stress, work life balance, and dealing with negative aspects of the job, the work, or the organization.

**Interpretation.** ED work relationships provide stability for nurses. Nurses rely on one another, demand high work standards, and hold one another accountable for actions, work, outcomes, and patient care. Opportunities to foster these relationships include providing support for staff and recognition by managers. This recognition requires leader involvement in the day-to-day work efforts to support teams, nurses, and provide praise, respect, and communication directly to the ED RNs. ED RNs are individuals practicing in a profession while working in a team environment, with ever-moving goals, patient needs, and demands to provide safe care and positive outcomes. The relationships developed through work and between RN are the foundation of ED RNs care. Whether overt or covert, relationships occur, and these relationships provide a correctness to care. These corrects include *the correct care to the correct patient in the correct amount of time by the correct person using the correct tools to produce the correct outcome.*

**Coaching, Mentoring, and Orientation**

ED RNs identified that nurses many times *do not know what they do not know*. This lack of knowledge occurs secondary to limited or inadequate coaching, mentoring, or orientation. Nurses discussed the need for formal processes, standard programs, and assignment of consistent preceptors as requirements aiding nurses to become familiar with the work environment. No hospitals provided a mentoring program and the orientation programs varied diversely between the hospital ED. The ED RNs identified differences between coaching, mentoring, and orientation. The nurses believed that each played a role in the satisfaction of the ED RNs and each required development, implementation, input from staff, and evaluation to provide improved assimilation of the RN into the work environment and in a continuous, safe manner.

**Interpretation.** Opportunities to improve coaching, mentoring, and orientation process are evident. The literature and the study provide sufficient information to support an ongoing process to provide comfort, establish a safe work environment, and integrate education, skills, and knowledge into the orientation process. Mentoring requires establishing programs to assist nurses from entry into the ED through the comfort period of providing care (Fitzpatrick, Campo, & Gacki-Smith, 2014). Benner described this importance especially related to the novice or beginning RN. ED environments are unique and require a unique process to incorporate the RN's current functional level into the ED environment. This process extends beyond orientation to the skill sets, physical environment, and required competencies of the ED RNs. This process encompasses coaching through the learning, orientation process and mentoring to ensure the nurse's

needs, expectations, and demands are met, understood, and acknowledged (Ke, Kuo, & Hung, 2017). These programs aid in increasing trust, decreasing stress, developing relationships, and building teams (Homer, 2017). Thinking beyond the traditional orientation process provides opportunities to increase nurse satisfaction and engagement simply by using staff, the staff's knowledge and expertise, and broadens the new employee's sense of belonging, trust, and inclusion.

**Sense of Accomplishment**

Maslow's hierarchy describes the importance of accomplishment and safety prior to the individual moving forward or toward a higher level of being. The sense of accomplishment occurs with successful completion of tasks, recognition, autonomy, and attitude within the work environment (DiNapoli, O'Flaherty, Carol, Clavelle, & Fitzpatrick, 2016). Benner stressed the importance of this sense of accomplishment and discussed how success directed the nurse toward learning, acceptance, and comfort. Throughout the interview process, the ED RNs provided information regarding the importance of providing safe care and the sense of accomplishment related to simple patient responses such as the patient saying thank you, a family hug, or positive patient outcomes. Nurses talked about the sense of accomplishment with patients and also discussed the importance of managerial acknowledgment of the work performed. The ED RNs discussed the lack of recognition from managers as an element impacting personal and professional satisfaction.

**Interpretation.** In many ways, working as a nurse is no different than working in any other service-oriented profession. Waitresses receive tips as recognition or sense of

accomplishment for a job performed, the store employee thank purchasers, and a bartender rings a bell when receiving a tip. Each exhibits a physical act which in turn provide an outcome leading to a sense of accomplishment. Nurses, care deliverers, pursue a sense of accomplishment for the job they perform. This sense of accomplishment varies for every nurse, in the individual ER, and provides positive reinforcement recognizing performance. The sense of accomplishment occurs on an individual or group level and is individualized for the nurse.

Programs to identify concerns such as workflow and patient throughput also require input from ED RN. The ED RNs is a front-line provider and is aware of barriers, opportunities, and methods to affect change. Making changes that improve patient care affords the RN a sense of accomplishment. The goal of providing sound, effective care provides the foundation for change and input from nurses allows the nurse to express their opinions, concerns, and ideas to improve patient care, flow, and throughput.

**Stress**

Stress is the body's way of dealing with a threat or challenge and is exhibited through physical, emotional, psychological, somatic, or other manners having a direct impact on the individual (Back et al., 2017). The impact on the organization includes an increase in call-outs, injuries, and behavioral concerns (Crilly, Greenslade, Lincoln, Timms, & Fisher, 2017). ED RN described stress as a normal and expected occurrence in an ED. While stress may be expected, the ED RNs discussed stress and appeared unaware of the severe impact of individual or peer stress. No hospital offered stress reduction services or programs for the staff. None of the organizations provided debriefing sessions

for staff when serious, unplanned events occur. The organization's response was described as reactionary by the staff. For example, an ED RNs expressed her concerns over the death of a child and the manner in which the Code Blue (cardiac arrest) occurred. The ED RNs was presented with a negative and hostile response telling her to '*get over the code and move on*'. The lack of respect, acknowledgment of the impact on the nurse, and the lack of standardized programs presents many opportunities for managers and leaders to aid ED RNs to decrease stress and improve their job and work satisfaction.

**Interpretation.** Stress is an issue frequently not discussed openly in the ED. ED RNs provided unrealistic views regarding stress and described stress as expected and required each nurse to learn how to deal with stress and to keep working even when stress affected the nurse's care, mental health, and attitude. The number of times the ED RNs walks away from a bad situation or bad event without support, debriefing, and a method to close the loop of the event are multiple (Kallberg, Ehrenberg, Florin, Ostergren, & Goransson, 2017). The negative responses to stress are well-known and include sickness, somatic illness, lost days, unhappiness, psychological or emotional issues, and a sense of helplessness or hopelessness (Gadirzadeh, Adib-Hajbaghery, & Abadi, 2017).

Nurses require a recognition of stress, management, and measure to decrease stress. The recognition includes an understanding that personal survival and health outweighs work completion. Orientation, staff meetings, and managerial support includes the need for stress reduction identification and programs to aid nurses in decreasing stress and improving emotional and psychological health and well-being of the nurses. Stress

recognition demands that leaders undertake programs to decrease nurse stress or continue to lose nurses secondary to the adverse responses to working in a stress filled environment.

**Compassion Fatigue**

The term compassion fatigue has been present in nursing literature over the last decade. During the interview process, ED RNs did not illustrate an understanding of compassion fatigue and categorized the concept to describe difficult patients, drug seekers, and patients frequently using the ED for trivial matters. Compassion fatigue is a state experienced by those helping people in distress and defined as secondary traumatic stress (STS). Individuals with compassion fatigue experience a lessening of compassion toward others over time (Gnerre et al., 2017). The lessening symptoms include a sense of hopelessness, decreased pleasure in providing care, anxiety, and negative attitudes and work behaviors (Sorenson, Bolick, Wright, & Hamilton, 2017). Beck (2011) estimated that 16-85% of healthcare workers develop compassion fatigue leading to the difficulty in doing the job of nursing.

The ED RNs interviewed discussed behaviors and attitudes but did not describe attitudes and behaviors specifically in relation to a lack of caring or difficulty in performing the job. The nurses described particular types of patients who directly influenced personal and professional stress, caring, and frustrations. None of the ED RNs interviewed described difficulty in continuing their job, their duties, or a lack of caring. The nurses voiced frustration about the types of patients and the impact these frustrations played in the care provided or not provided to other ED patients.

**Interpretation.** The ED RNs interviewed appeared to lack an understanding of the term compassion fatigue. Before asking questions related to compassion fatigue a description of compassion fatigue was presented to the participant to ensure they were aware of the definition and the central idea of the question. Even with this information, the ED RNs focused on the difficult patient populations of frequently ED misusers, drug seekers, psychiatric boarders, and malingerers. Nurses require further information and education regarding compassion fatigue and the potential negative attributes associated with this state. Nurse education could provide information for nurses to increase awareness of potential negative impacts on professional care and communication with patients, decreasing self-esteem, and decreased pleasure in providing nursing care.

Managerial support in providing outreach education, stress management programs, and open forums to discuss patient care and relationships would be beneficial to nurse well-being. As hospitals struggle to retain nurses, providing education and stress reduction to working nurses may aid in increasing job pleasure, lessening anxiety, and advancing positive attitudes and behaviors. The education and exposure to compassion fatigue also illustrate methods used to coach and mentor nurses. A collaborative and collegial relationship must be established between workers and leaders to identify, develop, and implement programs regarding compassion fatigue and the negative outcomes occurring when nurses lose the ability to be compassionate, caring, or involved in patient care.

**Violence and Safety**

ED are violent work environments. Copeland and Henry (2017) stated that 79% of all ED RNs experience violence with 81% reporting verbal abuse and 67% reporting physical abuse. Safety involves both an ethical and legal viewpoint (Bradley & Affleck, 2017). Perceptions of violence, ability to identify and de-escalate violent patients, and the increased number of violent patients impacts staff, families, and other patients in the ED. No direct correlation exists between what staff view as a safe environment and the actual safety of the ED setting (Wolf, Delao, & Perhats, 2014). The interviewed RNs voiced a sense of safety yet described a violent ED workplace. State laws are in place to protect healthcare workers. Even with these laws in place, many barriers exist to reporting violent behaviors. Interviewed RNs expressed concern that no consequences for the violent act occur after reporting to law enforcement, which leads the frustration and unwillingness to file another report, press charges, or *be bothered* to initiate any police action.

**Interpretation.** Violence exists, nurses are unsafe, and an atmosphere of pretending safety exists in ED (Nikathil, Olaussen, Gocentas, Symons, & Mitra, 2017). Education for nurses in de-escalation techniques, searching patients, removing barriers preventing consequences for violent behaviors, and the presence of security officers in the ED are essential. Nurses voice a strong sense of security when the literature and reality illustrate an unsafe, violent, and unpredictable work environment. Verbal abuse, attacks, and being placed in danger demonstrate the violent nature of the ED work environment (Urban, 2014). Issues impacting safety include slow screening, inconsistent

evaluation of intoxicated or impaired patients, and the elevated intent for self-harm with the homeless and mentally impaired patients. Facilitating change requires expanded communication related to patient concerns, issues, violent behaviors, and methods to control patients (Jetelina, Reingle-Gonzalez, Brown, Foreman, & Field 2017). Constant vigilance, open communication, and planning are required to protect the patient and the ED staff.

Violence and safety are directly tied to one another. ED are violent environments and protecting staff, families, patients, and perpetrators require careful planning, communication, and control of situations leading to the violence, during the violence, and post-event. These include identification of patient stressors, escalation of behaviors, and de-escalation techniques provided through ongoing education to manage the aggressive patient. The education must include discussions of aspects of care that worked well, did not work, were effective, and failures to control a violent situation without placing hands on the patient or involving law enforcement. Staff safety is paramount and requires input from staff, management, and organizational leaders (Carter, Pouch, & Larson, 2014).

**Overcrowding**

Beyond short staffing and the violent work environment lies a department with too few beds to meet the demand (Varndall, Ryan, Jeffers, & Marques-Trent, 2016). The days of nurses patiently '*waiting*' for the next patient are gone. Care in the ED requires the ED RNs to juggle care in an environment which could easily be described as circus-like at times. Triaging patients, no empty beds, ambulances in the hallways, beds filled with holding patients, complaints about long wait times, and many other factors influence

care and the ability of the nurse to care for patients (Wise-Harris et al., 2017). On a more personal level, the nurses feel stressed, have long since given up or forgotten about eating dinner, and are attempting to balance an assignment that requires more resources, time, or availability than the nurse can provide (Weiss, Rogers, Maas, Ernst, & Nick, 2014). And yet the patients keep coming, the halls fill, and patients appear everywhere. This scene is all too familiar in most ED. A question asked during the interview included what makes the nurse come back to work day-after-day not knowing what the day will bring. Nurses generally smiled when answering and express their love of the job they perform. Above and beyond the craziness lies an innate love of being a nurse.

**Interpretation**. Nursing is more than a job. The interviews provided valuable insight into the thoughts, perceptions, and beliefs about the role the ED RNs play in care provided to patients. The overcrowding frustrates nurses, yet the nurse remains dedicated to providing quality care. When quality suffers, the nurses expressed concerns and voiced their need to be heard and to discuss the limited resources (staffing), methods to improve throughput, and to '*simply unload'* about their concerns (Wolf et al., 2015). Unfortunately, ED RNs appears to accept the overcrowding, being short staffed and voiced concern over the hopelessness of the overcrowding situation in the ED. Opportunities exist to get nurses involved in finding solutions, developing workflow plans, and implementing change to reduce the overcrowding. These opportunities require a skilled facilitator to ensure that the process is not simply an act of futility with no expected change. The skilled facilitator leads the process and ensures that change occurs through small, incremental, measurable steps.

## Limitations of the Study

Trustworthiness includes credibility, confirmability, transferability, and dependability. A research study requires logical, consistent, and complete oversight. Consistency includes valid information without inferences. The study process requires oversight to ensure non-bias, a research plan, ongoing evaluation, and adherence to ethical standards.

The study was limited to three hospitals and three generational cohorts. As anticipated, approximately 71% (15/21) of the interviewees were born and raised in the region and attended a local nursing school. A study limitation included 39% (8/21) of the interviewees having worked solely at their current facility and had no experiences outside of that institution. Limited insight may alter the perspectives of the nurses interviewed secondary to limited knowledge of how other ED deal with factors described as essential to satisfaction and engagement. Another potential limitation was the flu epidemic impacting the three ED during the interviews and the impact of the increase in acuity and volume during the interview period. The flu epidemic could have potentially influenced responses due to exhaustion from the increased workload related to the severity of illness or health issues related to higher than normal illness rates secondary to employee flu symptoms and illness. Nursing shortages potentially influenced participant responses, particularly at Hospital C.

The interview data was member checked and presented in a logical, systematic manner with the focus on ED RNs satisfaction and engagement. The interview questions were grounded and supported by the conceptual framework of personal nursing

experience and the theoretical frameworks of Herzberg, Vroom and Yetton, Benner, Maslow, and Kahn. Research results were tired directly to peer-reviewed literature, conceptual framework, and research questions. The research is easily transferable to other hospital departments, persons, or situations. In an attempt to decrease inferences from the data, interviews, or observations all information was clarified, and member checked.

The review process included concurrent and ongoing review, analysis, and clarification. The materials were reviewed, coded, and analyzed using a detailed research plan to ensure consistency, quality, and thoroughness. The study was limited to three hospitals in upstate New York and Vermont. Many of the nurses working at the three hospitals were born and raised in the region, attended nursing school at a local college, and have strong family ties to the region. With this knowledge, limited insight or perspective is probable. The concerns, perceptions, and aspects causing dissatisfaction, engagement, and leaving the job may be ingrained in the culture and not reflective of satisfaction and engagement in other geographic regions. The study was limited to Emergency Department nurses. The culture of the Emergency Department may not be reflective of similar problems or issues experienced by nurses in other departments.

Personal biases could potentially have influenced this study. As an Emergency Department nurse, a specific, relevant bias could exist. For example, Emergency Department nurses possess a variety of skill sets and perceptions such as multitasking, interacting with a wide variety of patients over a short time, and working with the ebbs and flows within the department. Staying impartial, remaining the objective researcher, and listening was imperative. Data analysis required objectivity to ensure that any

personal bias did not influence data quality, interpretation, or dependability. Working as Baby Boomer included another set of issues and concerns with the data analysis. Responses, questions, and concerns were validated through member checking to assist in decreasing personal bias of a Baby Boomer RN to aid in keeping an open mind and objectively throughout the study.

## Recommendations

The research conducted provided a starting point in the understanding of ED RNs satisfaction and engagement. The opportunities to expand this research would provide more information for leaders to consider as they work to recruit, retain, and maintain adequate staffing levels. In this research study, interviews were limited to three hospitals in upstate New York and Vermont. The region is isolated, serves a limited population, and is family oriented leading to nurses remaining in the region related to family relationships, comfort, and familiarity.

The recommendations for further study outline expansion of this study to delve deeper into generational differences, regional distinctions, and unique elements of specialized hospitals, high satisfaction hospitals and hospitals with varying capabilities and capacities. The recommendations for practice outline specific elements related to team building, recognition programs, expansion of this study to other hospital departments, and the development of quality improvement processes to improve quality, outcomes, and input from ED RNs staff.

**Recommendations for Further Study**

The first recommendation would be to expand the interviews of the three generations interviewed in the study. Expanding the research could provide information to assess particular work habits, ethics, and work requirements of each generation. As outlined in Chapter 1, each generation projects different needs and expectations in the workplace. These expectations include the work environment, the connection with the organization, and specific needs to maintain a work life balance. This research focused on questions looking through a broad lens and narrowing the focus to the specific generational cohorts. More focused and in-depth questions from nurses of each generation could provide valuable information for leaders to revamp or modify plans to recruit, retain, and satisfy current RNs.

The second recommendation includes interviewing nurses at hospitals within and outside of specific regions. A multi-facility research study interviewing ED RNs at a regional level (for example, New England hospitals or Mid-Atlantic hospitals) could provide information related to regional needs. Regional salaries and benefits differ greatly and influence RNs from moving to specific regions. A multi-facility research study looking at a specific region could also provide information to be shared by network hospitals to assist in recruiting, retaining, or improving satisfaction.

A third recommendation would be to separate satisfaction and engagement into two distinct case study research studies. Engagement expansion would provide a fuller and richer of the elements focused on the connections at the job, the work, and the organizational levels. The terms satisfaction and happiness are used interchangeably in

the literature. Separation of these factors would provide information of the factors that influence each of these essential employee requirements. A secondary study comparing happiness and satisfaction would provide data to define both terms and determine differences, similarities, and consistencies.

The fourth recommendation for further research includes expanding the research to compare satisfaction and engagement at Magnet® versus non-Magnet® hospitals. Magnet® hospitals receive certification based on nurse involvement in quality improvement, decision-making, unit specific quality, and on meeting goals that exceed those at non-Magnet® hospitals. Do Magnet® staff feel more satisfied secondary to inclusion in the decision-making, reward and recognition, and communication processes? A research study outlining specific inclusion satisfiers would provide specific methods in which satisfaction is the employee rather than leader driven.

The sixth recommendation would be to expand this research to case study interviews at hospitals with high staff satisfaction scores compared with a hospital with low staff satisfaction scores. Press Ganey provides staff satisfaction surveys for hospitals. The opportunity to discuss how specific hospitals view the importance of satisfaction, programs/projects in place within successful hospitals, and speak directly with ED RNs could provide specifics related to staff satisfaction and engagement. Comparing interview responses could provide information on specific issues influencing satisfaction or successful programs, quality initiatives, or projects impacting staff satisfaction. Why recreate a successful program or not learn from others?

**Recommendations for Practice**

The first recommendation for practice includes expanding the case study interviews with other departments in the three participating hospitals. Understanding the similarities, differences, needs, and expectations of other nurses could provide valuable information at an organizational level. Since ED RNs are a sub-set of nurses within each facility, understanding needs on other units would provide leaders with an overall understanding of the organizational expectations related to satisfaction and engagement.

The second recommendation for practice would be to develop an in-house quality improvement initiative to improve satisfaction and engagement. The research would measure satisfaction and engagement pre-implementation of initiatives versus post-implementation outcomes. The in-house quality improvement project would promote input into decision-making, autonomy, teamwork, and relationships viewed as essential elements of employee satisfaction and engagement.

The third recommendation for practice includes the development of team building exercises in the ED and with other departments. The ED RNs work with other departments, nurses, and staff. Developing team building provides opportunities for the ED RNs staff to gain knowledge, experience, and expertise to lead or work as a team in a methodical, systematic manner to assess, analyze, implement, and develop programs to improve quality, patient care, and system or process issues.

The fourth recommendation for practice involves the development of recognition programs to inspire nurses to become more connected with the organization and to drive efforts for improved care, productivity, and fiscal solvency. Recognition programs based

on behaviors, peer-oriented and tied to the organizational mission describe programs to inspire employees rather than a reward for tenure within the organization.

The fifth recommendation for practice focuses on the lack of ethnicity in nursing. Nursing has always been a predominately white female profession. A geographical shift in demographics is occurring within the United States, and, still nursing is a predominately white profession. The focus becomes one of education, recruitment, and mobilization at the local, regional, and national levels to look beyond the traditional hiring, education, and recruitment methods and seek out the talent in other races.

This research provides a stepping stone for leaders to better understand specific needs of ED RNs staff members. Social change requires input from participants on all levels. This research is an initial step. As an RN entering the fourth decade as a critical care provider, the stories and discussion about the fun, successes, failures, and outcomes of patients resonate daily. The existing RN is dedicated to providing quality care even in situations which are unsafe, violent, and overcrowded. The altruistic nature of nursing drives many nurses to continue to work in this field of challenges, opportunities, and successes. Understanding what makes a nurse satisfied provides insight into the future of nursing in a time where every nurse is essential to optimizing patient outcomes important, and every nurse lost from bedside care directly impacts the co-worker, patient, and family satisfaction.

## Implications

The current healthcare debate ranges from the right to receive versus the privilege of receiving healthcare. The ongoing nursing shortage coupled with escalating costs,

limited access, an influx of retiring Baby Boomers, and reimbursement present multiple challenges across all levels of healthcare. Who will care for patients, the ability to care for the volume of patients, and the cost of providing care describe conditions for leader consideration. How will leaders promote retention and recruitment of staff in a fiscally unstable healthcare environment? ED RNs expressed specific factors outlining and defining essential needs to satisfy, retain, and recruit qualified, competent, and compassionate nurses.

The research provided valuable data to support challenges to retaining and recruiting RN into the nursing profession. The current RN workforce faces difficulties with short staffing, overcrowding, and violence. The positive social change of maintaining current staff, recruiting staff into the hospitals and profession, and promoting a satisfying and fulfilling workplace illustrates positive impact on healthcare. Nurses are key providers of care, and a healthcare system without nurses is unimaginable. Salka (2014) described the shortage of healthcare providers at a critical level. The shortage is expected to increase in the 21st-century. Every month one-quarter of a million individuals turn 65 with an estimated 12 million individuals projected to require long-term care by 2020 (AARP, 2014).

These dire statistics illustrate the need to maintain our current numbers of nurses, promote and recruit nurses into the profession of nursing, and satisfy nurses. Improved staff satisfaction is directly related to patient satisfaction and subsequent Federal value-based reimbursement. Providing safe, efficient, and equitable care in the 21st-century requires an understanding of factors influencing nurse satisfaction and engagement. No

matter how large or small the healthcare system, nursing plays a significant role in providing patient care and without an adequate nursing presence the potential for bad outcomes, poorer quality, and increased dissatisfaction from workers and customers increases (Blegan et al., 2011).

Social change within healthcare has taken three different paths. The first pathway is rapid quality focused change driven by unacceptable outcomes, death, disability, and money. The second pathway involves a process and system change to revamp a healthcare system broken, stressed, or hemorrhaging at a variety of points. This change is internally driven and focuses on improving the how and why of patient care delivery. The third pathway of change has taken a more complicated and emotional path. The third pathway of change is the social change required to provide fair, adequate, effective, and equitable care to people.

The increase of homelessness and the uninsured or underinsured influx of patients has placed a strain on healthcare resources and demands. Healthcare costs have escalated while reimbursement has not increased. Financial stressors, such as increased numbers of under or uninsured patients, influence hospital bottom lines. Social issues such as increased mental health patients, decreasing number of mental health resources and facilities, and increased homelessness have also had a societal impact on healthcare. The stress of caring for patients with chronic mental health conditions with no or limited resources available to break the cycle of illness presents major challenges to hospitals, communities, and individual patients and family. Individuals living longer are slated to consume greater amounts of healthcare resources and dollars. Who will pay and who will

care for the aging patients? Healthcare providers can gaze into the ED lobby to see the issues upfront and personal. And yet the debate about healthcare right versus privilege continues.

The national opiate epidemic has created social issues extending into the healthcare setting. Hospitals are experiencing an increased number of patients seeking drugs, violence patients, demanding, unreasonable individuals, and an increased number of overdoses. The impact on the ED staff is tremendous influencing the sense of safety, increased violence, and a sense of hopelessness to facilitate change and secure positive outcomes. As ED hospital beds become filled with non-acute patients, staff members struggle to care for the acutely ill or injured patients filtering into the ED. Long waits, delays in care, poor outcomes, and decreased quality present challenges to an overworked, stressed ED staff. At what point does the ED RN ask the simple question *is this worth it*?

Hospital EDs are experiencing overcrowding as patient numbers and acuity increase. The retirement of the Baby Boomers has increased the number of individuals seeking ED care. With individuals living longer, the number of elderly patients seeking ED services has also increased. There are fewer hospitals, scarcer providers, a national shortage of physicians, nurses, and ancillary care providers, and higher numbers and acuity of patients. Maintaining current staffing levels, recruiting qualified staff, and supporting an environment of satisfaction is essential.

Positive social change requires working to make changes, implement systems to advance practice, improve flow, and produce positive patient outcomes. Positive social

change denotes involvement and inclusion in processes impacting patients, families, and staff. Recommendations for practice include programs and projects to enhance current practice and provide quality improvement activities and to improve understanding of staff beliefs, needs, and demands. Social change programs also include the development of educational opportunities to assist staff with teamwork, relationships, communication, and connection with the job, the work, and the organization. Lastly, positive social change provides opportunities to recognize and reward nurses for the care provided. The study provided information to support four recommendations for nursing practice.

## Conclusions

Nursing is a wonderful, fulfilling, and tough job. Nurses love the job even through the smiles, the laughs, the frowns, the successes, the failures, and the tears. Nurses describe the care provided as essential, demanding, and enjoyable. Words written tell stories about these dedicated individuals and the joys experienced providing care and compassion to the ill and injured. Many quotes seen on billboards, blackboards, notebooks, or post-it notes describe the role of the nurse. The authors and sources are unknown, and yet these words describe the quality of nursing and aid in providing information to answer questions about why nurse satisfaction is so important in today's healthcare environment.

"*When someone is going through a storm, your silent presence is more powerful than a million empty words*." Nurses understand, and they get it, whatever it is. Satisfaction comes from those times when a simple presence makes a difference to the patient. Autonomy drives the RNs to be a better person and care provider. Being

recognized for being kind, patient, and considerate cannot be understated. Coworkers are many times another nurse's solace and partner. The coworkers understand the pain, the glory, and the needs. Nurses are team players and nursing a team sport. The team consists of managers, nurses, ancillary staff, doctors, patients, families, and anyone interacting with the healthcare system.

*"Nurses dispense comfort, compassion, and caring without even a prescription*." People might ask a nurse what keeps her or him coming back to the job day after day, and the simple answer is the patients. Nurse satisfaction comes from a sense of accomplishment, the input into decision-making, and personal or professional opportunities for improvement. Nurses coach, lead, become a family, provide resources, and do whatever is needed to make the patient or family feel important. Sometimes nurses meet patients on the worst or best day of the individual's life. What the nurse does makes a difference and understanding what satisfies or engages nurses is paramount.

"*When you feel like quitting, remember why you started."* Being satisfied improves patient care, patient outcomes, and patient satisfaction. How easy it would be to quit because there are too many patients, the patients are too sick, or there is too much violence in the ED. Nurses go to work every day, smile when things are chaotic and out of control, laugh to make someone feel better, and provide care when the nurse would rather be anywhere than doing CPR on a young patient who the nurse knows will die. Nurse satisfaction requires teamwork, strong personal relationships, a sense of accomplishment, methods to reduce stress, and the support, input, and empathy from managers.

*"Be the nurse you would want as a patient."* Short staffing, inappropriate nurse-to-patient ratios, and poor communication impact nursing care both directly and indirectly. No matter how stressed, the size of the patient load/assignment, or the acuity of the patients, the nurse is the central care provider of physical, emotional, cognitive, and psychological care to patients, families, and others. Nurses require trust, autonomy, control, and safety to provide safe and effective care. The ED is filled with violence, too many patients, and poor staffing, yet the nurse continues doing the job of nursing, taking care of patients and providing skills, expertise, and knowledge in that care. Protecting nurses from stress, compassion fatigue, and isolation becomes essential to the professional and personal satisfaction.

*"It's a beautiful thing when a career and a passion come together."* Nurses provide a variety of services beyond the patient and have a strong connection to the job, the work performed, the organization, and to the community seen as engagement. Nurses are fundamental participants through interactions with coworkers, managers, patients, and families. These connections tie the nurse to the job of nursing, the role they play within the organization, and to the organizational mission, vision, and values

Don Quixote was said to have tilted at windmills. Attempting to facilitate change is difficult. Nurses are hard-working, dedicated, altruistic, and driven individuals capable of enabling change. As healthcare systems become overloaded, stressed, and focused on outcomes the role of the bedside nurse becomes paramount to the patient, family, and nurse. Without the nurse, who will care for the patient?

Nurses are practice-oriented, intelligent, and decision-makers. Nurses provide quality care to the sick, ill, and injured and function as a pivotal, central point in the healthcare system. Safe, effective, efficient, and equitable healthcare requires adequate numbers of healthcare providers. Understanding why and how factors influence nurse satisfaction requires knowledge of how the current workers believe, sense, or conceptualize the role they perform in providing care. The question of who will care for patients and will the care be safe is a grave concern in an era of nursing shortages, poor patient outcomes, and a frazzled, strained, and stretched healthcare system. To maintain quality, consistency, and an adequate number of providers finding what satisfies and engages nurses is essential to the survival of the profession of nursing. This research provided valuable information on the beliefs, expectations, and needs of the ED RN in the 21st-century work environment. The national push needs to be to protect the nurses we have, improve satisfaction for the bedside nurses, and strive to make the nursing shortage a story of a past problem and not an ongoing issue.

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# Appendix A: Initial Pilot Study Interview Questions

**Satisfaction Interview Question 1**: How do you describe work satisfaction?

**Satisfaction Interview Question 2:** What factors can you tell me create dissatisfaction in your work?

**Satisfaction Interview Question 3:** What role does your leadership play in making you satisfied or dissatisfied in your work?

**Satisfaction Interview Question 4:** How does your lack or overabundance of resources impact your satisfaction? Tell me what your shortages are and how the impact your daily work?

**Satisfaction Interview Question 5:** Does your system of taking care of patients lead you to be dissatisfied? What components of the system work and what components don't work? Tell me how the system impacts your daily work?

**Satisfaction Interview Question 6:** Tell me about the culture of your workplace? For example, is there teamwork, is it overcrowded?

**Satisfaction Interview Question 7:** Tell me how employee attitudes and feelings impact your satisfaction

**Satisfaction Interview Question 8:** Why do you think ER nurses are dissatisfied or satisfied in the work performed?

**Satisfaction Interview Question 9**: What role does your direct supervisor play in your satisfaction?

**Satisfaction Interview Question 10:** What are stressors that make you dissatisfied?

**Satisfaction Interview Question 11:** How do you decrease your stress? Does the hospital assist or provide methods for you to lower your stress?

**Satisfaction Interview Question 12**: Do you think you make a difference in the day-to-day operations of your job?

**Satisfaction Interview Question 13:** What would you change to make work more satisfying?

**Satisfaction Interview Question 14**: Describe your staffing levels, outcomes, and productivity.

**Engagement Interview Question 15:** What does it mean to be engaged in the work you do?

**Engagement Interview Question 16:** Does your job allow you to be autonomous?

**Engagement Interview Question 17:** Do you feel engaged with the organization? What does your hospital mean to you?

**Engagement Interview Question 18:** Does your work make you feel like you are important to the organization or does the organization not really care/are you not a part of the organizational culture?

**Engagement Interview Question 19:** What does management do to get you involved or engaged? Does this work or not work? What would make you more engaged in the organization?

**Engagement Interview Question 20:** How would you describe your work engagement? Are you engaged in your work?

**Engagement Interview Question 21:** Are you engaged as a team member? How are you engaged?

**Engagement Interview Question 22:** What does team engagement mean to you?

**Engagement Interview Question 23**: What does self-engagement with your hospital mean?

**Engagement Interview Question 24**: Describe what are the key reasons you are or are not engaged in your work?

# Appendix B: Revised Interview Questions

The following are the revised interview questions which align with feedback from Pilot Study RN participants, literature review findings, conceptual framework, underlying theories used for this study, and the research questions.

**Satisfaction Interview Questions**

31. Tell me about your work. What is it like to work in your ER?
32. Do you feel satisfied in the work you perform in your ER? Describe why you are satisfied or dissatisfied in the work you perform?
33. If I asked you to describe a perfect and satisfying work environment, how would you describe that environment? What things would you say make for the perfect work place?
34. What are the top 3 actors that you consider essential for your satisfaction in your job?
35. Let's talk about staffing because resources are essential to doing your job. Tell me about the resources you have available in your job.
    a. Staff
    b. Equipment and supplies
    c. Education and continuing education
36. What happens when you don't have enough resources—Management, coworkers responses?
37. Communication occurs at many levels. Let's talk about what's good, what's bad, and what works in your ER.

a. Between staff
b. To and from leaders
c. Frequency
d. Is your voice heard? Why or why not?
e. What would make communication better?
f. How important is communication to your satisfaction?

38. How involved are you in decision-making? Does your input into decision-making or lack of influence your satisfaction? Why or why not?
39. Do you feel you have autonomy in your job? Why or why not?
    a. Is workplace autonomy important to you?
40. Are you recognized in your job? How are you recognized? How does recognition influence your satisfaction?
41. Tell me about your opportunities for improvement? Courses, education, continuing education
    a. Are you encouraged to go the extra mile and do more? Do you feel that you are provided encouragement and services to improve yourself in your job?
    b. Does anyone talk to you about your career pathway? How important are these conversations to your satisfaction?
42. Teamwork is an important aspect of ER nursing. We work as one. Tell me about your working relationships as a team? Does the team work cross into leadership?

How important is teamwork to your satisfaction? How do your coworkers interact and how do people work together?

43. We work very closely as ER staff. ER relationships are very important. Times can be tense, fun, and just a regular day. Tell me about your relationship with coworkers and how important those relationships are? Do you feel a group cohesiveness or do people just do what they want? Explain. Does the physical layout influence or impact teamwork and workplace relationships?
44. Coaching, mentoring, and orientation are important in nursing. What types of coaching, mentoring, and orientation occurs in your department? Why or why not is this effective?
    a. Were you coached or mentored in your job when you started? Are new employees given these opportunities?
    b. How important are coaching and mentoring to your satisfaction? Do you feel that new employees receive adequate coaching, mentoring, and orientation in your department—why or why not? Impact on your satisfaction?
    c. Do you feel that your role is important as a staff RN? Why or why not?
45. How is education provided to you? What types of offerings are provided? Does education or continuing education provided influence your satisfaction? Do you feel you are provided ample educational opportunities?

46. Stress is a big factor in ER nursing. Tell me about ER stress in your department. What ongoing stressor influence your satisfaction? Are measures in place to help you decrease your stress? What are those measures? What do you do to de-stress?
    a. Do you talk to each other about stress? What do you do to help each other when you are stressed?
47. Compassion fatigue and burn out are two concerns for nurses.
    a. How does your compassion fatigue impact your satisfaction and how you care for patients?
    b. Do you believe that compassion fatigue impacts your patient outcomes? Explain
    c. What do you know when you have reached the breaking point? What do you do to get yourself back on track?
    d. Do you think we do enough to decrease compassion fatigue or do we just expect that it's part of the job?
    e. Do nurses talk about fatigue and burnout with each other?
    f. What do you think causes compassion fatigue?
48. Violence—ER RN are exposed to violence on an almost daily basis.
    a. Describe the violence in your department?
    b. Is violence a problem and does it impact your satisfaction?
    c. Do you fear for yourself when working? Why or why not?
    d. Do you feel safe? If not, what makes you not feel safe?
    e. How do you prepare for ER violence?

f. Is leadership understanding and doing anything about the violence?

49. Sense of accomplishment—what make you feel like you accomplished something when working? Describe how you get things accomplished? What impact does a sense of accomplishment have on your satisfaction?
50. Overcrowding—ER are overcrowded. How does overcrowding impact your work and your satisfaction? Does anyone seem to care that the ER is overcrowded?
51. What is it about being an ER RN that keeps you coming back day after day? Tell me the reasons
52. What is the most pleasurable aspect of your job?
53. What is the most unpleasant aspect of your job?
54. What are the top three things you would do to make your job more satisfying?

**Engagement Interview Questions**

1. Engagement occurs at three levels—job performed, work, and at the organizational level and occurs at a physical, cognitive, and emotional level.
2. Do you feel engaged in the job you perform? Tell me why you are engaged. What aspects of what you do make you feel engaged?
3. Do you feel engaged in your work? What aspects of your work make you want to be engaged? Do you feel you can trust the people you work with? Explain.
4. Do you feel engaged on the organizational level? Do you know your organization's mission, vision, and values? Why or why not are you engaged with the organization?
5. Is it OK to not be engaged? Why or why not?

6. How engaged to you feel in your job, your work, and with the organization?

Appendix C: Theory Alignment with Study Results

**Herzberg's Motivation Hygiene Theory**

| Hygiene | Motivation |
|---|---|
| Resources | Recognition |
| Violence | Compassion Fatigue |
| Overcrowding | Communication |
| Standards of Care | Attitudes and Behaviors |
| Opportunities for Improvement | Decision-making abilities |
| Workplace Culture | Sense of Accomplishment |
| | Work Culture |
| | Autonomy |
| | Recognition |
| | Opportunities for Improvement |
| | Teamwork |
| | Continuing Education |

**Maslow's Hierarchy of Needs**

| Level | Theme |
|---|---|
| Self-actualization | Personal fulfillment, sense of accomplishment, autonomy |
| Aesthetics | Beauty and balance, autonomy, workplace culture, relationships |
| Cognitive | Knowledge and self-awareness, Autonomy, Decision-making, coaching and mentoring |
| Esteem | Status, recognition opportunities for improvement, autonomy |
| Belonging | Teamwork, attitude, behaviors, relationships, culture |
| Safety | Violence, compassion fatigue, overcrowding, stress |
| Physiologic | Resources, communication, standards of care, workplace culture |

**Benner's Stages of Clinical Competency**

- Novice
  - Lack experience
  - Lack confidence
  - Require continuous verbal and physical cues
  - Little discretionary judgment

Themes: Stress, attitude, behavior, decision-making skills autonomy, "don't know what they don't know"

- Advanced Beginner
  - Marginally acceptable performance
  - Limited experience
  - Require less cues
  - Knowledge developing

Themes: Resources, Communication, Decision-making, Stress, "know a bit more but still don't know what they don't know"

- Competent
  - Efficient and coordinated care
  - Confident
  - Plan
  - Conscious, analytic care planning

Themes: Compassion fatigue, attitudes and behaviors, sense of accomplishment, autonomy, team

- Proficient
  - Sees whole instead of parts
  - Holistic approach

Proficient and organized

Themes: Opportunities for improvement; workplace culture; communication, attitudes and behaviors, compassion fatigue, team and co-worker relationships

- Expert — Intuitive grasp of knowledge and care
  Deeper understanding
  Fluid, flexible
  Teacher, coach, mentor

Themes: Coaching and mentoring, orientation, stress, compassion fatigue, opportunities for improvement

**Vroom and Yetton's Expectancy Theory**

**Expectancy:** Resources, skills support

| | | |
|---|---|---|
| **Themes/Patterns** | Resources | Decision-making |
| | Autonomy | Recognition |
| | Opportunities for improvement | |
| | Coaching | Education |
| | Relationship with leaders | |

**Instrumentality:** Clear understanding, trust, transparency

| | | |
|---|---|---|
| **Themes/Patterns** | Communication | Attitudes and feelings |
| | Standards | Teamwork |

**Valence:** Importance of Outcomes

| | | |
|---|---|---|
| **Themes/Patterns** | Accomplishment | Outcomes |
| | Teamwork | Attitudes and behaviors |

**Kahn's Theory of Engagement**

**Physical:** Sympathetic illness, skill use, productivity

**Mental:** Autonomy, workplace culture, attitudes and behaviors, outcomes

**Emotiona**l: Outcomes, teamwork, autonomy, trust, connection with coworkers

**Cognitive:** Relationship with leaders, teamwork, attitudes, trust

# Appendix D: Hospital U

## Current Work Environment

I began each interview with the open-ended question "tell me about your work. What is it like to work in your ER?" The purpose of this ice-breaker was to garner an idea of satisfaction based on the information provided with this opening question. Ninety percent (9/10) RN answered that the ER was stressful, unpredictable, and stimulating but stressful. "It is organized chaos but not necessarily organized" (1BBU). "It is a fun and exciting place to work though and my coworkers are amazing" (10MU).

To set the stage for the remainder of the interview I also asked each nurse to describe what they would see as a perfect work environment and the top three factors they considered as essential for workplace satisfaction. I also asked if the RN was satisfied in their current job.

## Perfect Work Environment

A Baby Boomer RN (2BBU) described the perfect workplace environment as

- "having enough staff to care for patients, enough physicians and ancillary staff to take care of patients, and time off when needed to help our sanity. You sometimes need to get away from this place."

Every nurse (10/10) responded that safe nurse-to-patient ratios were essential for their satisfaction.

- "You can't provide good care if you don't have staff to do it" (4GU). Each RN also responded that continuing educational opportunities were

essential to maintain their skills as well as keep them satisfied that they were "current in what needs to be done" (5GU).

"Having a bed available for every patient who needed one" was determined to be essential by 10/10 respondents. These questions provided valuable insight into the overall or larger issues that ED RN face on a day-to-day basis. From the responses I was able to delve deeper into these factors and through coding determined that resources were an essential element required by U ED RN for satisfaction.

**Job Satisfaction**

The next question asked focused on the participant's view of persona satisfaction in their job.

- To an extent yes I am satisfied…At times it is discouraging when we have a lot of expectations from us…I feel we have a lot of expectations that we as nurses have to fulfill" (9MU). "I feel mostly satisfied in what I do" (5GU).

Concerns were also expressed related to management and the tenure of new ED RN. Generation X participant 6 stated "I think deep down I am an ER nurse. I feel like where I work there is a lack of support from management and value of experienced nurses. I feel like it is dangerous because they have recently with six months experience." Generation X RN 6 also stated "I feel like I am looked at negatively when I make comments like 'are you kidding me?'." "I think I am satisfied but at times afraid for what is coming. For example, there aren't enough nurses now and what is going to happen next?" (2BBU). All 10 of the ED RN interviewed voiced a sense of satisfaction in the job

they perform and work done but 9/10 felt that particular issues such as ED tenure, staffing, and compassion fatigue played a role in dissatisfaction.

**Resources: Staffing**

Nine of the ten respondents stated that staffing was an issue that directly impacted satisfaction. Staffing is a "difficult issue to address because you never know what is going to roll through the door" (1BBU).

- "One day we are slammed…They made three to a team…. Our charge nurse was running around…. They don't cap us" (6GU).
- "I would say staffing is sporadic at best" (10MU).
- "I think it is great that our management tries to utilize contract workers" (9MU).
- "There are times when patients keep coming, we don't have beds, we don't have staff and we can't stop taking patients. It's just crazy" (2BBU).

One RN felt that resources were adequate and that "physical resources tend not to be frustrating as much as the need for administrative resources" (3BBU). "Generally, we're expected to suck it up and deal with it" (10MU). Resources also include equipment and supplies.

**Resources: Equipment and Supplies**

The responses from Hospital U ED RN was mixed regarding equipment and supplies. Although a variety of issues were mentioned. No RN stated that equipment and supplies played a major role in their overall satisfaction. Specific issues included a lack of thermometers, ancillary staff quantity and scheduling, and adequate stocking and

location of supplies.

- "Thermometers that work inside the room…I think that one EMT for 20 some odd patients in GT is not acceptable…issue is that people who are assigned to an area do not stay within their designated areas" (1BBU).
- "The problem tends to be they are adequately stocked and in the right places" (9MU).
- "I say it is mixed…the support staff is hit or miss…I think the equipment is here but the education is lacking…if support staff is not available than the expectations are that the nursing staff carry that by themselves" (5GU).

In general, nurses agreed that equipment and supplies were available but inconsistent and not assigned appropriately in many cases. The response from management was viewed as inconsistent and lacking in responsiveness and support. "

- "There is always a delay from management I guess they were told they need more presence in the ER" (7GU).
- "Especially when you have a hallway assignment and you don't have the resources to do your job" (4GU).

**Communication Between Staff**

Communication is essential for nurses. This communication occurs on many levels including between staff, upward and downward with leaders, among ancillary services, to and from patients and families, and with providers of care. How communication occurs and the degree of success directly impacts satisfaction. Not

knowing what to do, who to turn to for assistance, and what others are thinking presents many challenges for those providing care to the sick and injured.

- "I think the communication between staff at this facility is really good. I think every1 does a really good job of supporting each other which is really nice to see" (10MU).
- "I would hope if someone was drowning they would tell me. I think there has been a culture that if you cannot keep up with your assignment your best bet is to keep your mouth shut and do the best you can" (1BBU).
- "In general, I think the communication is good. There could be better communication between the charge nurse and staff especially when you are receiving a patient" (9MU).
- A new charge nurse stated "I think I'm more aware of communication now that I am in charge. I see opportunities where I can do a better job in communicating with other staff."

Upon review, 100% of nurses felt that communication was adequate in the ED. The importance of open communication was stressed by all participants. "Without good communication between staff we lose our ability to help each other, anticipate what is needed, and keep the flow moving. I know that I talk to my coworkers all the time. I like to know what is happening. We also have unspoken communication especially in crisis situations" (2BBU).

**Communication with Leaders**

Responses to communication to and from leadership illustrated major dissatisfiers among participating ED RN.

- "Very poor. For the most part I work nights and they are just not there" (3BBU).
- For the most part we don't have an established mechanism in place. We used to have staff meetings which are no longer held. We now have huddles. If you're an in-between shift you don't get to go to huddles. There really isn't a forum for two-way communication in the department" (5GU).
- "A lot of times communication is one-way" (10MU).
- "We got a second assistant manager and I was under the impression that they were going to more of an off-shift manager and be present on off shifts. That has not happened" (9MU).
- "It could be better. There are times that I need an answer immediately and I never get a reply. It seems so inconsistent. Sometimes I would be dead in the water and I need a response and none comes. It is frustrating" (6GU).

A seasoned Baby Boomer stated "It is like we're a nuisance or bother. You send an email an nothing. Sometimes it would be nice to be recognized as a professional by your boss. What an easier way—respond to my email and I would think that you care" (2BBU). When assessing respondent replies to communication to and from leaders a pattern of inconsistency and disregard for staff. The simple act of communication was described as a key factor influencing staff satisfaction. The staff voiced concern over the

lack of acknowledgement and inconsistency between managers. “It depends on the manager. You may get a response back from one and never hear anything from another. It’s frustrating. I expect to be treated with respect even when I ask a simple email question. It’s like we don’t exist” (7GU).

**Decision-Making**

While decision-making plays a major role in patient care ED RN felt that they were ‘semi’ included in decision-making, many times directly related to their personal interest in what decision was being made.

- “I feel that management tries to make us part of the decision-making process but many times we hear ‘we are doing this now, does anyone have anything to say about that?” (9MU).
- “I think my decisions are valued when I am working both as a job and as a person. I do what I do and I work with what I have and I am fine with that for the most part. I don’t want to be a major part of the decision-making process” (3BBU).
- “I definitely think on the patient level I have a role in decision-making. Management does not seek input from the entire staff just a selected few are chosen” (10MU).
- “Absolutely not. I think they try to engage us…I feel like I have not been heard when asking to work on specific projects or issues…I would be a great advocate for patients but don’t feel like anyone cares” (1BBU).

A Millennial participant stated "between staff and with physicians absolutely. when it comes to patient care I think my voice is heard. I have never really brought concerns to management but I get the sense that they would get pushed to the sidelines" (10MU). I assessed decision-making as a key theme and determined that in the Hospital U ED there were issues and concerns about the involvement, connection, and sense of engagement between staff and leaders. Participants expressed reservations about wanting to participate in decision-making as well as empathy or caring from leaders seeking input or inclusion into the decision-making process.

**Autonomy**

ED RN care requires autonomy. Patients enter the ED, situations change rapidly, and the ED RN is expected to 'take charge, provide care, and be autonomous' as the rule rather than an exception. Each of the Hospital U ED RN participants stated their sense of autonomy, trust between coworkers and physicians, and quality of care required by their patients.

- "I feel the physicians trust us to make assessments and initiate treatment plans" (10MU).
- "I feel very autonomous. Our providers trust us and they have a good understanding of what our level of knowledge is" (9MU). "
- With direct patient care and the way, we have to set up and our relationships with doctors and the EMTs and the other nurses I think that everybody's role is valued…we're expected to be competent and know what we're doing" (3BBU).
- "I would say kind of middle of the road. We always have physicians available.

Overall we have fairly good autonomy in the ER" (5GU).

- "I feel like I am autonomous depending on the provider I am working with. Some providers expect less of us" (1BBU).
- "You can't work in an ER if you're not autonomous. If you waited for the MD sometimes our patients would die. We have standards and all possess a level of skill and expertise" (2BBU).
- "I feel I am autonomous and that I am backed up by the physicians. I know there is always someone there with more experience or expertise who can help if I am in a jam" (7GU).

The theme of autonomy was found to be a key factor in ED RN satisfaction among the Hospital U participants.

**Recognition**

Recognition was viewed as important in the overall satisfaction of the ED RN. RN reflected on the recognition. How, who from, and frequency of recognition was discussed by participants.

- "I didn't go into this job for the recognition" (10MU).
- "It's not about being recognized all of the time. It's about knowing that I do a good job" (2BBU).
- "I think recognition is tremendously important. I think staff are good at recognizing one another…our patients are sick…they don't have an obligation to thank us…we don't hear anything from management" (9MU).
- "I don't get feedback very often. I don't think we are recognized beyond our

coworkers and physicians" (3BBU).

- "Recognition occurs through yearly recognition during our annual evaluation…other than that it is peer-to-peer. I don't see a formal process in place for recognition" (5GU).
- "I wish we were recognized more often. Sometimes a simple thank you can go a long way in making you feel appreciate. It's hard when patients are complaining, the number of patients keeps increasing, and no one except your peers are standing shoulder to shoulder with you. Sometimes we get pizza when it's busy but…" (2BBU).

While ED RN may state that they do not expect recognition for what they do I disagree. Human nature tells us that we all want to be appreciated, belong, or feel needed. Nursing is in the forefront of those human characteristics. Each participant spent time explaining the importance of satisfaction and like many ED RN made an assumption that doing your job was enough and maybe you did not need that recognition. Once again, I sensed that the need for recognition was high among the participants and my observation of their facial expressions when describing a time when they were recognized told a different story than the verbal discussion I heard during the interview.

**Opportunities for Improvement**

Individuals become stale and stagnant in their job if not provided opportunities to grow and develop (Herzberg, 1976). These opportunities originate on many levels.

- "I think there is support there but it is not something that is in a formal framework…now we have an RNIII and RNIV level which recognized when

nurses are taking those initiatives on and making themselves better" (5GU).

- "No because when you want to go to Grand Rounds or something like that there is not enough staff to cover you to pursue those opportunities" (1BBU).
- "Yes, I'm always getting emails about continuing education opportunities that I could attend" (10MU). "I think our hospital is trying to promote staff to increase to RNIII and RNIV, so they are offering more continuing education money and education opportunities to advance professional status" (9MU).
- "The opportunities are out there. Unfortunately, they cost money. There are some funds available but many times you pay out of pocket" (3BBU).
- "If I seek something out I feel like I am getting the support and time to do that because I rarely ask for time to do things to increase my education" (3BBU).
- "There are a ton of committee, too many I think…Years ago there was a big push for CEN and it's back…there's really not a lot of incentives to better yourself" (7GU).

The responses were variable. Most nurses (70%) felt that there were adequate opportunities for improvement while 30% felt that the opportunities were limited. I asked participants about their involvement in obtaining certification, ongoing professional education, and focus toward further their nursing education. The lines were split along the 70%/30% split in these answers as well. The 70% who responded positively to adequate opportunities for improvement had recently attended a conference or seminar, were pursuing advancement in nursing, or were working on certifications or RNIII/RNIV clinical ladder advance. The remaining 30% had no plans for continuing education

outside of Hospital U or advanced certification or education. The importance of opportunities for improvement could not be determined as significant as a key satisfier for ED RN.

**Teamwork**

ED nursing could be described as a team sport. No one person is more important than another and the process is multidisciplinary.

- "I think that teamwork is the highlight of the ED, that it is a team approach…I don't know what has happened by team work doesn't flow as naturally as it used to" (5GU).
- "I can tell what kind of day I'm going to have depending on who is working with me…working with certain nurses means a good day, others not so much" (1BBU).
- "It is impossible to succeed in the ER completely by yourself. The patient acuity and load will chew you up and spit you out. I think how well the department works together is a huge part of how successful each nurse and the department are as a whole" (10MU). "You can't do this job by yourself. It's about being a team" (8MU).
- "As a whole it is good. I think my sense of teamwork might be a little different than others" (4GU).
- "My perception is that people work well together. Some might disagree and think there are cliques that have developed. I feel I get along well with my coworkers" (7GU).

Despite different perceptions were provided regarding teamwork, 100% of participants defined teamwork as an essential component for ED RN satisfaction. Without teamwork patient care would be fragmented and disjointed. These relationships on the team aid in providing care that is consistent, steady, and carefully planned and executed.

**Relationships**

The importance of working relationships becomes apparent in the everyday care provided to patients and significant others. Nursing is not one person providing care to one patient. The care is multifaceted and multidimensional on many levels. How staff work together, unit for a common purpose, and provide care are essential to patient satisfaction and patient outcomes.

- "I feel I have a good working relationship with my coworkers. Oftentimes some of the younger members look up to me because I am a great resource" (1BBU).
- "I couldn't do this job without my coworkers. Sometimes we forget when we complain about each other how difficult this job truly is. Without the laughter, tears, and relationships at work this job would truly suck" (2BBU).
- "Sometimes I'm afraid that the younger, newer staff don't know what they don't know. It scares me because I don't want them to fail. I try to look out for newer and younger staff so they don't have to learn the hard way like I did (7GU).
- "We all work well together…each shift has their own vibe…at the end of the day you can ask any co-worker to help and they are there for you" (10MU).
- "Our layout is very broken up. Sometimes you don't see other people because of

where you are working. This definitely changes working relationships" (9MU).

- "For the most part I don't tend to be best friends with the people I work with. I have a professional working relationship" (3BBU).
- "I like the people I work with and see them outside of work. We work as a team and that is the most important part of this job" (8MU).

The development of work relationships is dependent upon many factors such as communication, coaching, stress, support, and mentoring. Work relationships were described as essential to maintaining satisfaction because they provide a sense of safety, opportunities for sharing of knowledge and expertise, and a refuge when care is stretched, staff is stressed, and care is potentially compromised.

**Coaching and Mentoring**

Nursing requires coaching, mentoring, and orientation for successful transition into any aspect of nursing. Benner (2001) described the logical progression in knowledge and expertise and the essential needs to learn, gain knowledge, and become comfortable in the role of providing care. ED RN are no different and requires a more structured approach secondary to the need to be knowledgeable across the age continuum, the unplanned, and fluid environment of meeting the needs of unanticipated patients entering the department, and the lack of adequate staff to care for patients which impacts numbers to orient, mentor, and coach new staff.

- "When I first started here we were smaller and everyone knew everyone. We had ways to orient. Now we have grown and I don't even know some of the staff. We have lots of agency nurses and I'm not always sure they received an adequate

orientation to how we do things" (4BBU).

- "We have failed in orientation and mentoring in this department. There is not a clear process in place. The orientation process if often broken up and handled by multiple people instead of having one person assigned to the new staff" (5GU).
- "I feel that I am a strong mentor and resource. Frequently I think management forgets and puts people into mentoring or orientation positions who need more orientation themselves" (1BBU).
- "I worked a couple of shifts on each shift before I was assigned a preceptor. I was assigned a preceptor and this worked well and I formed a bond with my preceptor. She knew what I knew, was able to pass that information on, and what I needed to be successful" (10MU).
- "Recently I have been asked to mentor EMT and nursing students. Our census has been high and I don't feel that I can do my job adequately in showing them what they need to know and be a mentor at the same time. I think a formal program would be helpful" (9MU).
- "I was lucky and had a great preceptor. He had been an EMT before becoming a nurse so he knew the department from two levels. Very good information and he protected me but also let me fly" (8MU).
- "I had a terrible orientation process. Because I had ER experience I don't think they gave me what I needed. My preceptor was retiring so he was not invested in what I learned or what he did. Terrible that the process is geared to a list of words which don't necessarily portray what we do in the ER" (2BBU).

- "In the past we tried a mentoring program and it really never took off. It is essential that staff be oriented and cared for throughout their time in the ER. That doesn't happen right now and it's a shame" (6GU).

Orientating individuals into the department was viewed as an essential skill. What the new employee grasps as the ED culture, how things are accomplished, and the seriousness of the care provided directly influences satisfaction, outcomes, retention, and attitudes and behaviors of the staff. Nine of ten ED RN felt that a formalized process should be implemented. These nine RN expressed concerns about how new staff are oriented and whether the new staff are fully prepared to work in the ED. The three Baby Boomer RN and two Generation X RN expressed concerns about *younger* nurse skill levels, recognition of knowledge deficits, and potential for failure without proper education and orientation. "You can't expect a new RN to know things if they are not exposed to them. Our orientation makes too many assumptions about capabilities and not enough about reality" (2BBU).

**Education**

The ED at Hospital U has two nurse educators each with less than five years of experience as an ED RN.

- "I'm not really clear on what each of the educators does. It has never been well communicated. They always look stressed and don't communicate well all of the time" (2BBU).
- "Our management is pretty good when you ask to go to a conference" (9MU)
- Many times, education is provided via email. I'm not always here so I usually

have to track down who is doing the education and figure it out. It's not always clear and communication is lacking" (3BBU).

- "It's important to me. Most people who work in the ER are self-driven. If you're not provided with education staff becomes dissatisfied in their jobs because there is so much to learn all of the time" (5GU).
- "I tend not to attend the education days. They are not offered at convenient times for everyone" (1BBU).
- "I never feel like I have enough education. Things are always changing. We don't seem to keep up. We have two educators and yet we're always behind in getting information out to staff before something new arrives or we need to change how we do things. Not a great deal of pre-planned for sure" (4GU).
- "I feel like we need education but it's never planned. It seems like it is always on the fly. We have an education committee but I'm not sure what goes on with the committee. Like so much here communication about things just doesn't flow" (7GU).

The ED staff interviewed expressed frustrations to the current education provided to them. All ED RN interviewed had negative comments about how, when, where, and with whom education was conducted. The ED RN agreed that the provision of education is essential to RN satisfaction. This correlates directly with the unpredicted nature of ED nursing and the need to have information available cognitively as well as being physically able to perform tasks. Frustration with the lack of knowledge and skills leads

to further stressors which in turn potentially influence staff, patient, and significant other satisfaction as well as patient outcomes.

**Compassion Fatigue**

The ED RN commented on factors influencing compassion fatigue including attitude, anxiety, stress poor coping skills, call-ins, frequent return visitors, and mental stability.

- "It's all about patient care. Grandma is in with a broken hip and the ER is crazy. I feel I need to provide care of turning and taking care of Grandma as well as the new acutely ill patient. I think the stress tends to be very high and most people in the ER tent to just swallow it" (1BBU).
- "Currently the boarding of patients and psych patients have increased the stress around here. This stress is only complicated by the frequent flyers who are back again and the 30 patients waiting to be seen in the ER" (10MU).
- "I definitely think it is a real thing…I'm not malicious, but I realize that there is a lot of room where I could be friendlier or understanding of their situation…You go back and you think 'how did I get like this, how did I get so cynical?" (9MU).
- "For me I don't see it. My personal life is more stressful than work" (3BBU).
- "Moving our patients is huge. We can't move our patients. This just adds to our stress" (6GU).
- "I'll admit that I'm tired. This work is exhausting and we never have any break. No there is no measures in place to help us destress. It's like do your job and suck it up, you'll get through this shift. I hate never seeing management when it hits

the fan. It's like we're forgotten" (2BBU).

- "There are many things that we should tap into like debriefings but we don't any more. I think we should put more emphasis on keeping our staff happy in their minds and being able to cope with stress. We don't even get meal breaks. Imagine a job where you eat at your desk between IV starts and new patients. It's insane" (7GU).
- "For me compassion fatigue is more toward the institution and the policies or lack of policies more than the patients themselves. I think I provide compassionate care but always feel like I'm running into a wall like not having equipment, staff, or resources. Those are the things that lead to my fatigue, not the patent's themselves. (5GU).

EDs provide for a stressful, unplanned, and fluid method of caring for the sick, ill, and injured across the age continuum. How nurses deal with these stressors can provide long lasting negative impacts on patient care, home life, and work life balance. Nine of the ten RN described an environment ripe with stress and staff working hard to deal with the stress without a great deal of assistance or support from leaders. The staff discussed calling in, physical and mental exhaustion, and the need to destress as imperative to the survival of the profession of ED nursing.

- "If we don't help each other, we're doomed to become cynical and hate our jobs, our patients, and the work we provide to our patients" (2BBU).
- "It is essential that we recognize when we are stressed and when our coworkers are stressed. We need to talk about stress and how it impacts us" (7GU).

**Violence**

The ongoing opiate crisis, increased in domestic and gun violence, and mental health issues have changed the landscape of the ED. The ED RN experiences violence at an alarming rate and the information provided during the interviews supported the increase in violence and the fears, safety, and preparations ED RN are taking to protect themselves.

- "There have been episodes of violence especially with the boarding of psych patients…I think all of us feel that the way we are currently treating our psych patients would make any patient lash out" (6GU).
- "It doesn't happen daily but it certainly has become an issue that we all need to deal with and to protect ourselves" (7GU).
- "I did not grow up in a home with violence so this is all new to me. I have been dealing with it in nursing for several years but it is more prevalent than it used to be, and it seems to be more socially acceptable" (1BBU).
- "With the psych boarding and the drug problem going on we are seeing a lot of violent or potentially violent patients" (10MU).
- "What's interesting is how we talk or discuss issues with violence. For example, this staff member was assaulted by a metal so it is somehow his fault that you didn't make this room safer by taking the tray out. We file a police report when assaulted, we will press charges if you want to, but take the tray out of the room because that is what the problem occurred. Missing the point about safety on all levels" (9MU).

- "Violence is an issue. I worry about our other patients who get scared during these violent episodes that they are forced to witness. I'm not sure what the answer is but we've got to do something" (3BBU).
- "The environment is set up for violence. We board out of control patients with the general ER patient load. It's crazy. I can't tell you how many times we sedate our patients because we're in a terrible, logistical mess with our psych boarders. You can't care for all patients at the same level" (4GU).
- "I think we deal with the violence pretty well overall. Unfortunately, violence does happen. Security is in the ER with helps. The whole set up is bad for patients" (8MU). "I try to keep myself out of the violence if possible. We have so much work to do. It has helped that we now have psych travelers to take care of the psych boarders. MOAB (management of aggressive behavior) classes and training have helped" (7GU).
- "I think we take for granted that it is safe in this ER. Unfortunately, that may not be the case and I don't think people see the potential threats like some of us who have worked in other places. It scares me to see unseasoned staff, especially younger staff getting engaged or not understanding the severity of the situation they are currently involved in" (2BBU).

In today's healthcare environment, especially ED, violence is a foregone conclusion. Simply turning on the news and hearing about another school shooting, the drug epidemic, or lack of social resources such as drug rehabilitation services is the norm. ED RN participants recognize the violent nature of their work environment and the work

they perform. Being safe is a basic need outlined by Maslow (1999) and does not differ in how ED staff view the importance and impact of daily violence. This violence was described in terms of physical, emotional, and verbal violence projected toward staff.

- "I hate that even when I'm working my butt off, someone is yelling about having to wait or is in my face telling me that I'm not treating them nicely" (2BBU).
- "It's a battle to not want to scream at someone and say 'I'm doing the best I can'. Why do people think it's OK to yell at a nurse who is trying to help them" (7GU)?
- "People get upset when they have to wait. Throughput of patients impacts so much" (8MU).

The entire group of participants felt safe in their work environment but felt that they had to be constantly aware of their surroundings, rely on communication, and be cognizant of who is in the department.

**Stress**

Baby Boomer participant two stated "I think we're all adrenaline junkies to some extent. This is a stressful place to work. We hold our patient's lives in our hands. We have to be at our best at all times. I sometimes wonder what our cortisol levels are, especially after a horrible shift when we're exhausted on all levels" (2BBU).

Stress occurs in the ER and can be perpetuated by a variety of factors. The RN underlying state of mental and physical health on a given day, the workload, the patient acuity, patient flow, communication, culture, and relationships all play a role in the stress load and how well or poorly the RN handles the stress. Unfortunately, RN are frequently

told to leave their home life at home and focus on their work. The reality of this statement is that our home life does influence how well or how poorly we function on any given day.

- "I think I handle my stress well but sometimes find myself speaking shortly or uncaringly to the patient" (9MU).
- "I realize when I'm not handling my stress because I become sarcastic and give smart remarks" (2BBU).
- "Stress is everywhere. I rely on my coworkers to help me with the stress. We're all in this together" (7GU).
- "I don't know of any one thing that management does to help us reduce our stress except give us pizza on busy nights. That is nice but doesn't change my stress only my hunger" (6GU).
- "I think over all we talk about stressful days but at the time we all work as a team. Guess we just suck it in and do our job" (8MU).
- "I'm more aware of stress when I'm in charge. People sometimes just need someone to know they need help" (3BBU).
- "Management doesn't seem to care if we're stressed or not. You never seem them around so why would they care" (4GU).

Similar to compassion fatigue, ED RN interviewed provided strong statements regarding the impact of stress on their physical and mental well-being. Younger nurses voiced concerns over the impact of stress on patient outcomes and the feeling that they could not complete tasks as needed. Stress was viewed as an important component of

satisfaction and understanding stressors, providing opportunities to destress, and inclusion in measures to reduce stress were viewed as important.

- "It's not about the patients entirely. If the RN can't function then we can't do our job. I don't want one of my peers to not get the help they need because we have to take care of patients. I've experienced times when I just wanted to quit and walk away. A kind fellow RN realized this and we talked. I figured out ways to decrease my stress. I wish management cared or recognized home important stress is on outcomes, call-ins, and nurse or patient satisfaction" (2BBU).

**Sense of Accomplishment**

EDs ebb and flow based on patient needs, acuity, provider expertise, and patient responses to treatments. For the ED RN time is a key component of care to be provided, patient responses to treatment modalities, and patient flow through the department. At times, a patient is being discharged from a bed while the ambulance transferring a new patient to that same bed is waiting outside the door. The ED RN struggles to find a balance between providing adequate care such as discharge instructions and preparing for the next patient to occupy the bed. The ED RN interviewed provided insight into the sense of accomplishment when working in the department where chaos may be the manner in which the shift has progressed since their arrival in the workplace.

Baby Boomer RN one described a day "when the kid I was taking care of used heroin. I spent a minimal amount of time talking to him about choices. Two days later he is dead. That sense of accomplishment or lack of sticks with me. On a positive note, I will see a stroke that comes in and we do whatever and I am very privileged that I get to see

them go on to ICU."

- "I think it is hard to feel accomplishment if you are only basing it out of patient outcomes. I try to have my sense of accomplishment on the improvements that I have made for the patient" (10MU).
- "Most of the time we are trying to get our tasks completed and get the patient whatever they are going and get ready for the next patient. Sometimes I don't feel a sense of accomplishment because I can' figure out and follow through with my patients" (9MU).
- "I think we do a good job, not amazing, in the care we provide to our patients. I used to feel more accomplished at the end of my shift. It is a rare occasion for me to leave a department now and feel that it was a good day. Even though you try, you work hard, and you skip breaks and meals, I feel like the system is set up against us in to truly succeed in caring well for our patients" (5GU).
- "I never feel like I get everything done that I need to do. It certainly impacts patient care. The slowness of our providers certainly influences that sense of satisfaction and accomplishment. Patients get frustrated with slowness and I feel pressured to keep them satisfied even when providers don't do anything to change their practices" (7GU).

Nine of the ten ED RN interviewed voiced strong sentiments regarding their personal sense of accomplishment in the ED. These frustrations ranged from time spent with discharge instructions, time to teach and education patients, availability of open beds in which to care for patients, and the rapid movement of patients in the ED without

adequate time spent discussing care, problem solving, and working with families. The one RN who did not voice strong views on the sense of accomplishment stated

- "I don't do patient care very much so I don't see it as a problem" (3BBU).

Timeliness issues and lack of adequate time to educate, discharge and care for patients is further complicated by ED overcrowding.

**Overcrowding**

EDs provide care to patients without prejudice to race, ability to pay, or illness, injury, or disability. As the Baby Boomer generation retires, a new influx of patients using ED services increases, and social services to provide outreach for mental health, drug use, and other issues become less scarce ED will experience increases in the number, acuity, and types of patients seeking care, being held for further treatment, or require long-term care and management. Overcrowding was described by the ED RN participants as a major factor influencing satisfaction.

- "It negatively impacts my care. I cannot provide the best patient care when I know that there are people in the waiting room who need to be seen. Especially with discharge instructions. I think overcrowding plays a major disservice to our patients when we are trying to discharge them. I feel like I throw the paperwork at them to get them out the door before answering questions" (10MU).
- "It doesn't seem like hospital administrators care or are concerned if we're overcrowded. Just send them to the ER. They'll take care of everything" (10MU).

Millennial RN 9 described her problems with overcrowding "I like to say I give

equal care and I give the best care possible but when we are overcrowded and you need to quickly turn over your room I probably don't provide the best care for discharge or give the best report."

- "I can deal with beds being full, no place to put patients, and other problems. The real issue is moving patients through the system and to the floors. We have a new plan that works but we still have provider delays. There's a lack of staffing here and in the hospital, which directly impacts my personal satisfaction" (3BBU).
- "It is not as much that we're overcrowded as much as the types of patients that get held with no plan in sight. I've worked all over the country and what happens with our psych patients is terrible. We are many times overcrowded because these patients are here for day and weeks taking up bed space and I feel bad for them because the system is failing them" (4GU).
- "It's terrible for our patients to come in and have to wait three hours to see a doctor. Even worse is being put in a hallway bed. How degrading is that? You come in to be seen and we put you in the hallway because we think that works for you. I hate the system and what we do with our patients. Overcrowding occurs everywhere in this department from physicians who are slow, to staff who don't discharge patients, and to holding patients" (6GU).
- "Overcrowding is a real problem. I feel bad for our hold patients. We are doing them a disservice. We can't find beds because we are chronically holding psych patients. The mental health system is broken and the ER seems

to be the solution" (2BBU).

All RN interviewed voiced frustration with the overcrowding problem. The RN felt that they could not perform or did not perform as well as an RN due to the lack of beds, rapidity in which beds turned over, and the lack of care provided to the boarded patients. Two of the RN voiced concerns stating

- "the psych patients take the brunt of the hostility for not having beds but that's only one part of the problem" (2BBU).

The second RN stated "we need to address overcrowding as a group and not just through managers. Our voices should be heard in this dilemma" (7GU).

## Hospital U Satisfaction Theme Summary

Other factors also impact how an RN functions in the job, the work performed, and with the organization. This engagement provides the second portion of the ED RN interviews.

## Engagement Themes

Engagement occurs at the physical, cognitive, emotional, and mental level (Kahn, 1990). Questions were posed related to engagement aligned with connections with coworkers, optimal use of the participants skills and skill sets, trust with staff and managers, connection to the job, to work, and with the organization.

### Connection with Coworkers

A strong sense of connection with coworkers was expressed during the interviews.

- "I feel that I am connected with the majority of my coworkers" (1BBU).
- "Yes, I do. I do lots of things with my coworkers. I feel very connected to them. We all go through it together" (9MU).
- "I feel like we're connected" ((3BBU).

All participants expressed a strong sense of connection with coworkers (100%).

**Skill Utilization**

Each person interviewed was asked if they believed their skills were used to the maximum in the job performed. All RN responded that they felt their skills were used to the maximum.

- "I can say that some days I don't use many skills but on other days I am full out busy and use many of them" (2BBU).
- "You are not allowed to not use your skills down here" (7GU).
- "Sometimes with new equipment or education I wish it was provided earlier so I could learn about it earlier and feel more comfortable" (9MU).

**Trust**

Trust was addressed in the satisfaction review but I focused more on the trust in the job performed and the work aspects related to engagement. I focused on the emotional and mental connection versus the physical components that influence trust.

- "I trust my coworkers to be there for me" (7GU).
- "You have to trust others. Sometimes I don't even have to look and I know someone has my back" (2BBU).

All RN interviewed described the need for trust and the sense that workers were trusted on the physical, emotional, cognitive, and mental levels as outlined by Kahn.

**Connection with Job**

The respondents had difficulty separating connection with job and connection with work. To better operationalize the differences, I described being a nurse as the job and working at U (or any of the participating hospitals to describe the work. ED RN who participated felt a strong connection with the job.

- "I love being an ED RN" (6GU).
- "It's what I do. I do it because I care about the patients" (2BBU).
- "I couldn't imagine doing anything but this" (7GU).

During the interviews specific barriers to providing good nursing care were addressed but in no interview did an ED RN describe her dislike or unhappiness with her job.

**Connection with Work**

Distinct differences were expressed as related to connection with the work performed at Hospital U. Nurses described barriers to work place satisfaction. These included a lack of management response and involvement, stress, overcrowding, violence, lack of empathy and concern for staff healthy, and the need for improved methods to provide reward and recognition, education, and coaching.

- "It's not just about being a nurse. U doesn't seem to see the problems that are right in front of them" (7GU).
- "Management doesn't seem to care" (2BBU).

- "We need formalized processes for education and orientation. We are failing our new staff" (5GU).

**Connection with Organization**

A strong sense of disconnect was seen between the staff interviewed and connection with the organization.

- "I come to work, do my job, and go home" (3BBU).
- "I know what the mission, vision, and values are but am not involved at the organizational level" (10MU).
- "I used to be on committees but they don't seem to go anywhere so I'm not involved" (5GU).

No ED RN stated they felt a strong connection with the organization. Two of the 10 (20%) felt a slight engagement and 80% felt disengaged at the organizational level.

**Hospital U Engagement Themes Summary**

The ED RN at Hospital U felt fulfilled in their jobs as an RN with multiple layers of frustration expressed on the work level. These frustrations parallel issues addressed earlier as satisfiers. This strong sense of fulfillment in the job performed may stem from the reasons the RN decided to become an RN.

- "I've always wanted to do this" (2BBU).

The differences in commitment on the work level could be explained as directly related to the work environment, work culture, attitudes, behaviors, and managerial leadership. The lack of engagement on an organizational level illustrated the strong

disconnect expressed between staff, mid-level managers (ED Managers), and hospital leaders.

- "I don't trust the upper leaders because I don't think they care about us" (2BBU). "When all else fails, send them to the ER. They always do that and you know what, maybe they should come down here and see what it is really like" (7GU).

One participant stated

- "I don't even bother reading some of the stuff upper management sends out. It's all fluff" (7GU).

From interviews with Hospital U ED RN I determined that trust, relations with coworkers, fulfillment, and commitment to the job were key factors influence ED RN engagement.

## Finalizing the Interview Process

To finalize the interviews process I returned to open ended questions focusing on why the RN comes back to work day after day and what the most pleasurable and frustrating aspects of the job were to the RN.

### Day-to-Day Work

RNs interviewed described why they return to this stressful job with enlightening information.

- "I am getting paid pretty good money to do this, I have flexible hours, and it pays my bills at home" (3BBU).
- "I love my job. It's a challenge every day and I make a difference" (2BBU).

- "My coworkers, my patients. The challenge and the excitement of everyday" (10MU).
- Constant opportunities to learn and grow…I feel like opportunities to learn and grow have stopped…You have to make them for yourself…I'm not as happy about the work I do here anymore" (5GU).
- "The team I work with. Working with a group of really good people makes the job enjoyable" (9MU).
- "My coworkers. My daughter told me I can't leave the ER because the people sound cool" (6GU).
-

**Pleasurable Job Attributes**

The interviewees also described the most pleasurable aspects of their job.

- "Working with good people" (9MU).
- "Money, flexible hours. I am astounded every day how much nurses get paid compared to when I started" (3BBU).
- "My coworkers. The sense of impacting someone's life" (10MU).
- "My coworkers. We're a team and it often feels like a family" (5GU).
- "The opportunities to learn from others" (7GU).
- "I think it's the team I work with. They are a great group of people. They work hard, play hard, and we enjoy being together. The work is hard but we all love it" (2BBU).

**Job Frustrations**

The frustrations expressed mirrored some of the areas described earlier in the satisfaction themes. “I feel relatively helpless at this point to effect change on some things that are challenges or barriers to us. I think that the biggest thing you feel like is that you are stuck in this and there is no way to easily improve things with it. Lack of input and communication are key factors” (5GU).

The information obtained in the closing questions provided a sense of what ER RN required for satisfaction and frustrations experienced. The elements related to engagement were closely relatable to similar elements ED RN feel are essential for satisfaction as well.

- “Psych patients, holding patients, overcrowding, the census, the sense that management is nowhere to be found when they are needed” (9MU).
- “Lack of communication from my bosses…I feel like I am working in a void…I feel I have the right to follow up from managers” (3BBU).
- “Overcrowding and being understaffed” (10MU).
- “I hate that people don’t get enough education before starting work. I also get frustrated that we assume that new nurses can handle what is happening and we don’t sit down with them and talk about things. We’re setting them up to fail” (2BBU).
- “I feel like we don’t get the respect that we deserve. We’re always the underdogs who pick up the slack and it would be nice if someone said thank you occasionally. Might make the staff feel appreciated for the work they perform”

(7GU).

## Hospital U Generational Cohorts

I analyzed the data of the three generational cohorts at Hospital U looking for patterns or themes. A summary of findings is provided for each generational cohort.

I interviewed three Baby Boomer ED RN with ages ranging from 52 to 63 years (mean 56.3). The Baby Boomer generational cohort was less vocal than I had anticipated. The responses focused on prior experiences and how the person viewed the ED at the present versus how the ED had functioned in the past. The Baby Boomers stated that staffing and staffing ratios were essential to maintaining satisfaction as well as retaining staff. Each Baby Boomer acknowledged changes that have occurred related to staffing shortages, increased patents volume, and patient acuity levels. The Baby Boomers described concern over the lack of knowledge of the Millennial generation in knowing 'what they don't know'. The Baby Boomers described a sense of fear for the new providers and a sense of protectiveness toward this group. The Baby Boomer cohort also described the work ethic differences that they are seeing in the workplace. These differences included a lack of sense of urgency, a degree of complacency with younger staff, and an increased willingness to call in by the younger staff. The degree of respect was also addressed by BB1 who described

- "younger staff doesn't listen and they appear to know everything. Some of them don't know what they are doing but we turn them out to take care of patients anyway."

Key factors related to communication, decision-making, autonomy, and recognition showed no differences between the generational cohorts. Baby Boomers felt a strong sense of teamwork. This cohort discussed similar problems relating to communication with managers, education, and coaching. Violence was viewed as a more serious concern and expressed as

- "the younger group doesn't always know how close they are to something bad happening" (2BBU).

Overcrowding, compassion fatigue, and stress provided no definitive differences for the Baby Boomer cohort group.

Engagement was strong on the job level and somewhat weaker at the organizational level. The four RN in this cohort stated that they had been involved at the organizational level previously but were currently either minimally or non-engaged at the organizational level. The cohort members voiced the importance of work life balance and the need to set personal priorities to gain more satisfaction at the work and job levels.

Four Generation X ED RN were interviewed with ages ranging from 41 to 50 and a mean age of 44.7. The Generation X cohort provided a vast range of responses to the interview questions. This generational cohort was outspoken and provided more information than the other two cohorts. A consistency among the groups was staffing ratios and being understaffed. Both were viewed as factors negatively influencing nurse satisfaction. The lack of communication from managers was expressed by all of the Generation X participants. All of the participants act in the Charge Nurse role and

expressed frustration, pessimism, and a lack of caring by managers as a key factor influencing their satisfaction and for the satisfaction of patients. Education or lack of a formalized process was outlined as a key to ensuring safe care. This generational cohort described an environment of getting staff out on the floor and not caring if they were prepared or not to meet the demands of being an ED RN. Fifty percent of this group expressed concerns over the quality of care and their lack of enthusiasm or optimism about the future of the Hospital U ED.

- "It's not the same now. I worry about what will happen. We have people working who are ill-prepared and they don't know that" (4GU).

The Generation X ED RN were involved at the work and job level with two of the RN stating they were involved minimally with committees and with the organization.

Three Millennial RN were interviewed. Ages ranged from 25 to 26 with a mean age of 25.3. The Millennial RN were well versed and aware of how older RN felt about their care and work ethic. Millennial 10 described "each shift as being different. The day shift has their own way. They are the older nurses and they don't work the way we do."

The Millennial group was direct and to the point. The group provided answers and solutions and did not dwell on what did not work as much as what could work. The Millennial cohort group also provided information focusing on solutions rather than problems. The Millennial group had a strong sense or feel for the patient conditions and the role they played in the care provided. This group was engaged on the job and work level. The Millennial RN voiced the need to be involved and each stated they were trying to find where they wanted to become involved.

**Hospital U Generational Cohort Summary**

Consistency was found between generational cohorts related to staffing, ratios, communication between staff, autonomy, recognition, opportunities for improvement, teamwork, and relationships. Consistency also was found in the need for a sense of accomplishment and educational needs. The Baby Boomer cohort voiced concerns regarding the lack of knowledge of the Millennial RN. This group also appeared less trusting of staff. The Baby Boomers were more protective of the younger nurses and wanted to be used as a resource. This generational cohort also described a lacking sense of urgency and respect toward the older, seasoned RN.

The Generation X RN voiced a change in the level of care provided and how care has changed. These changes were attributed to less formalized education, younger workers not understanding their limitations, and a change in work ethics. The Millennial cohort participants observed vast differences in how nurses on different shifts related to one another, treated ancillary staff, and viewed problems. The older nurses were viewed as focused on negativity, were frequently frustrated and flustered when providing care, and were less helpful and understanding of the younger nurse needs and expectations.

Agreement was shown in the areas of engagement. The Millennial nurses appear more prone to become involved in committees and ‘making change happen’. The Baby Boomer nurses had a withdrawn mentality of getting involved and stated they were frustrated that things were talked about but nothing came to be when making change. The Generation X participants discussed their concerns with the negative aspects of the ED and how these changes had directly impacted them becoming involved or engaged. One

nurse felt that having her family was more important than being involved or engaged at U.

# Appendix E: Hospital C

Hospital C has 341 beds and serves as a regional referral center for four counties in New York. Hospital C is a partner in Hospital U Healthcare Network. Hospital C provides services to over 150,000 residents of three counties as a full-service provider of critical care, medical, surgical, pediatric, oncology, and other specialty services. Critically ill and injured patients are referred to the tertiary care center at Hospital U including all open-heart patients, pediatric critical care patients, and other patients requiring specialized care from the regional referral university hospital. The 26-bed ED has an annual volume of 50,000 patients.

## Hospital C Results

Six ED RNs were interviewed from Hospital C Medical Center. Ages ranged from 29 to 54 with the mean age of 24.9. Nursing education included 33% with bachelor of nursing preparation and 66% associate degree prepared.

## Satisfaction Themes

The tone of the interviews was very different and facial expressions, responses, and general demeanor illustrated anger, frustration, and mistrust. The interviews were difficult due to the anger expressed by the ED RN. The nurses tried to present information in a positive light but interview answers frequently digressed into negative answers requiring clarification.

### Current Work Environment

The current work environment was described by all participants as busy, chaotic, and short staffed.

- "High acuity. Hit the ground running" (12BBC).
- "It is constantly busy. It's stimulating, sometimes overstimulating. It hits all spectrums, usually one end or the other" (11BBC).
- "Recently it has been pretty stressful, heavy workload" (13GU).
- "It's just crazy all of the time. Never enough staff and no one cares" (4GU).
- "It's a 29 bed ED with four large trauma rooms and seven fast track beds…It can be pretty stressful between the acuity and the numbers of patients who come through the ER due to lack of resources in the outpatient community" (15MC).
- "It is a controlled environment with a whole lot of new staff. A lot of our nurses have either five years or less of experience and we are getting more patients and sicker patients" (16MC).

This ice breaker question set the stage and tone for the remainder of the interviews. Only one of the RN appeared (15MC) to be looking beyond the current situation and looking at the ED as a whole instead of basing replies on staffing, acuity, and ED RN tenure.

**Perfect Work Environment**

The next ice breaker question focused on the 'perfect work environment' and responses varied among the interviewees.

- "Clean, positive, stimulating" (11BBC). "Where everyone feels they are getting their work done: the tasks, the jobs, the education, providing safe care. Being on top of your patient, being able to give them pain medication when they need it because you aren't caught up…Where

everybody has a job and everybody is professional and doing a good job for the patient" (12BBC).

- "Education, opportunities on the floor, conferences. Better work ratio. Able to take down the workload. Have a 4:1 ratio" (13GC).
- "Being professional in what we do. Having better staffing. Communication to us and not about us" (14GC).
- "Having the resources required by the number of patients. Support from management during the times when the numbers might be outside the norm" (15MC).
- "Not too stressful but not boring either. I like the chaos of the ER, I just think that sometimes it is too much because of the volume" (16MC).

The responses illustrated frustration and the need for improved staffing. Communication and managerial support were touched on and will be discussed in the communication with leadership section. The responses provided information on the ED RN enjoyment of being busy and stress with quantifying that 'too' much was not good and that stress was expected in the role that the ED RN performs and the nature of the department they work in.

**Job Satisfaction**

The degree of satisfaction in the workplace varied among respondents.

- "Most always I feel satisfied. There are times when you feel defeated and feel like there was too much and not enough of you…stretched a little too thin" (12BBC). "

- I feel satisfied in the job that I have as an ER RN. I just feel overwhelmed, I don't feel I am doing what I need to do to satisfy my clients, my patients" (11BBC).
- "I love ER nursing…I feel there is a lack of support from management and value of experienced nurses. I feel like it is dangerous because they are hiring nurses with six months experience" (13GC).
- "I am not satisfied because we don't have enough resources to do what we need to do" (14GC).
- "I feel satisfied in what I do. Ask me another day and I might tell you no" (15MC).
- Mostly. I feel like I can't give the best care because there are too many patients" (16MC).

Staffing was mentioned in all of the ice breaker responses. The next series of questions focus on resources and provided valuable insight into the importance of resources to the ED RN at Hospital C.

**Resources: Staffing**

Six of the six ED RN interviewed viewed staffing as a major issue and satisfier for their work in the ED. Each staff member voiced concerns over patient safety, patient care burnout, and how Hospital C is viewed within the community. All of the ED RN interviewed expressed regret and a sense that they were not providing adequate care to meet patient needs. The frustration in the interviews and facial expressions illustrated a

staff frustrated, tired, and paralyzed to move forward to make positive change within the department.

- "Staffing is a huge issue. Between call-ins and people leaving, we have such a high turnover" (16MC).
- "We seem to have a large turnover. So, consequently, we are at the minimum in terms of coverage. 50% are seasoned nurses, and 50% are new nurses which is great, they bring a positive outlook. But can be challenging because the knowledge is not there, the assessment skills aren't there the way they think they are" (11BBC).
- "I work nights most of the time. We go down many nurses. You may start with five patients and suddenly because of ambulances you have 10. That's unsafe. So, your teams are left wide open with less help to make the staff happy and for things to happen" (12BBC).
- "I mean it is huge. One day we are slammed and everyone including the charge nurse is running around and everyone is fine. You can sometimes take a deep breath and actually do nursing care. Otherwise you are running around with two nurses with 15 plus patients. They don't cap us" (13GC).
- "It's always short staffed. Management knows but they aren't willing to work with us. It's like we should just suck it up, accept that we don't have nurses and keep moving" (14GC).
- "I would say that lack of resources would just the chronic understaffing due to the lack of employees and people leaving" (15MC).

The tone of the interviews was one of frustration and a sense of helplessness. Each nurse described a chronic issue that when questi1d further has been an ongoing problem at Hospital C. No nurse could remember a time when the ED was fully staffed and there were not 'holes' in the schedule on all shifts. I probed further during this portion of the interview and discussed morale. All of the nurses told me that morale was horrible, terrible, low, and that management appeared not to be concerned although as of late managers have been asking staff questions regarding satisfaction. The staff interviewed also stated that response to short staffing by management was reactionary, inconsistent, and viewed as a 'bother' instead of as an 'assister'. Staff voiced concerns that managers viewed the staff as complaining when short staffed and did not respond to the expressed concerns or patient safety issues.

- "It's all about some1 telling our managers that they need to do something to fix this problem. Suddenly, they are talking with us. They are asking questions but I don't expect that they really care about what we say. They are all worried they might get in trouble or worse lose their jobs" (14GC).

**Resources: Equipment and Supplies**

When addressing the importance of resources such as equipment and supplies to the ED RN satisfaction the participants in general felt that equipment and supplies were adequate.

- "I think our resources are pretty adequate. They are working on increasing and updating the resources that are out there. Of course, money is an issue" (15MC).

- "I don't think equipment and supplies are a big issue" (16MC).
- "Yes and no. Suddenly we're short of blood pressure cuffs. We have pretty good equipment" (13GC).
- "In terms of equipment, we have a terrible time with computers. They are slow and when standing in triage you can't get people registered quickly. I feel like the computer requirements are not sufficient with the speed and that we need updates. I also feel we lack basic equipment like thermometers and pulse oximeters" (11BBC).
- "Supplies are pretty good. You have to leave the room sometimes to find the equipment that you need" (12BBC).
- "In general, we have what we need. If not, we need to replace or let someone know" (14GC).

Beyond the routine issues of equipment not being restocked, out of service, or not in the proper location the Hospital C ED RN did not convey that equipment and supplies provided a sense of satisfaction. The responses provided information about situational frustrations secondary to equipment and supplies not be available when needed.

**Communication Between Staff**

Through ongoing interviews and assessment through the interview process, I established that communication was a key factor influencing satisfaction among ED RN. Communication occurs on many levels including between coworkers, physicians, patients, families, and leaders. Communication between staff was an important element described by Hospital C ED participants.

- "It is based on who you are talking to. There are always a couple who are above everybody else but that is to be expected I suppose" (15MC).
- "I feel that communication between staff is fine" (16MC).
- "Communication is poor. It is punitive and you don't know what you have done. You get pulled into the office and you're gone" (13GC).
- "Most of the time it's OK. I have had my issues, but I don't speak up because I'm fearful of making someone feel bad. I think overall on a team basis we can work together well" (11BBC).
- "Right now, we have a survey going around from the retention committee to ask every staff member specifically what makes them happy at work and what can be changed to make it better. With all that said every week we are still losing staff" (12BBC).
- "I think we try to communicate but we're so overwhelmed with what is going on in the department we're not as good as we should be" (14GC).

Communication between staff is essential in an ED. Without communication care is fragmented and aspects of care may be forgotten, not done, or done inappropriately. The Hospital C ED RN responses showed a staff struggling to meet basic communication needs. Only one (16.6%) participant viewed communication as adequate with 5/6 (83.4%) stating that communication was OK, punitive, or inconsistent.

**Communication with Leaders**

As the interviews progressed with the Hospital C ED RN I sensed that I would require further questioning to determine specific factors that dissatisfied RN related to

communication with leaders.

- "When it comes to management some of them are very receptive or seem as though they actually care and will do something with what you have discussed with them. Others, they don't want to hear it, they say go to that person because it is that issue and they try to divert it" (15MC).
- "For the most part it is fine. Sometimes they are not super forthcoming but I am not sure if that is because they can't be or not. If people above them don't want them to say certain things" (16MC).
- "For example, I don't trust them. They pulled a nurse into the office and put her on administrative leave and took her off grounds. It ruined the morale of the department" (13GC).
- "In my experience it has been alright. I work on days but I still feel that sometimes they are just letting me vent versus actually interacting and trying to solve problems" (11BBC).
- "Depending on the leader. I think that there is a lot of talk and not a whole lot of action. We just voiced concern as a group and told managers that if we saw more being done and not being told things are occurring that would help" (12BBC).
- "Yes, they listen but I don't think they hear us. They call us names. We're complainers, ungrateful, and it is hurtful. I don't seem them to communicate because they never come down to the floor. It's like we tell them something, they smile and nod, and then they forget that it is about patients and not just about us" (14GC).

The overall tone regarding communication with leaders was negative. Even when a participating RN said the experience was alright, the following sentence outlined negative experiences or expectations of the nurse from the managers. The ED RN responses showed the need for open lines of communication and follow-through by management. Only one RN (16.6'%) stated that communication was not forthcoming and attributed that to managers being stifled from passing information downward to staff.

**Decision-Making**

All six RN interviewed voiced concern in their level of involvement in decision-making with the majority stating they felt removed from the decision-making process.

- "This is input from staff. They will come and ask opinions, ask you to join work groups if they are striving to get more staff level decisions" (15MC).
- "I think we need to be included more. Sometimes we're just told what we're going to do with no input from staff" (14GC).
- "On the day-to-day maybe but big decisions, no" (16MC).
- "They have attempted to make committees to increase our involvement. They are trying to be more proactive. I think a red flag went up when they started losing experienced staff. Other people have tried to get involved but got frustrated and walked away. We need more involvement but I'm not sure how to break through with management" (12BBC).
- "We are just told what is going to happen. We are just told that we need to sign it. For example, for punching in you only get so many strikes and we had to sign something about that" (13GC).

- "I have to look personally at myself to determine if it is me or management. I don't think they take a broad sampling of nurses and what their ideas and thoughts are. I honestly don't go running to the office to talk about events or things a great number of times" (11BBC).

Nurses make decisions at a variety of levels. ED RN make decisions about provision of care, initiation of orders, and many other issues at a variety of levels. The ED RN at Hospital C voiced concern over feeling 'outside' of the decision-making process. The nurses acknowledged that management was 'trying' but discussed concerns about being told what would happen versus being involved in the decision-making process. The nurses appeared frustrated during the interviews and the distrust of management was an undercurrent woven through the interview discussions. Nurses described the importance of work relationships, communication, and decision-making on the staff level and described how exclusion dissatisfied them emotionally and cognitively.

**Autonomy**

Autonomy is an essential requirement for ER staff. Physicians are many times busy with other patients and many patients cannot wait for the physician to 'drive' or 'initiate' care for a seriously ill or injured patient. Autonomy allows the RN to begin care using standing orders, standards of care order sets, or care algorithms. Without a form of autonomy, delays, poor outcomes, and even death might occur.

- "Autonomy sometimes comes down to the provider you are working with and how long you have been working with them. We have our protocols. Occasionally people get carried away with things and it gets pulled back some but other than

that it is pretty good" (15MC).

- "I feel I have autonomy. I follow our standing orders and I think I am capable of working with physicians who trust me" (14GC).
- "Super important to me. I feel like I need to have control in what I am doing. I feel like I am pretty autonomous" (16MC).
- "I feel that I have autonomy. I have many years of experience and I feel I am recognized for that experience. I have gained the trust of my coworkers and physicians" (12BBC)
- "Yes, with my relationships with the physicians. I am well respected with the physicians" (13GC).
- "I do feel autonomous in my job and I do get satisfaction from that. Having worked so many years in the ER I do think I have a sense of what the doctors, patients, and what others need" (11BBC).

**Recognition**

As discussed earlier, recognition is important for ED RN satisfaction. Whether from a supervisor, a patient, or co-worker employees gain a sense of pride from being recognized.

- "Most of the recognition occurs when it involved management in one way or another. IF the manager sees it or is involved with it somehow you get recognized more. We have a service program where we fill out papers that describes what you did to be recognized (15MC).
- "I get recognition from my peers. I don't know if management even knows when

you do a good job. Usually we only hear about what we did wrong" (14GC). "I get recognized from the staff I work with not from management" (16MC).

- "I feel recognized from my peers. From management not so much. I don't think they realize what they have and they don't recognize that they need to say thank you and recognize us all for what we do. No big strokes there no big deal, just acknowledge that what you do makes a difference" (12BBC).
- "We are usually recognized by our peers but never by management. We usually hear about what we did wrong instead of what we did right on a day when all hell was breaking loose" (13GC).
- "It is normally just from coworkers. They usually say thank-you or they can fill out a form. Most of it is from patients actually" (11BBC).

**Opportunities for Improvement**

Cultivating an employee by providing opportunities for improvement can be compared with growing a plant. You need the soil, the seed, the water, and the fertilizer to get the plant growing. From there it is all about constant watering, weeding, and watching the growth and development of the plant. Opportunities for improvement provides valuable information for the employee and is a key factor influencing satisfaction.

- "With the new education manager, we have more opportunities for education. The educator focuses on who is good at certain things, who enjoys certain things, and tries to focus more education and opportunities to those people so they can expand." (15MC0.

- "We have opportunities but unfortunately we can't get time off because we don't have enough staff" (1GC).
- "I would like better education. I would like education to roll out more smoothly" (16MC).
- "They are pushing for advanced certification which is great. I have always been encouraged to learn" (12BBC).
- "I played around with getting my masters. We have education" (13GC).
- "There are opportunities at work. We are encouraged to become charge nurses but there is no career pathway promoted within the department" (11BBC).

**Teamwork**

Emergency Nurses work as team members. The team may include other nurses, staff, ancillary staff, patients, or families. Care is multifaceted and multidisciplinary. Knowing your team and their capabilities is essential.

- "You see someone that needs help and you go help the without putting your patients at risk. Try to help them in order to succeed and they do the same back" (15MC).
- "We work pretty well together. Unfortunately, we're so busy that we sometimes can't get out of our own rooms to help others" (14GC).
- "Teamwork is super important to me and I think we have a good team" (16MC).
- "They call it team nursing for a reason. When you have someone less skilled and doesn't have the same work ethic that you do that can be challenging. But overall, I am satisfied with the team I work with and the teamwork concept we work

within. (12BBC).

- "I feel like in the ER teamwork is huge and if we don't have communication nothing is going to work. I feel like workers have good communication and teamwork (13GC).
- "It is critical, it is essential. You have to know who you can trust and you can rely on. You also need to know they are going to be there and do the right thing" (11BBC).

**Relationships**

As teams develop and work becomes shared relationships are formed. These relationships provide opportunities to communicate, debrief, share information, and other important elements needed to work in a stressful, dynamic, and ever-changing environment. These relationships provide a sense of stability to the staff.

- "For the most part it is positive. There are two people that brought a lot of negativity but they moved on to different parts of the hospital" (15MC).
- "I like my coworkers. I interact with them outside of work. We're pretty tight as a group. There are a few who don't work well with others" (14GC).
- "We have pretty good relationships between staff. There are a few who need to retire because they can't keep up but in general we do OK" (16MC).
- "I think it is positive. We give encouragement, we see when one person is down and try to help them through their shift and talk about what is bothering them. I've seen more of this lately. I people are trying to be easier on each other which is a good thing" (12BBC).

- "I know the people I can have a good relationship with and those that I don't. For the most part I feel I can trust them" (11BBC).

**Coaching and Mentoring**

No one simply walks into an ED and is ready to start work. Simple things such as where to change, place your valuables, and punch your time clock require a systematic method to orient staff to the surroundings. Beyond orientation is coaching which aids the orientee or new employee to provide the best, safest, and efficient care. Many times, the terms coaching, mentoring, and orientation become blurred and used interchangeably.

- "Orientation was structured. It was extensive. As orientation progressed you would become more independent. They would be there for you and review what you were doing. My experiences were great" (15MC).
- "We lack structure now. We're hurrying to get nurses out and working. I'm afraid we're hiring nurses who can't do the job and they won't know if they can or not because they are so new and green" (14GC).
- "Orientation, coaching and mentoring should be important. At times it isn't. We're so short staffed that we can't always provide what people need" (16MC).
- 'I think we are trying but still have some ground to make up. We have an educator who is proactive and hopefully we will see some change. Our criteria for hiring has changed so dramatically that I am afraid that some of our new staff won't get the full orientation that is required. It's very scary that we're not able to provide orientation to provide safe care. We're a hospital and that's our job" (12BBC).
- "Those people who orient are burned out. I was asked a couple of times but

refused. They take only certain nurses to do it and being that person who is asked frequently burns you out a little" (13BBC).

- "I used to be actively involved in orientation and mentoring. The faces change so much that I'm a little burned out. I'll ask orientees where they are in their orientation process and many times they cannot answer. We need a system that meets the needs of our new employees (11BBC).

**Education**

The ED is ever-changing. New equipment, procedures, and methods of providing care are being invented and distributed daily. ED RN require ongoing education to maintain proficiency and competency as well as to discover and learn new ways of providing care, delivering care, and ensuring safety, efficiency, and quality in the care provided to their patients.

- "We have an educator who really is working well" (15MC).
- "I'm hoping our education will improve. We're always needing education and sometimes it's not there when you need it" (14GC).
- "We have a new educator, let's hope things change. We are provided education and sometimes, rarely we can attend a meeting or conference. Usually short staffing doesn't allow this so we miss out" (12BBC).
- "We have a new educator so we'll see. I hope the information flows out to the staff" (13GC).
- "Usually presented in mass presentation or at pre-shift. Otherwise it is email. I don't have time for email" (11BBC).

**Compassion Fatigue**

EDs are difficult places to work. Violence, coupled with high acuity, high patient numbers, and social issues further complicates the work provided by healthcare workers. The RN with the physician coordinates patient care. The process is tiring, demanding, and many times not a satisfying experience for the nurse, family, or patient. Understanding how RN feel about the stressors is important to fully understand compassion fatigue.

- "I definitely see it in our employees. Right now, we have a very low number of employees in the ER compared to previous times. That is how I realized that staff is at their burnout point, they are looking for new jobs. Me, I don't know if I experienced that or not. I have dealt with my stress by working less" (15MC).
- "I know I'm tired and sick of doing what I do and never hearing a thank you. The patients keep coming and no one seems to notice what is happening to the staff. They keep leaving and managers just shrug their shoulders" (15GC).
- "It feels pretty bad around here. Patients who come in with nothing wrong with them adds to the frustration. We see people who don't give Tylenol to their child with a fever, people who have a doctor's appointment in 12 hours but don't want to wait, and our frequent flyers. No wonder we're tired and burned out" (16MC).
- "I think we first need to take care of ourselves. It's OK to put up your hand and say stop. We need to provide breaks. I would love to see more talk down sessions after a terrible patient experience. Something as simple as providing a place to eat at night is a big deal. The cafeteria is not open so fend for yourself" (12BBC).

- "I think that people deal with it in a lot of different way. It is pretty stressful, people are always yelling at us and aren't the nicest. And we don't always know what will come through the door, like a pediatric code. I don't know, some people exercise or they eat" (13GC).
- "I'm glad someone has identified this, it's a step in the right direction. I talk more with my patients when they get frustrated. I try to communicate to each person whether it is effective or not" (11BBC).

**Violence**

Although the degree and type of violence differs between healthcare center the violence in today's society remains. From school shootings to mass suicides violence permeates our society. How ED staff assess, function in, and evaluate violence plays a major role in satisfaction. The input from staff, management response, and outcomes also influence ED RN satisfaction.

- "I think there is a lot of verbal harassment and verbal violence from patients. But that doesn't necessarily get the attention of management. When there are things like physical violence, the hospital doesn't care. They say it is a metal health patient who isn't in control of themselves. They don't want you to call law enforcement" (15MC).
- "It's terrible. Patients sit here for long times and they are sometimes out of control. We hear how we should be understanding and not call the police. Sometimes I fear that I am going to hurt. Violence is here to stay and the psych patients are only one part of the problem. The drug problem is a big deal here and

needs more attention from management" (14GC).

- "Most of the time I feel safe. We have some violent people coming in—people who try to attack us intoxicated, or psych patients who try to hit us so they can leave" (16MC).
- "Violence is everywhere. They are currently trying to set up so we have bullet proof glass at triage. We're just 1 big open area out there. We red-flag charts and try to lower stress with violent patients when we can. We only have security when they make their rounds" (12BBC).
- "Oh yeah it is real. I tell the story of some lady getting into my face telling me she was going to punch me in the face if I didn't take her IV out. I called the police and her address was on file as the sheriff's department. Yeah, it is real" (13GC).
- "I think it is becoming more prevalent. I was actually threatened one time. I know that there are more strikes to staff, we are addressing the issues a little more" (11BBC).

**Stress**

ED RN are expected to continue caring for patients even when stressed or emotionally drained after a death, horrific experience, or busy shift. The ED RN moves from crisis to crisis with high expectations from providers, patients, and families to provide quality care. The amount of stress can be overwhelming and may carry over into the work life balance of the RN. The stress also can be manifested with mental, physical, and emotional issues leading to call-ins, inappropriate care, or intent to leave.

- "Definitely very stress environment. When I get more stressed I do less overtime.

That's my break away from here" (15MC).

- "This is stressful even when it's not stressful. The attitudes and morale are terrible. You can feel the pressure and tension. It's not much fun to work here" (14GC).
- "It's always stressful. I know when I get stressed because I start lashing out at my coworkers. We all understand but it still is a nasty thing to do. It's because I'm so tired of the nonsense and see no end in sight" (16MC).
- "Yes, we are stressed but we also have a job to do. I know when I am getting stressed and have to take a step back and think about why I am here and what I am doing. It's about the patient and I have to work to decrease my stress so I can be effective" (12BBC).
- "I expect the ER to be stressful. Unfortunately, with short staffing the stress has increased tremendously. You can feel how stressed people are. Managers do nothing to decrease the stress and many times add to the stress. They are invisible only when they want to make you feel bad or to say something negative" (13GC).
- "The stress is at times overwhelming and makes it difficult to do your job. We don't have any back-up to help us unless a manager comes in or they come down from the offices" (11BBC).

**Sense of Accomplishment**

At the end of the day it's all about what was accomplished. For the RN these accomplishments can be seen as completion of care, safe transport of the patient to a higher level of care, or in a multitude of other ways. The sense of accomplishment might

be described as that ‘feel good moment’ when you feel something as gone right, you can smile, and you get a sense that what you have done has truly made a difference.

- “I think the biggest accomplishments is the patient you are able to see when they come in and you can see them admitted, discharged, or transferred. I don’t find a lot of accomplishment from the patients that I work with for a few hours. It’s frustrating to never find out what happens when the patient leaves the department—did they live or die?” (15MC).
- “I love the fact that my patients either get better, admitted, or transferred. I feel a sense of accomplishment when I know I have done a good job with my patient. That’s what I’m here to do” (14GC).
- “Seeing someone come in, close to dying or feeling terrible, and they leave feeling better and are able to say thank you or they are still living” (16MC).
- “To me, the sense of making a difference is for my patient and my families. The second they come or the second they leave I want them to have a good experience. It is more than a paycheck” (12BBC).
- “I think my feistiness keeps me feeling like I’ve accomplished things. I keep being involved and that’s when I feel most satisfied” (13GC).
- “I try to. I don’t feel that way all of the time. You try to talk about smoking cessation and just get nowhere. I guess you have to pick and choose your battles” (11BBC).

**Overcrowding**

Imagine an ED with 50 beds. The beds are full of sick patients and there are 20 patients in the waiting room with 16 ambulances coming to the ED within the next 45 min. While this may sound like an exaggeration, in reality, for many ED this is what they face on a daily basis. Who gets the bed, what resources will be used and who will care for the patient? Those questions paired with long waiting room times, delayed throughput from ED, and a stretched and exhausted ED staff is a setting for poor outcomes, potential deaths, and a staff of uncaring RN.

- "We start putting patients on stretchers in the hallway and just increase the number of stretchers. You end up running all over and taking care of the sickest and ignoring the not sick patients who might be appropriate in the ER setting" (15MC).
- "It creates a bad situation and makes it worse. We put patients in the hall and then we don't have enough staff to provide adequate, safe care for them. We just keep seeing patients. No one helps and we're on our own" (14GC).
- "Our overcrowding problem has gotten a little bit better. We actually have a throughput nurse now who checks in ambulances and doe discharges. It actually is working very well and goes from 11am to 11pm" (16MC).
- "You feel overwhelmed You feel like you are not providing the best care you can. One problem is the lack of knowledge, maybe common sense, from our patients. For example, a girl comes in four times this week because she has a cold. She has not taken Tylenol, gotten her prescription filled, or been drinking fluids. It's crazy, you want to look at her and say—Don't you understand what you need to

do?" (12BBC).

- "This flu season was terrible. We had patients everywhere and they all felt like they needed one-on-one nurses. It was incredible how many people didn't take Tylenol or anything but they all wanted antibiotics or Tamiflu to feel better" (13GC
- "Overcrowding negatively impacts my satisfaction and our relationships with other departments. We feel put upon to do everything" (11BBC).

**Hospital C Satisfaction Theme Summary**

The general tone of the interviews with Hospital C ED RN was negative and focused on frustrations and ongoing issues directly impacting staff satisfaction. The ED RN focused on staffing, a lack of managerial support, poor communication with management, and trust as the key areas impacting their immediate satisfaction. The ED RN expressed strong statements to support for autonomy, teamwork, relationships, stress, and a sense of accomplishment. These were viewed as working inconsistently in the current work environment. The work place culture could have easily been described as toxic although no RN used these words to describe the ER environment. I had difficulties listening to the negative aspects of the ED environment and personal impact on the ED RN at Hospital C. I worked diligently to listen and not make generalized assumptions about what was being said during the interviews. I separated the key elements I coded from the interviews and will break them into resources, leadership, and personal needs categories.

The resource needs for satisfaction included adequate staffing levels with

assigned nurse-to-patient ratios. Methods to deal with overcrowding and throughput were also identified as elements directly impacting ED RN satisfaction at Hospital C. Leadership issues included the need for strong managerial support and presence, open-lines of communication with managers, increased input into decision-making, recognition from managers, and formalized education and orientation processes. The personal needs found included the importance and support of positive staff communication, teamwork, relationships, and fostering an environment to provide a sense of accomplishment. An overarching need was described as taking care of the staff and treating them with dignity, respect, and value as well as understanding the importance of the mental, emotional, and physical health and well-being of the staff.

Key factors included

- Staffing
- Resources
- Communication between staff
- Communication with leaders
- Recognition
- Coaching and Mentoring
- Sense of Accomplishment
- Trust
- Decision-making

The purpose of this research was to determine specific factors influencing ED RN satisfaction and engagement. Engagement factors include connection with coworkers,

trust, connection with the job, the work, and the organization.

## Engagement Themes

### Connection with Coworkers

The connection or relationship with coworkers provides a perceived safety net for the staff. The staff who connect with coworkers have expectations of their partners while providing ED care.

- "I would say not really any more than a day-to-day co-worker level. We have some emotional connections during the stressful things but on a day-to-day basis not a lot of connection" (15MC).
- "I feel connected on some levels but on others not so much. When it's busy I wish I could help more but I'm swamped with my own patients" (14GC).
- "Most of us are friends and a lot of us do things outside of work" (16MC).
- "I tend to be connected with people who have the same work ethic that I do" (12BBC).
- "I feel like it is a family. We have each other's backs and we can trust each other. We can vent to each other and we know each other's strengths and weaknesses. There are certain nurses that I know are strong and will get right in there with me" (13GC).
- "I do feel connected with my coworkers. You have to see patients so you have to rely on the other person. You are both in the situation, you have to complete care, and you have get through your shift" (11BBC).

### Skill Utilization

ED RN provide skills through a variety of means. The skills are an important tool used in the care provided to patients. Every nurse has strengths and weaknesses in the care they provide. These strengths and weaknesses also occur in the skills they have in the tool bag as well as in how these skills are used to their maximum.

- "I think my skills are used to the max. I know I can always learn more but what I have for skills is pretty good" (15MC).
- "My skills are used. I have strong clinical skills and am confident in what I do" (14GC). "Sometimes, not all of the time. It is the nature of the ER" (16MC).
- "I do. I feel that people seek me out when they need special skills or help with a skill" (12BBC).
- "Not necessarily. For certain things, I feel like it is a who knows who issue. Only certain nurses are allowed to do certain things. Sometimes there are nurses who have experiences outside of the ER who could help out but are never asked" (13GC).
- "It is hard to say. I think what we are asking is for a fast and not brilliant assessment, they just want fast, fast, fast. I don't think my skills are used" (11BBC)

**Trust**

Without trust, engagement does not occur. To be fully engaged with a person or coworkers an individual must trust that the person, organization, or situation is safe, protective, supportive, and mutually engaged.

- "For the majority yes. I say I trust management less than coworkers" (15MC).

- "I trust my coworkers for the most part but do not trust management at any level in this hospital. They're in this for themselves and not for us or the patients" (14GC).
- "I trust some of the people I work with. Trust is a big thing. You need to be able to trust each other as staff members. If I am in charge I need to be able to trust the people working on the team that they can care for the patients that they have" (16MC).
- "You always want to believe yes. I think you learn, usually through the hard way. I am a person who is going to tell you upfront. There are some staff who would just as soon hang someone out to dry. I don't function that way. You have to have trust when you work this closely with people" (12BBC).
- "In general, I trust my coworkers but I do not trust management. I think they would fire you at any time. They are backstabbing and wonder why staff is leaving. Go figure" (13GC).
- "Yes, I do trust the majority of my coworkers. I think we have to have trust to get our jobs done" (11BBC)

**Connection with Job**

The connection is between the RN and their expectations, perceptions, or sense of the importance that nursing plays in the care they provide.

- "I feel very connected with my job as a nurse" (15MC).
- "I feel connected as a nurse and love what I do" (14GC). "I feel very connected with the job" (16MC).

- "I wouldn't have been doing this for all these years if I didn't feel a strong connection with my job. I love what I do and think I do a good job" (12BBC).
- "I feel connected with my job. I love being a nurse and really love the ER" (13GC).
- "I feel a strong connection as a nurse. This is what I wanted to do and I'm good at my job. At the bedside I am definitely engaged. Otherwise I don't think I'm engaged" (11BBC).

**Connection with Work**

The engagement connection with work is between the RN and the work performed within the organization. This connection includes patient flow, work performed, standards, policies/procedures, and care flow within that institution.

- "I feel somewhat connected with my work at Hospital C but am frustrated with staffing" (15MC).
- "I know I should be connected with work but I find myself wishing I didn't work at Hospital C" (14GC).
- "I've never worked anywhere else and I hope that this is not normal for ER. I don't feel as connected as I should because I am frustrated with staffing and management. I think we could do better which might help me feel more connected with the work I do" (16MC).
- "I am connected with work. There are many other opportunities out there, some closer to my home, but I like Hospital C despite all the problems. I like my job and am hopeful that things will change for the better" (12BBC).

- "I don't feel connected with work at Hospital C and am actively looking for another job possibly at another hospital. I like the people but between staffing and management I a frustrated beyond words" (13GC).
- "I don't feel engaged in my work except for getting the patient's the care they need. I try to be engaged at the work level but I have been here long enough to know that things are many times not going to change. For instance, we are chronically understaffed and it goes on and on" (11BBC).

**Connection with Organization**

The organizational engagement connection occurs between the RN and the organization based on alignment with the mission, vision, and values of the organization, strategic plan, and involvement on unit or hospital levels.

- "Not really. I feel that if something were to happen this organization would just replace you and that would be it. They aren't overly ambitious in terms of connecting with you as a person. Makes you feel like you are just a worker" (15MC).
- "Hospital C doesn't seem to care about its people. The number of ER nurses who have left or are leaving should tell them that something is wrong. The shortages are not new. The shortages have been going on for years and the issues are the same—no one cares about the staff" (14GC).
- "I do not feel connected to the organization at all" (16MC).
- "I don't have a lot of stock in management and don't think they value their people. It is a place that could do a lot of learning from the staff if they only took

the time to do this" (12BBC).

- "I feel no connection with the organization at any level. I don't serve on committees and have a life outside of here that is far more important than worrying about Hospital C" (13GC).
- "I do not feel a connection with the organization. I come to work and get paid" (11BBC).

### Hospital C Engagement Themes Summary

The participants at Hospital C described specific needs to maintain or achieve engagement in the ED. To promote engagement participants outlined specific areas of importance to their safety, mental well-being and trust. Key elements required for engagement included a close connection with coworkers, trust, relationships, and fostering the nurse dignity and respect to do the job they were trained to perform. There was limited connection to the work which I believe is secondary to the rampant dissatisfaction shown during the interviews. The resentment and almost hostile discussion toward the organization were expressed and I believe are deeply rooted in the dissatisfaction described as ongoing and a chronic condition rather than an acute event.

### Finalizing the Interview Process

The final questions from the interview attempted to tie the discussion into three simple categories. These included what brought the RN back to work day-after-day, pleasurable job attributes, and job frustraters. These closing questions were asked to close the interview and allow the participants to focus what brought them back every day, what pleasures they received from working in the ED, and what frustrations they felt about

their job.

**Day-to-Day Work**

The closing question was As an ED RN what is it about your job that keeps you coming back day after day?

- "I enjoy not knowing what is going to happen. You aren't hoping for something dreadful to happen to patients but the sicker patients do give a higher adrenaline experience. Every critical patient you pick up something and learn" (15MC).
- "The ever-changing environment makes me happy. I like taking care of a sick patient and having them get better before my eyes. It's rewarding" (14GC).
- "I have no idea. I keep asking myself that every day" (16MC).
- "I love the ER and being an ER RN. I like the adrenaline and knowing that every day is different. I like the diversity" (12BBC).
- "I like fixing things, I like adrenaline. I like the critical thinking part of it. I love some of my coworkers. I do at times think I am a valuable piece because I want to help families and I don't want a new nurse taking care of a sick person, either child or adult" (13GC).
- "Nursing, patients, and the almighty dollar" (11BBC).

**Pleasurable Job Attributes**

The second closing question asked What are the most pleasurable aspects of your work?

- "Having a patient get pain relief after interventions. Taking care of the sick patient in crisis and seeing the impact you have on them" (15MC).

- "Helping people feel better. It's about caring and compassion" (14GC).
- "We save patient's lives which is nice" (16MC).
- "Wish we had more help…to feel valued that is number one. To hear those five words: You did a great job" (12BBC).
- "Talking to people and making people smile. Sometimes the patients do say nice things. It is those times that make you breathe easier because they give you compliments instead of yelling at you" (13GC).
- "The patients" (11BBC).

**Job Frustrations**

The final closing question asked What are the most frustrating things about your job?

- "Management be more receptive to staffing. I would like to clear out some equipment and supplies and replace them immediately" (15MC).
- "Staffing, staffing, and staffing. Management needs to listen to us. We can't keep working like this" (14GC).
- "You can't save everybody. The psych patients are chronic and they are taxing all of the staff" (16MC).
- "Staffing. We need more resources. Need to feel valued for us a person and for what we do" (12BBC).
- "Getting off time for vacations. We get denied all of the time" (13GC).

- "I come in, it's disorganized and dirty and sometimes people are tired. The attitude, you never know what you are going to walk into that day. And it can all set the tone for your day and your patient's day and their experience" (11BBC).

The closing questions presented to the ED RN at Hospital C did provide a more positive description of why the nurses come back day-after-day and provided words that were focused on providing good care and the importance of patients, coworkers, and trust. The closing statement provided insight into the underlying reasons these nurses come to work and do not leave their jobs. The emotional attachment to patients, the sense of unity with other nurses, and the underlying reasons for becoming a nurse were seen in these statements. The frustrations were restated and the entirety of the chaos, poor communication, and lack of staffing was expressed.

## Hospital C Generational Cohorts

### Baby Boomer

Two ED RN were interviewed from the Baby Boomer generational cohort. The ages ranged between 52 and 54 with a mean age of 53. The two RN were insightful and provided lengthy answers related to the whys of the issues that are ongoing at Hospital C. These RN expressed concerns about the direct the ED is moving related to the hiring of inexperienced staff. "We're hiring people with six months of experience" (12BBC).

### Generation X

Two Generation X RN were interviewed and ages ranged from 41 to 42 with a mean of 41.5 years. The two Generation X RN interviewed expressed a lack of trust, frustration with staffing, and a general tone of unhappiness. Both described an

environment ripe with unhappy, dissatisfied staff discouraged by a lack of managerial support, input, and communication. The two RN also expressed concerns expressed by the six RN interviewed recounting episodes in which the RN felt humiliated, degraded, or unheard by managers. The RN provided information depicting stress, overwhelmed, unappreciated, and frustrated to provide even basic care. Despite the negative responses each RN felt a strong connection with their job, coworkers, team members, and patients. The underlying sense was that the nurses provided care based on altruistic needs and support the rationale provided for why they became nurses.

**Millennial Results**

Two Millennial RN were interviewed. Ages ranged between 29 and 31 with a mean age of 30. Each RN provided interesting responses to the interview questions. BB15 provided answers less reactionary. For example, BB16 responded with an overall sense of pessimism while BB15 provided a more optimistic and thought-provoking assessment of situations. BB16 “I know when I get stressed and I work less” while BB16 “No one cares if you are here or not. I feel totally useless when I come to work.” When analyzing the totality of the data I found no distinct differences in the interview data obtained from the Hospital C RN.

## Hospital C Generational Cohort Summary

The generational cohort participants interviewed at Hospital C provided consistent information with minor differences between the groups. The Baby Boomers were reflective and protective attempting to be proactive and optimistic about the challenges and chronic issues seen in the ED at Hospital C. The Generation X group was

angry, distrustful, and vocal about managers and their personal expectations, relationships, and problems as an RN in the ED. The Generation X group voiced exhaustion and their desire to find another job. The Millennial group was small and showed marked differences in the thought process, optimism, and interpretation of the issues occurring in the department. The issues underlying the frustrations were seen as chronic and each group voiced mechanisms or solutions to drive the change process.

# Appendix F: Hospital E

Hospital E located in New York is a critical access hospital serving as a stabilization hospital for critically ill and injured patients. Hospital E is also a partner with Hospital U and the healthcare network. Hospital E operates 25 beds used for medical, surgical, swing bed patients, and patients awaiting nursing home or long-term placement. To maintain critical access status, the hospital must provide 24-hour emergency services, have less than 25 licensed beds, be a part of the rural healthcare network, and be located greater than 25 miles from a tertiary referral or larger hospital able to provide advanced patient care. Hospital E provides basic and intermediate care and provides services to transport ill and injured patients to either Hospital C or U. The ED has approximately 5000 visits annually in an established six-bed unit.

Five RNs were interviewed from Hospital E. The ages ranged from 44 to 51 years of age with a mean age of 47.6. Two (40%) of RN were associate degree prepared and 60% were bachelor of nursing prepared. The RN were engaging, open, and provided valuable information regarding their work environment, coworkers, and patients. The individuals being interviewed were happy, enjoyed their job, and were very happy to discuss the ‘good’ aspects of their work and how well they worked as a team.

## Satisfaction Themes

Interview ice breaker questions were asked of the five participating ED RN.

### Current Work Environment

Each RN interviewed from Hospital E provided valuable information about the hospital and ED environment. The nurses were open, honest, and smiled throughout the interview. The RN described a happy, cohesive, and productive work environment.

- "I'm on 3 am to 3pm. I am the only RN at the beginning of my shift. We always have access to management's numbers if we do start to get overwhelmed" (11BBE).
- "It can be busy or not so busy. We work as a team and work well together" (18BBE). "It's different every day. I work in an ER in a small critical access hospital. There are good days and there are bad days, there are hard days and there are easy days" (19BBE).
- "We have a pretty small ER. The people who work there are well connected. There is great communication and everybody know what is going on at all times" (21GE).
- "Critical access hospital with not a lot of back-up resources. You are required to be very independent and really drive the care provided" (20GE).

The opening question provided a foundation for the remainder of the interview. As shown, the RN described a small, critical access hospital with strong team work, relationships with coworkers, and support.

**Perfect Work Environment**

The second ice breaker asked specifically about how the RN would describe the perfect work environment. The RN provided thick, rich data focusing on satisfiers.

- "I love having a Hospital E. Recently they started with a second nurse which I think is wonderful to have back-up there. PAs are great and work with us well" (17BBE).
- "Enough staff. Happy staff" (18BBE).
- "Teamwork, not just among the nurses, but with all provides and ancillary staff. Having the support and resources that you need is critically important" (19BBE).
- "Having the appropriate amount of staffing. I also think having access to all the equipment you need and available to have the appropriate testing in a readily available manner" (21GE).
- "Support from management to allow us to work independently and support education…good patient ratio…team approach…joint efforts" (20GE).

The RN responses focused on positive elements related to staffing, management support, and teamwork. Similar to Hospital U and C staffing and staff ratios were immediately identified as essential requirements for the perfect work environment.

**Job Satisfaction**

Each RN interviewed voiced satisfaction in their current job. Each RN was smiling and positive elements of job satisfaction were repeated throughout the interview.

- "I feel satisfied in my job" (17BBE).
- "I am satisfied. Am I satisfied all of the time? Probably no but I like what I do" (18BBE).

- "I am very satisfied. I love working in the ER and like the people I work with. It's all about teamwork" (19BBE).
- "Staffing is important to my satisfaction. I like what I do" (21GE).
- "A lot of good people work here. We don't have a lot of the problems other places face such as homelessness, drug issues etc. but we are still busy. It is rewarding when our patients come here and they appreciate the care and the speed of which we can get patients in and out being a small place" (20GE).

The responses provided a foundation for the remainder of the interview. The positive nature, the smiles, and the nods of approval when discussing Hospital E were evident and were in stark contrast to interviews completed at the other participating hospitals. Each time I interviewed at Hospital E I found myself relaxed, smiling, and genuinely amazed at the happiness of the staff. This amazement forced me to ask probing questions seeking why and how this happiness occurred, what external and internal factors influenced the staff satisfaction, and specifics on how the happiness continued.

**Resources: Staffing**

As with the other two participating hospitals, staffing was first and foremost a concern and element directly influencing staff satisfaction. Although Hospital E did not experience staffing shortages as a norm, the simple act of taking a vacation or calling in sick did directly impact staffing. The responsiveness of staff, for example to come in when called on their day off, was an unwritten policy but was considered a professional and personal expectation of coworkers and management.

- "We have not had many problems with staffing We recently added the second RN which has been wonderful" (17BBE).
- "Staffing is good on my shift. I know we can call people in if we have to. We also will come in if it's really bad in the ER" (18BBE).
- "We do and we don't. If there is a bug going around and our staff is sick then we have a problem because we don't have a lot of nurses as back-up. Generally staffing is not a problem unless someone is sick or needs a vacation. We make it all work" (19BBE).
- "If we get busy, I work 3pm to 3 am, it would be nice to have an extra pair of hands. We can call people in if we need to" (21GE).
- "Staffing is an issue because we have a small team. If I want to take a vacation or someone is out sick it does impact everyone. When we hire staff, we look for people who have experience and aren't coming in green because of the need for independent practice" (20GE).

**Resources: Equipment and Supplies**

All RN agreed that equipment and supplies were available and if needed could be easily obtained and/or requested. The openness of communication was expressed as a positive element between staff and management.

- "We have ample equipment and supplies. It's nice to be able to find things. Our ER is pretty new" (17BBE).
- "I don't think we have a problem with equipment or supplies. We pretty much have what we need" (18BBE).

- "Our ER is pretty new and we have the equipment and supplies that we need" (19BBE).
- "We have adequate resources of equipment and supplies" (21GE).
- "For the most part we have decent equipment. We've gotten and upgraded equipment over the last few years" (20GE).

**Communication Between Staff**

Each RN was open and provided valuable information about the personal and professional nature of communication. Each RN understood the importance of communication and how communication needs to be direct to the person, on-point, and not viewed as aggressive but seen as direct. The RN described an environment where everyone feels free to talk to each other, call 1 another out if needed, and to professionally not take communication personally when the communication aided in improving care or outcomes.

- "We mostly have been working together for a long time so it is really easy, we can tell when someone is having a bad day or if something is on their mind. We can say 'I'm not happy with that why did you do that?' No one holds a grudge because we have been together for so long" (17BBE).
- "We're pretty up front with each other. We have to work together so we have to communicate. Many times, the communication is so good that you don't have to speak and someone is right there doing what you need" (18BBE).
- "Most communication is face-to-face. Sometimes we email but that's not the best for us. We do have staff meetings…sometimes we have lunch meetings to say

thank you for our hard work" (19BBE).

- "Communication between staff is wonderful. Even the manager, if we call him he will do everything in his power to help us get what we need" (21GE).
- "I think it is pretty good. Our nursing station was designed to promote communication and the seats face each other. Even the level of providers is there and there is mutual respect between them (20GE).

**Communication with Leaders**

The RN interviewed described open lines of communication with management. The RN outlined the importance of this communication and the need to provide staff with up-to-date and pertinent information. The only caveat to communication with leaders was the rare sense that administration was not providing enough information to the staff. The staff's connection to the organization and need to be aware of ongoing events, issues, and concerns was expressed by the participants.

- "Sometimes I feel we could know more of what is going on behind closed doors. It seems there are meetings all of the time. We do have town hall meetings which the CEO does inform us of what is going on. We are going to taking over Ticonderoga so there is lots of information" (17BBE).
- "I think they communicate pretty well with us. If we have a question we ask and usually get an answer. We all know each other and share information well" (18BBE).
- "Leaders are available and I've never had a problem communicating with them. They answer us when we have questions" (19BBE).

- "He is also there any time we need to talk to him or need something. I am able to call them at any time and get what I need" (21GE).
- "Pretty good. We have monthly staff meetings and min are available for those who cannot attend" (20GE).

**Decision-Making**

All RN felt that management did consider their input into decision-making but the level of input varied. The concern for how much or how little was articulated by one of the RN (20%).

- "I think they do take it into consideration. We are still voicing for an increase in security with the increase in the opiate war going on. Sometimes we don't feel safe at night with all that is going on around" (17BBE).
- "I think we have a voice. How much or how little I'm not sure" (18BBE).
- "We are asked about many things by our leaders. They want us to be involved" (19BBE).
- "Management keeps us aware of what is going on and asks for our input. That's really important" (21GE).
- "Sometimes I think staff doesn't think they are heard when they speak but I know they are" (20GE).

**Autonomy**

In a small ED where you are the single RN provider, autonomy is crucial. The ED functions with RN and PA (Physician Assistant) staff with no MD on duty (provides

oversight and coverage and will come to the ED if required). The use of standing orders and trust were described as vital to the successful care of the ED patient.

- "We have protocols and we don't have to sit around and wait for doctor's orders. We know our protocols and what we can do and what we can't. We know how far we can go without sitting there until and order is put in" (17BBE).
- "I know I am autonomous. I get in and start taking care of the patients. We have a great relationship with the PA and MD and they trust us. We know what we can and can't do" (18BBE).
- "I'm as autonomous as a person can be here. We do have to work within the constraints of policy and within standards of care. But I am autonomous within those constraints" (19BBE).
- "I feel like it is a wonderful thing at the place I work. Anything that we think needs to be done we can ask the PA and doctors. They listen to us" (21GE).
- "It is a requirement at Hospital E. You have to be independent. We don't have a lot to fall back on so we have to be the proverbial jack of all trades" (20GE).

**Recognition**

The participants described an ongoing system of co-worker, ancillary staff, and managerial staff recognition of the ED staff. The ED RN described a culture of teamwork and personal recognition for a job well done. The interviewees described rewards such as attendance at conferences, lunches to say thank-you, and personal recognition as ongoing for the staff.

- "They come down personally. We have Press Ganey scores which are 100%

satisfaction. We're proud of that and so is the administration. A lot of times you hear the bad reports but we actually get nice cards and phone calls on how satisfied our patients were" (17BBE).

- "They feed us and have luncheons for us. It's nice to have some1 say thank you to us" (18BBE).
- "Informally, frequently. Both by leaders and coworkers" (19BBE).
- "I am recognized every year at my evaluation. I have always been told that I have done a nice job. They provide lunches and treats throughout the year for us" (21GE).
- "Management does try to reach out. If brought up by a co-worker an individual is recognized at the staff meeting. If we have specific situations they will buy us lunch for the day to say thank-you" (20GE).

**Opportunities for Improvement**

The RN interviewed praised the management team for providing them with educational and professional opportunities as well as time off to attend conferences. The ED RN listed numerous opportunities and described a nurse manager who assisted them and allowed them to attend educational events. The RN also told me that Hospital E is encouraging BSN (Bachelor of Science Nursing) and is assisting nurses to pursue this goal.

- "They want us to get our bachelors. If we want to get a certification we are encouraged to get it" (17BBE).
- "There are always classes going on and we are encouraged to better ourselves. We

go to classes" (18BBE).

- "The hospital encourages us to attend different training, seminars, pursuing advanced certification and things like that. They are very supportive. They also encourage us to go over to Burlington to attend the SIM labs and learn and practice new skills. Tap into the resources available at U" (19BBE).
- "Yes, there are always opportunities for us. I got information today in my email. Any time we want to go to any of the we just let him know and he sets them up for us" (21GE).
- "There is lots of continuing education materials. There are always courses going on. There is a push for all nurses to get a bachelors" (20GE).

**Teamwork**

Teamwork was viewed as essential and robust at Hospital E. The nurses described the pride of being part of the Hospital E ED team. Each RN believed that staff worked well as a team and high expectations or performance were in place and expected at the professional and personal level of interaction.

- "I think everyone works together fairly well. No one expects somebody else to do their job. We all pitch in. It's a team effort" (17BBE).
- "We like each other and we work well together. We're like a family in many ways. No one is afraid to say what they feel and no one takes things personally" (18BBE).
- "I think that within the department we consider every patient that comes in as ours. There is no set number of rooms that are considered ours. It's all about

teamwork. I count on that" (19BBE).

- "Teamwork is just essential. If I don't have my team behind me I would not be able to do half of what I do. Even from the registration person. We all work together" (21GE).
- "Important to feel like a team because we are limited. The staff rely on each other. We all each other out if we are out of line. No hard feelings. Just the way we are" (20GE).

**Relationships**

The relationships were described as strong, professional, personal, and honest. Each RN interviewed discussed the importance of these relationships especially in a small hospital ED with limited resources. One RN focused on her connection with a co-worker who works the same shift and their immediate connection based on work ethics, patient care, and mutual expectations to provide optimal service.

- "When we were smaller and the units were closer it was easier to know more about the other nurses in the departments. We don't see the floor nurses covering us as much except on the 3 am to 3 pm shift" (17BBE).
- "We are close. We go out and do things outside of work. We are friends. I can't say more than that" (18BBE).
- "We're a close group. We rely on each other and have high expectations from one another. We work as a team. I enjoy my coworkers and have close relationships with them" (19BBE).
- "I think that communication provides an ample amount of that. Just being able to

voice your concerns or ask for help or just say I need something and having them be receptive is wonderful" (21GE).

- "For the most part but there are small interpersonal issues sometimes. The job we do, we all expect a level of professionalism" (20GE).

**Coaching and Mentoring**

Every nurse interviewed had tenure in hospital nursing. Only one RN was new to the ED team (less than two years of ED experience). The nurse with limited experience discussed how the staff had mentored her and how to date still work with her to ensure that she is not overwhelmed and provide the nurse with time to discuss issues and concerns. The importance of coaching and orientation was described as essential secondary to a single nurse being on duty for 12 hours each day.

- "With new grads orientation is 6 months. Experienced nurse orientation is variable. We train them to be aware and able to stand on their own. If they are not, we do extend their probation period" (17BBE).
- "We spend a lot of time making sure the new nurses fit into our department. We've been together for a long time and want to make sure we learn from each other. We don't know everything so we work as a unit during orientation. We're close so you always have someone to ask questions to" (18BBE).
- "We always have some type of educational offering. Our manager keeps us informed via email. We all have opportunities. I feel free and confident that I could ask any person to help and they would in a second" (19BBE).
- "Before coming to the ER full-time I was a preceptor on the nursing unit. Another

co-worker and myself revamped that program ad that was wonderful. We were able to put out there what new people needed to know when they come to our facility" (21GE).

- "It's an ongoing thing. We have basic orientation which is more competency based. We don't have a formal mentoring program" (20GE).

**Education**

No full-time educator is available at Hospital E. The nurses provided multiple examples of educational opportunities available to them and the willingness of management to allow them to participate in the learning events.

- "We don't have a full-time educator but we are provided with many opportunities. We are always getting things in email or a flyer in our mailbox. If we want to go to a course we are allowed to go and it is welcomed so we can share the information with our coworkers" (17BBE).
- "We are encouraged to attend conferences, classes, and any educational program that benefits us as a staff nurse. We come back and share what we learned with the staff. I appreciate being able to go to conference it keeps me fresh and up-to-date" (18BBE).
- "There are many opportunities and we are encouraged to attend them" (19BBE).
- "Lots of opportunities for us in many different manners" (21GE).
- "Many opportunities which we are encouraged to attend" (20GE).

**Compassion Fatigue**

I found that Hospital E as with the other participating hospital RN did not fully understand the term compassion fatigue. The RN focused on stress and the impact of stress on their work. With each RN, including the other participating hospital RN, I was unable to elicit or garner information beyond work stress from the interviews. The Baby Boomer group was slightly more vocal about exhaustion and burnout but did not provide valuable information from the interviews.

- "It is mostly an opiate driven crowd that feels entitled to everything…And sometimes you can't take it. That is, the only time I can see us burning out. That population that expects everything. It makes you bitter" (17BBE).
- "I think we know when someone is reaching a point when they need some time away from here. We are close and take care of each other" (18BBE).
- "It's hard when the same patients come back over and over. I think we all have times when we are tired and stressed. Of course, it could influence my care but I don't see that as a problem right now" (19BBE).
- "I haven't found that yet. I haven't been in the ER that long so maybe I'm just new and haven't experienced fatigue from taking care of patients" (21GE).
- "I don't think we have that problem right now. We all deal with patients and stress differently. Most of the staff are seasoned veterans" (20GE).

**Violence**

The Hospital E participating RN did not feel that violence was a central issue in the facility. Only on episode of physical violence had occurred over the last two years and verbal altercations or violence was rare. Each RN was fully aware of the changes

related to the epidemic opiate crisis in upstate New York.

- "Violence is not a problem yet. We had an episode last year when a nurse was assaulted" (17BBE).
- "It's not a real problem. We do call the police if we need them but in general it's not a violence ER" (18BBE). "
- We don't have a lot of violence. If we do someone might be yelling but usually it's not violent" (19BBE).
- "I have seen a couple of people who have been rude or mean. I know we had an issue last fall when a nurse was physically injured. Otherwise it's pretty safe here" (21GE).
- "Thank goodness not much violence in our ER" (20GE).

**Stress**

' The Hospital E interviewees described the ED as stressful but believed they were able to control the stress through open communication, relationships, teamwork, and use of resources. All RN expressed stress related to having one RN during the night. These issues have been addressed with managers and staffing changes are being made.

- "It is sometimes stressful when you are the only RN. I get stressed because I don't know what's coming through the door. Our PA and other staff are great. They pitch in and help" (17BBE).
- "Yes, it can be stressful but we rely on each other and even when you're alone you've got the PA and other staff that will help out. The nice thing is that management will come in if you're crazy busy" (18BBE).

- "We try to deal with stress in many ways. As a group we rely on each other when we're stressed. My coworkers are great. We talk, we laugh and we cry about things" (19BBE).
- "Sometimes with certain patients or situations I feel stress. Not to the point where you think I don't think I can go back and do that again tomorrow" (21GE).
- "Sometimes we do see some changes in behaviors. For example, my humor changes. I try to lighten the mood. We all deal with stress differently. I think the staff keeps track of one another" (20GE).

**Sense of Accomplishment**

A high sense of accomplishment was described. The RN stated that they obtain this through interactions with patients and many times a simple thank-you. The RN communicated stories of patient interactions, return visits, or outcomes that directly impacted their personal and professional sense of accomplishment.

- "I think overall you try to do the best you can and if you can't then we try to find the most appropriate place to send the patient or make things better" (17BBE).
- "I think I feel a sense of accomplishment when a patient gets better or we have a 'save" (18BBE).
- "We work hard and our patients appreciate what we do. It's nice to get a thank you from a patient. That's a great sense of accomplishment. Sometimes it's hard when you're busy to feel that you've done all you could for the patient. I think our staff feels satisfied in the care they provide" (19BBE).
- "I feel a sense of accomplishment. I really have enjoyed our new data base and

want to see what happens once they have left our care" (21GE).

- "We are very proud of the care we provide here. Sometimes we don't feel recognized but we tell each other. We had 100% satisfaction on our Press Ganey surveys. That is a real sense of accomplishment" (20GE).

**Overcrowding**

The RN at Hospital E were aware of the problems with overcrowding even on the small scale seen within the facility. The RN expressed concern over opening hall beds and the sense that care was less than optimal. Each RN interviewed described a back-up plan which to date has worked well. The sheer fact that RN come in (on their day off) when called to help out during increased census validated the statement regarding teamwork, relationships, and value of patient care.

- "We usually don't have a problem with overcrowding" (17BBE).
- "If we get busy we open hall beds. Otherwise, we generally can handle the patient load. If it is an emergency we call everyone in" (18BBE).
- "Overcrowding is generally not a problem. We have a back-up plan that includes calling in managers" (19BBE).
- "At times it gets really busy and we end up putting patients in the hall. But most of the time we are not overcrowded" (21BBE).
- "Overcrowding is generally not a problem. We do use hall beds and can call in managers if needed" (20GE).

## Hospital E Satisfaction Theme Summary

A high degree of satisfaction was demonstrated by the nurses interviewed at Hospital E. The key factors influencing satisfaction included staffing, communication between staff and with leaders, autonomy, opportunities for improvement, relationships, mentoring, and a sense of accomplishment. The sub-categories discovered during coding were interwoven and contained within each key theme description.

## Engagement Themes

### Connection with Coworkers

A strong connection was told during the interviews. Each RN expressed the need for this connection at the physical level of work, the emotional and psychological level of stress, and the cognitive level of support during patient care.

- "We're connected and we work well" (17BBE).
- "I feel connected with everyone that I work with. It's a small community hospital. We know the staff, the physicians, the patients, and the families" (18BBE).
- "I feel a strong sense of connection with my coworkers and we do things together both in and outside of work" (19BBE).
- "We are very close. Even in our off time we do things together. It is a close-knit group of people who regularly engage with each other, both professionally and personally" (20GE).

### Skill Utilization

The RN at Hospital E understood the ramifications of skill deterioration secondary to lack of use. The RN attended skill workshops to ensure that skills would not

be ‘lost’. Each RN felt that skills were used to the maximum and that each RN possessed adequate skills to work independently in a small hospital ED.

- “My skills are used to the max. I’m a good resource” (17BBE).
- “I think they are used. I am able to perform my job and people come to me to help them. I guess that makes them used to the max” (18BBE).
- “I do feel that my skills are used to their maximum. I like my job” (19BBE).
- “There’s one nurse I work with most of the time. Ever since she came to our facility we have always worked together. We hit it off. We are just willing to help each other with whatever comes in” (21GE).
- “I feel that I use my skills to their maximum” (20GE).

**Trust**

A strong sense of trust was expressed among the RN interviewed. The element of trust was felt to be essential to providing safe care.

- “I trust my coworkers and trust managers. I think we’re all in this together” (17BBE).
- “I trust the people I work with. We’re like a family working for the patient and the families” (18BBE).
- “I trust the people I work with and feel engaged” (19BBE).
- “You have to trust the people you work with” (21GE).
- “Huge sense of trust between staff and with management” (20GE).

**Connection with Job**

The RN at Hospital E demonstrated a strong sense of connection to job and all expressed their love for the job. Nursing and the outcomes provided a convincing statement for connection with the job.

- "I'm very connected with my job. I love what I do" (17BBE).
- "I feel a connection with the job, what I do and how I work. It's a great job with great people." (18BBE).
- "I am totally connected with my job. I am an RN and I love what I do especially at Hospital E" (19BBE).
- "I feel a strong connection with my job as an RN" (21GE).
- "I am connected with my job as a nurse" (20GE).

**Connection with Work**

Hospital E has recently undergone renovations and the ED has been expanded and updated. Every RN interviewed described a connection with work. They described an environment where people want to come to this hospital.

- "Hospital E is a great place to work. I feel a connection with the community here and we make a difference" (17BBE).
- "People come for hours to be seen in our ER. I know I am committed to making their experience good" (18BBE).
- "Hospital E is a great place to work. I am connected to and with them" (19BBE).
- "I wouldn't want to work anywhere else. Hospital E is great. I feel connected with my work because it is a great place to be" (21GE).

- "I have great pride in working at Hospital E. I am connected to my work" (20GE).

**Connection with Organization**

Hospital E is located in idyllic portion of the Adirondack Park (Forever Wild) in upstate New York. The hospital is community centered and focused and the only hospital in the count with less than 36,000 county residents. The RN feel a strong appreciate for the connection with the organization and the community.

- "I feel a strong connection to Hospital E and part of the community" (17BBE).
- "It's a great place to work. I love my coworkers and wouldn't work any place else" (18BBE).
- "I like my job and I feel a strong connection to the organization. We're part of the community" (19BBE).
- "I am part of the Hospital E family. I love my job. I love the community" (21GE).
- "I am personally with projects and other things I am doing with the hospital. I think the nurses, in general, are engaged with Hospital E" (20GE).

## Hospital E Engagement Themes Summary

The RN interviewed described a strong sense of engagement with coworkers, the job, the work, and with the organization. Each RN was aware that skill utilization was important and that trust was imperative in the day-to-day functioning of the ED at Hospital E. The themes were consistent similar to the themes analyzed for satisfaction.

## Finalizing the Interview Process

The final questions for the interviews of Hospital E ED staff inquired about why

these RN returned to the ED day-after-day, pleasurable elements of the job, and frustrations occurring in the daily life of the Hospital E RN.

**Day-to-Day Work**

The responses of the Hospital E RN focused on the dynamic flow, ever-changing patient population, and the people. The people included staff, ancillary departments, patients, and families. Each RN talked and smiled when describing their feelings about coming to work at Hospital E.

- "It's going to be a new day. Even though you have heard this story a thousand times, it is this patient's first time telling his story" (17BBE).
- "It's the people and the place. It is a great place to work" (18BBE).
- "I love my job and I feel that I make a difference in what I do. Hospital E is a great place to work and I enjoy working with the people I work with. It's a great team" (19BBE).
- "The patients. I feel that if I can do anything to help the, giving the support to make them feel better. That is a holistic model with our whole team working together to do that" (21GE).
- "Paycheck. The ever-changing environment. It's a dynamic process. It's never routine. I think we see people at their worst and at their best and it is rewarding to make people feel better" (20GE).

**Pleasurable Job Attributes**

The responses helped to validate essential components for RN satisfaction which included recognition, relationships, connection with the organization, job, and work, and

autonomy.

- "I guess when people say thank you. The person who tells you they love coming to Hospital E because they feel like a person and not just placed in a corner or hallway. We get upset when patients storm out after having to wait for five min" (17BBE).
- "It would be the staff and the patients. I like that we make a difference every single day" (18BBE).
- "The staff, the patients, and the Hospital" (19BBE).
- "I love our little facility. I have been here since graduating nursing school. I have never felt I wanted to be somewhere else. The staffing, the management, the having access to everything we need when we ask for it" (21GE).
- "Knowing that it's OK to have a bad day and your coworkers are still there for you. The reward of hearing thank-you" (20GE).

**Job Frustrations**

The frustrations described were focused more on specific patients and staffing issues, primarily working alone. During the interview, four staff members had a difficult time stating frustrations.

- "This one is coming in for narcotics. The one who tells me when we won't give him narcotics that we aren't helping him. It's frustrating" (17BBE).
- "The patients who are drug seeking. Drives us crazy" (18BBE).
- "Not having enough time to spend with the staff" (19BBE).
- "Sometimes on nights there isn't enough staff. It's hard to be the registration

person, the nurse and everything else with a patient" (21GE).

- "Solace of working by myself. Frustration in moving patients. Having to pitch our patients to other Hospital s when we know we can't take care of them at the level of care they need" (20GE).

## Hospital E Generational Cohort Summary

### Baby Boomer

Three Baby Boomer RN were interviewed at Hospital E. Ages ranged from 48 to 51 with a mean age of 49.3. After careful analysis and review of the transcripts and coding I was unable to differentiate any distinct differences between the generational cohort interviewees.

### Generation X

Two Generation X ED RN were interviewed. The ages of the participants ranged from 44 to 46 years of age with a mean age of 45. I was unable to distinguish any notable differences in responses between the Baby Boomer and Generation X generational cohort interviewees.

No Millennial ED RN were available for review or work at Hospital E.

## Appendix G: Personal Background and Dissertation Foundation

As I enter my 39th year as a RN, I recognize the importance of increasing retention, stimulating recruitment, and identifying what satisfies and engages nurses. The impetus for the dissertation topic of nurse satisfaction and engagement comes from a personal connection and understanding of working side-by-side in less than optimal staffing situations and not wavering from my underlying oath to provide safe, effective, and quality care to my patients. Even with this core belief and value system, there were many times when questioning why nurses were unhappy, dissatisfied, and disengaged in the caring, compassion, and meaningful work performed as a nurse. The focus geared directly on satisfaction and engagement and not nurse happiness.

When I began my nursing career, I could never have expected the tremendous growth of the healthcare industry and the rapid expansion of technology into the diagnosis, treatment, and care of patients. While these advances have aided in my growth, development, and advancement within the nursing profession, I am also acutely aware of changes during my tenure in nursing. My initial reason for becoming a nurse was altruistic with the patient being the center of my decision to pursue this career. What could I do to make the patient happy, content, and prepared for their experience in healthcare? I also asked what was required of me to become a quality healthcare provider. My checklist of personal attributes included caring, compassion, intelligence, and social skills. I fondly remember the happiness I garnered with each patient experience.

However, somewhere during my nursing experiences, the collegial nature of nursing changed, and I found myself immersed in a profession of dissatisfied, jaded, and cynical individuals looking for reasons to be dissatisfied, unhappy, and angry at leaders, managers, hospital systems, and patients. Although I initially rejected this anger, I found myself clearly drawn into the dissatisfaction and disengagement and transformed into one of the disillusioned. While I had the opportunity to work in a variety of locations across the United States, I realized that my experiences were not unique to one unique hospital, department, age group, or demographic region. Nurses complained about dissatisfaction but not one given theme or reason for the lack of fulfillment in the nursing care provided to patients was found. Rather multiple reasons for the dissatisfaction and disengagement are expressed and many times lack substance or validity.

During my nursing journey, I found myself, like many of my coworkers, engaged in a search for satisfaction and entwined in being disengaged, unfulfilled, and searching for the perfect job, role, or position. However, deep within me, I recognized that beyond the angry discussions, blaming of others, and cynical nature of many of my coworkers the fundamental care and compassion was still intact. Even with these traditions deeply embedded in my thoughts, words, and deeds as a professional nurse, something happened to my way of thinking and viewing healthcare, patients, and nursing over this time. While fondly remembering times when individuals worked as team members, patient care came first, and strong work ethics were essential and expected of every worker something had changed in my professional world. Whether I became skeptical, pessimistic, or tired the

world of nursing, I was keenly aware that nursing had suddenly taken on a new appearance and was moving in a different direction.

The greater questions became when did I lose the joy of being a nurse and become dissatisfied and disengaged and why was nursing no longer the satisfying profession I entered in 1979? I began to question why the dissatisfaction and disengagement are so rampant among nurses and what factors directly or indirectly influence satisfaction and engagement. During what stage of my professional development did I become dissatisfied with a profession that I loved and admired? These thoughts, introspection, and revelations formed the foundation for my dissertation.

I wanted to understand and gain further knowledge about the factors influencing nurse behaviors, satisfaction, and engagement. To understand these feelings, behaviors, thoughts, and ideas I needed to hear, listen, and analyze what nurses described as key themes and ideas influencing nurse satisfaction and engagement. I decided to delve into understanding why nurses are dissatisfied and disengaged and speak directly to nurses about this complex issue. As a scholar-practitioner, I wanted to understand the complex phenomena of the nurse experience, expressly nurse satisfaction and engagement.

In my academic journey, I focused on theory and concepts devoted to understand and recognize communication, leadership, engagement, and components of satisfaction, engagement, and retention. The reading and research lead me to want to use my voice to aid others searching to find solutions to the ever-present nursing shortage. These theories and concepts of satisfaction and engagement form the foundation for this dissertation. The foundations lead me to ask why nurses are dissatisfied and disengaged and why the

clear-cut act of providing care is not enough to illicit a sense of enjoyment, satisfaction, and engagement.

I chose case study to investigate and determine key attributes and definers of why nurses are dissatisfied and disengaged. However, while my practices have remained constant and patient-centered, the environment I work in has changed dramatically. This knowledge provides valuable information to move from conversations focused on what is wrong, what management has done or is not doing to 'fix' issues and problems, and discussions about patient attitudes, behaviors, and dysfunction to a better understanding and focus on what is needed to improve nurse satisfaction and engagement.