2018

Emergency Room Nurse Perceptions of Emotional Intelligence

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This is to certify that the doctoral dissertation by

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Walden University
2018

Abstract

Emergency Room Nurses' Perceptions of Emotional Intelligence

by

Ingrid Astralaga

MA, College of Saint Elizabeth, 2015

BS, College of Saint Elizabeth, 2012

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Nursing Leadership

Walden University

December 2018

Abstract

The delivery of quality care has been a priority for the health care industry in the United States. Researchers have established positive correlations between the levels of emotional intelligence of registered nurses and their clinical performances. However, new evidence suggests the need to enhance the use of emotional intelligence (EI) in high-risk clinical units. With the intent to understand the use of EI, a phenomenological research approach was used to identify the emergency room nurse's understanding of EI. The Four-branch Model of Emotional Intelligence was used as the theoretical framework, while the research question identified the emergency room nurse's perception of EI. Eight emergency room nurses from two facilities participated in the study. The inclusion criteria consisted of emergency room nurses with one to ten years of experience, nurses that worked thirty-six hours or more per week, and were not in leadership roles. The data were collected through face-to-face interview sessions and analyzed using the Colaizzi's Method of Data Analysis. All participants reported unfamiliarity with the concept of EI. Nevertheless, evidence that indicated the presence of all elements of this concept such as the ability to perceive emotions, understand emotions, use emotions to enhance reasoning, and manage emotions, were apparent in the stories shared by the nurses. The results of the study indicated a potential influence toward positive social change at the organizational and professional level. The implementation of educational activities to improve the use of this concept and the modification of current health care policies to incorporate emotional intelligence as clinical competencies are actions that can influence positive social change.

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Dedication

I would like to dedicate my research study to God, my Lord, my daughter Valerie Ann Astralaga, my husband Fernando Astralaga, and my mother, Marta Treto. I would have never reached my dream of achieving my Doctoral of Philosophy in Nursing Leadership without the guidance, faith, strength, and wisdom of my Lord, Jesus Christ. I would have never seen my dream come true without the understanding and commitment of my daughter and my husband. The support of my daughter, my husband, and my mother made long endless night shorter, difficult and situations more manageable. Therefore, I grateful dedicate my research study, "The Emergency Room Nurses' Perception of Emotional Intelligence" to God my Lord, my daughter, my husband, and my mother.

Acknowledgments

I would like to take this opportunity to express my most profound appreciation and gratitude to those individuals who guided me and supported through the doctoral program. I would like to thank my Lord who gave me the health, strength, faith, and wisdom to be able to accomplish my dream. I would like to thank forever my extraordinary husband, Fernando Astralaga, and my daughter Valerie Ann Astralaga for their sacrifices and commitment to help me become Dr. Ingrid Astralaga. I'm especially grateful for my parents Marta Treto, Pedro Martin and my mother in law Francia Astralaga for believing in me and giving me hope and confidence when needed the most.

I would like to thank my dissertation Chair, Dr. Donna Bailey who guided me through the entire program and was always willing to chair her expertise in a kind and positive way. Dr. Janice Long whose detailed reviews and feedback helped me raise my dissertation to a higher level. Dr. Eileen Fowles and other members of the faculty team who supported and directed me through the dissertation process. I would like to use this opportunity to thank a very special friend, Marilyn Bates, who was always there to listen when I was overwhelmed and needed to talk. Without the support and guidance from all the individuals involved in my dissertation journey, I would not have been able to see my dream of obtaining a Doctor of Philosophy in Nursing Leadership come true.

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Chapter 1: Introduction to the Study

Emotional intelligence is a topic that has captivated the interest of researchers from different disciplines. However, it is still considered a relatively new concept. Although many researchers referred briefly to the existence of this concept in the 1960s, the evolution of emotional intelligence started with the work of Mayer, Salovey, and Caruso in the early 1990s (Mayer, Salovey, & Caruso, 2004). These authors perceived emotional intelligence as a set of abilities needed to identify emotions in self and others, manage emotions, comprehend emotions, and use emotions to enhance reasoning (Mayer et al. 2004). The work of Dr. Bar-On has also been considered critical to the advancement of emotional intelligence. Dr. Bar-On (2010) defined *emotional intelligence* as a group of personality traits. On the other hand, Dr. Goleman's publications evolved this concept to another level by suggesting that emotional intelligence is a combination of both abilities and personality traits. Goleman associated this idea with four essential competencies including self-awareness, social-awareness, self-management, and relationship management (Goleman, 2000). Furthermore, the researcher's scientific evidence has demonstrated clearly that emotional intelligence is equally important as intelligence quotient (Checa & Fernandez-Berrocal, 2015; Goleman et al., 2013; Mayer, Caruso, & Salovey, 2016).

Researchers have found positive correlations between the levels of emotional intelligence and academic as well as professional success (Romanelli, Cain, & Smith, 2006). It is essential to note that an ample number of research studies have associated this concept with the effectiveness and accuracy of the clinical practice of health care

providers. Furthermore, substantial evidence has indicated positive associations between the clinical nurses' level of emotional intelligence and care quality indicators, nurse/patient relationships, staff retention, job satisfaction, and team cohesiveness (Adams & Iseler, 2014; Codier, Kamikawa, Kooker, & Shoultz, 2009; Quoidbach & Hansenne, 2007; Rakin, 2013). Although the health care professional's emotional intelligence has been shown to improve the quality of care delivered to patients and families, a need to enhance the use of this concept, especially in the emergency departments, has been a topic of concern for the health care industry (Bailey, Murphy, & Porock, 2011). In this qualitative study, I focused on identifying the emergency room nurse's perception of emotional intelligence with the intent to not only provide clarity to the limited use of this concept but also influence the quality of care positively. This chapter is organized into the following sections: background, problem statement, the purpose of the study, research questions, theoretical framework, nature of the study, definitions, assumptions, limitations, delimitations, and significance.

Background

Although the application of emotional intelligence in the nursing practice continues to be a developing topic, strong evidence indicates how this concept influences clinical practices, and therefore the care provided to health care consumers. Codier, Freitas, and Muneno (2013) showed that nurses who had received training on emotional intelligence were able to not only establish an emotional bond with their patients but also developed emotional care planning addressing the emotional needs of their patients. Similar findings were reported by Adamson (2014), who concluded that nurses who use

emotional intelligence skills in their clinical practices demonstrated caring behaviors and were less likely to experience burnout. Furthermore, evidence of effective communication, constructive conflict resolution, individual and team performance were associated with the nurse's levels of emotional intelligence (Codier & Codier, 2017). Effective communication and positive conflict resolution techniques are vital skills to provide high-quality care.

A new set of emerging studies indicates the need to foster the use of emotional intelligence in the clinical practice of emergency care professionals. Codier and Codier (2015) demonstrated not only the essential role that emotional intelligence plays in the emergency nursing practice but also the limited use of this concept. The authors explained that teamwork, staff retention, and burnout prevention are vital components to care for patients safely in the emergency department. They also associated these elements to the different abilities of emotional intelligence such as the identification of emotions, reasoning with emotions, understanding, and managing emotions (Codier & Codier, 2015). The work of Holbery (2015) also supported not only the importance of the emotional components of nursing care but also the need to incorporate elements of emotional intelligence into the clinical practice of emergency room nurses.

The end-of-life care in the emergency department is a common practice that has been growing at a rapid rate. Emergency room nurses are facing the challenge of caring for dying patients more common than in previous decades (Hogan, Fothergill-Bourbonnais, Brajtman, Phillips, & Wilson, 2015). The work of Wolf et al. (2015) revealed that emotional burden can result from caring for patients at the end-of-life

without the use of appropriate resources. The authors demonstrated the urgency to incorporate emotional intelligence skills as vital resources for emergency room nurses caring for patients at the end-of-life (Wolf et al., 2015). Being able to establish a relationship with patients as well as family members is critical to emergency room nurses. The delivery of unpleasant news or having a conversation of encouragement can be affected by the health care provider's ability to develop and manage relationships. Reed, Kassis, Nagel, Verbeck, Mahan, & Shell (2015) validated the need to expand and strengthen the communication domain of emergency care professionals. The authors explained further how the professional's low level of emotional intelligence correlates with their inability to communicate effectively (Reed et al., 2015). To understand the lack of emotional intelligence among emergency room professional, identifying the nurse's perception of this concept is vital.

Problem Statement

Delivering high-quality care to health care consumers continues to be a priority for the health care industry. Several variables such as the technical performance of the clinicians, the accessibility to the care, equity, efficiency, cost effectiveness, and the health care provider's emotional intelligence abilities have a direct influence on the health care provided to patients and families (Joshi, Ransom, Nash, & Ransom, 2014). Researchers have used numerous definitions to explore the concept of emotional intelligence. Goleman (2000) recognized emotional intelligence as a combination of personality traits and emotional abilities. The author associated this concept with four competencies: self-awareness, social-awareness, self-control, and management of

relationships. Another vital definition of this concept was presented by Mayer et al. (2004). The authors identified *emotional intelligence* as a group of cognitive abilities needed to recognize emotions in self and others, understand emotions, manage emotions, as well as utilize emotions to enhance reasoning (Mayer et al., 2004). These definitions of *emotional intelligence* demonstrate the significant role that this concept plays in the practices of health care professionals.

In addition, researchers have demonstrated positive correlations between emotional intelligence and the quality of clinical decision-making abilities, as well as the overall clinical performance of professional nurses (Codier et al., 2009; Smith, Profetto-McGrath, & Cummings, 2009; Winship, 2010). However, new evidence suggests a need to enhance the use of emotional intelligence skills, especially in high-risk clinical environments (Bailey et al., 2011; Codie, Freitas, & Muneno, 2013). Although the limited use of emotional intelligence in stressful clinical areas such as the emergency room is apparent, the emergency room nurse's understanding of this concept has not been well researched.

The quality of care provided to behavioral health patients by emergency care providers has also been associated with the nurses' levels of emotional intelligence. The work of Carmona-Navarro and Pichardo-Martine, (2012) not only highlights the need of initiatives to increase the emergency provider's emotional intelligence but also explains how the limited levels of emotional intelligence interfere with the emergency nurse's use of practical approaches towards patients experiencing suicidal behaviors. Moreover, caring for patients and families at the end-of-life is not only a challenging situation in

emergency departments but also an area where opportunities for improvement have been identified. Researchers have confirmed that the quality of care provided by emergency room nurses to health care consumers at the end-of-life can be improved significantly by establishing emotional nurse-patient relationships using emotional intelligence abilities (Bailey et al., 2011).

Furthermore, emergency nursing is a fast-paced and demanding practice that relies significantly on the teamwork abilities of the emergency room professionals (Codier, & Codier, 2015; Holbery, 2015). Recent studies have indicated that emotional intelligence not only has a positive influence on team performance but also on conflict management skills and the long-term cohesiveness of clinical teams (Codier & Codier, 2015; Quoidbach, & Hansenne, 2007; Winship, 2010). Holbery (2015) explained that emergency nursing practice lacks an emotional touch and argued how the use of emotional intelligence can influence this caring component positively. Strong evidence demonstrates the essential role that emotional intelligence plays in the clinical practice of emergency room nurses; nevertheless, its use continues to be limited. To positively influence the quality of care delivered to patients and families in the emergency room, understanding the emergency room nurse's perception of this concept is necessary (Scott, 2015).

It is essential to note that the emergency room nurse's understanding of emotional intelligence is a topic that has not been well investigated. A comprehensive review of the literature indicates that researchers recognize the nurse's perceptions of emotional intelligence as a phenomenon needing to be explored (Bailey et al., 2011; Codier &

Codier, 2017). Scientific evidence continues to support the urgency to not only investigate this topic but also explore how emergency room nurses construct their interpretation of emotional intelligence through their clinical experiences (Hogan et al., 2015; Holbery, 2015)

Purpose of the Study

My purpose in this phenomenological research study was to identify the emergency room nurse's perception of emotional intelligence to gain an understanding of the limited use of emotional intelligence skills in high-risk clinical environments. This information is essential to promote and enhance the use of emotional intelligence with the purpose of improving the quality of care provided to patients in the emergency room. The results of my study can be instrumental to not only the development of educational activities but also address the gap in knowledge associated with the lack of scientific evidence exposing the emergency room nurse's understanding of this concept.

Research Questions

My qualitative study includes one central research question and four subquestions. The four subquestions were created based on the theoretical framework of the study. Each question represents one of the four branches of emotional intelligence found in the four-branch model of emotional intelligence, also known as the ability model of emotional intelligence.

RQ: What is the emergency room nurse's understanding of emotional intelligence?

Subquestion 1. According to the emergency room nurses' description of their clinical experiences, what evidence demonstrates their ability to perceive emotions in self and others?

Subquestion 2. According to the emergency room nurses' interpretation of their clinical experiences, what evidence demonstrates their ability to understand emotions?

Subquestion 3. According to the emergency room nurses' interpretation of their clinical experiences, what evidence demonstrates their ability to control or manage emotions?

Subquestion 4. According to the emergency room nurses' interpretation of their clinical experiences, what evidence demonstrates their ability to use emotions to enhance reasoning?

Theoretical Framework

The evolution of the concept of emotional intelligence has been marked by three essential models. The personality model of emotional intelligence also known as the bar-on model, the mixed model of emotional intelligence, as well as the ability model of emotional intelligence, also known as the four-branch model of emotional intelligence (Bar-On, 2000). The Four-branch Model of Emotional Intelligence is the theoretical framework that I used in the study. This model was developed by Mayer, Salovey, and Caruso. In this model, the authors considered emotional intelligence as a group of emotional and social abilities different from what we know as intelligence quotient. Four principles, referred as four branches, have guided the work of these researchers. These

principles include the ability to perceive emotions, use emotions to enhance reasoning, understand emotions, and manage emotions (Follesdal & Hagvet, 2009).

Perceiving emotions in self and others is not only the most fundamental ability of emotional intelligence but also the principle that makes possible the other abilities. This branch consists of the individuals' capacity to identify their own emotions as well as interpret emotions in faces, pictures, voices as well as cultural artifacts (Salovey & Grewal, 2005). The second branch consists of the ability to use emotions to facilitate cognitive actions like thinking or problem-solving. It includes being able to select the appropriate mood that will help to complete the task at hand. For instance, Salovey and Grewal (2005) explained that being happy enhances creative and innovative thinking while being a sad mood allows people to perform careful and complete methodical tasks.

The third branch consists of people's capacity to understand emotions. It includes the ability to comprehend the language of emotions as well as the relationships and variations of emotions. It is essential to know that this ability gives people the opportunity to be sensitive to the evolution of emotions such as how the feeling of shock can evolve to grief (Salovey & Grewal, 2005). The ability to manage emotions is the fourth branch of this model. It includes the ability to regulate emotions in self and others. In other words, Mayer, Salovey, and Caruso (2002) indicated that a motivational speech delivered with anger could arouse righteous violence in others.

The four-branch model of emotional intelligence served as the theoretical framework for this study. The conceptual components of this model were used as a guide throughout this qualitative inquiry. The four subquestions of the study represent the four

branches of this model. Furthermore, four of the interview questions employed in the in-depth face-to-face interview sessions were created based on the participant's ability to identify emotions, use emotions to enhance reasoning, understand, and manage emotions. This model was also instrumental in the different stages of data interpretation. The various codes and themes emerged from the stories of the emergency room nurses were grouped according to the four branches with the intent to identify commonalities.

Nature of the Study

This phenomenological inquiry aimed to identify the emergency nurse's perception of emotional intelligence with the intent to gain not only an understanding of the limited use of this concept in their clinical practices but also improve quality of care. A transcendental phenomenological approach was used to assess the nurses' understanding of this concept and identify the existence of emotional intelligence in the emergency nursing practice as well as how these nurses make sense of the world through lived clinical experiences (Patton, 2015). The original plan was to recruit the first two participants via email based on the inclusion criteria of the study. I intended to use the snowball sampling to select the rest of the participants until saturation of the data is achieved. The variation to the original plan is presented in chapter four. The participants consisted of emergency room nurses from two different facilities to assure the trustworthiness of the data. The primary source of data included face-to-face semi-structured interview sessions. The interviews were recorded and transcribed. This information was submitted to several manual coding cycles with the intent to sort and identify categories as well as themes. The study was conducted following the parameters

established by both Walden University Institutional Review Board and the Institutional Review Board of the partner organizations to assure the protection of the participants.

Definitions

Ability Model of Emotional Intelligence or Four-branch Model of Emotional Intelligence: Refers to a conceptual model developed by Mayer, Salovey, and Caruso to describe the concept of emotional intelligence. The authors defined this concept as four essential cognitive abilities needed to perceive emotions, understand emotions, utilize emotions to enhance reasoning, as well as manage emotions (Mayer et al., 2016).

Clinical Decision-Making Process: Is the interaction between a situation where a clinical decision needs to be made and the person who is making that decision (Halama & Gurnakova, 2014).

Emergency Nursing: Emergency nursing is a specialty within the nursing profession. It is defined by the Emergency Nurses Association as the care of patient across the lifespan with supposed or actual emotional as well as physical alteration of health. Emergency nursing care can be sporadic, primary, acute, and occurs in different settings (Emergency Nurses Association, 2011).

Emotional Intelligence: Is a term originated from social studies used to represent non-cognitive abilities of individuals. Researchers have defined emotional intelligence as group of skills necessary to comprehend emotions in self and others, manage emotions, as well as establish and maintain relationships (Bar-On, 2000; Goleman, 2000; Mayer et al., 2004).

Emotional Intelligence Competencies: Refers to the four abilities of emotional intelligence identified by Goleman including self-awareness, social-awareness, self-management, and management of relationships (Goleman et al., 2004).

End-of-Life: Refers to the care of a dying patient (Bailey et al., 2011; Hogan et al., 2015). It consists of care given in the time directly preceding death. Good end-of-life care is considered when death is experienced free from distress and suffering for the patient, family members, as well as health care providers (Decker, Lee, & Morphet, 2014).

High-Quality Care: Refers to the greatest and positive accumulative impact of all what happens to a patient while in a health care organization. In other words, this definition refers to the care delivered by health care providers and the best possible outcome for the patient (Joshi et al., 2012).

Intelligence Quotient: Consists of a numeric test utilized to measure individual's cognitive abilities and therefore academic success (Goleman et al., 2013).

Mixed Model of Emotional Intelligence: This model was created by Dr. Daniel Goleman to explore the concept of emotional intelligence. Goleman defined emotional intelligence as a combination of both personality traits and emotional abilities (Goleman, 2000). He associated this concept with four essential competencies including self-awareness, social-awareness, self-management, as well as relationship management (Goleman et al., 2013).

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Clinical Decision-Making Process: Is the interaction between a situation where a clinical decision needs to be made and the person who is making that decision (Halama & Gurnakova, 2014).

Nurse-Patient Relationship: Refers to the mutual emotional investment of both the nurse and the patient. In the nurse-patient relationship, the nurse gets to know and recognize the patient physical as well as emotional needs (Bailey et al., 2011).

Personality Model of Emotional Intelligence or Bar-On Model of Emotional Intelligence: This model was developed by Dr. Reuven Bar-On to describe emotional intelligence as a group of personality traits highly influenced by the social interaction of individuals (Bar-On, 2000)

Professional Nursing Practice: Includes an organized process assumed to provide nursing care to patients and family members. Elements of professional nursing practices are autonomy, accountability, mentoring, collegiality, respect, integrity, trust, knowledge, and activism (Kooker et al., 2007; Winship, 2010).

Team Cohesiveness: It is defined as a group of people who have formed meaningful and influential relationships as well as a solid support system working together toward the accomplishment of common goals. Empathy and social networking are essential components of team cohesiveness (Quoidbach & Hansenne, 2009).

Assumptions

I made numerous assumptions in this qualitative inquiry. The assumptions were separated into two categories, those associated with the methodology and those related to the outcomes of the study. The first assumption of the study was that in-depth face-to-face semi-structured interviews is an appropriate method to identify the emergency nurse's perception of emotional intelligence. Another assumption was that the use of the standardized open-ended interview approach will facilitate the consistency of the data. The third assumption was associated with the snowball sampling method that was going to be employed to recruit some participants. This assumption was that the participants recommended by the interviewees will support and provide new perspectives about the phenomenon being explored.

The following assumptions was related to the overall outcomes of the study. I assumed that the results of the study will aid in better understanding of the limited awareness of emotional intelligence in the clinical practices of emergency room nurses. Another assumption included that the findings of my study will serve as a baseline to develop educational and training programs to enhance the emotional intelligence of health care providers. The last assumption is that high-quality care can be delivered to

patients and family members in the emergency room by increasing the emergency care providers' use emotional intelligence skills.

Scope and Delimitations

All participants in the study consisted of emergency room nurses working thirty-six hours or more per week, with a year to ten years of experience in this clinical area, and do not have administrative responsibilities. Only clinical nurses working in the emergency room were included in the study. To add variety in the data, emergency room nurses from two facilities were considered. The sample size was selected based on the scientific recommendations for phenomenological research design where the participants are recruited until saturation of the data is achieved. Emergency room nurses with whom I have a personal or professional association were not included in the study to avoid perceived coercion. It is apparent that the transferability of my study can occur in different clinical settings.

Limitations

The study was limited to only one type of health care organization. Although the participants work in two separate acute care facilities, there are strong similarities among these two organizations. For instance, these health care agencies have comparable annual emergency care visits, alike nurse to patient ratios, as well as use very similar available services. Therefore, a limitation of the study is that I did not consider exploring the emergency room nurse's perceptions of emotional intelligence in university hospitals or trauma-level facilities where the complexity of the patients is higher and more specialized services are available. Another limitation of the study is that the participant's age, gender,

educational, as well as cultural background were not taken into consideration. Studies have demonstrated that although emotional intelligence is not often associated with gender differences, age, educational, as well as cultural background have an impact on this concept (Benson, Ploeg, & Brown, 2009; McNulty, Mackay, Lewis, Lane, & White, 2016).

Another limitation of this inquiry is that the study will be restricted to the perception of nurses working in one specialty area of health care. It is important to note that nurses with other clinical expertise who have had different types of clinical experiences with patients and families might provide new insights into not only the limited use of emotional intelligence but also the overall understanding of this concept. The study was conducted with rigor regarding the research methodology to facilitate the trustworthiness of the data. The researcher's biases were controlled through the bracketing strategy and the use of reflective memos during the data collection as well as the data analysis process.

Significance

The significance session of my study is divided into two categories. The first category consists of the contributions that this quality inquiry will add to the theory while the second focuses on its implication in the nursing profession as well as social change.

Significance to the Theory

This qualitative study addresses the lack of evidence describing the emergency nurse's perception of emotional intelligence. Although researchers have demonstrated the role of emotional intelligence in the clinical practices of health care professionals, this

concept is significantly needed in high-risk clinical areas such as the emergency department (Smith et al., 2009). There is no doubt that the results of the study provided much-needed insights into why there may be limited use of emotional intelligence among emergency care professionals.

Significance to the Nursing Profession and Social Change

It is essential to note that the study of emotional intelligence in the nursing practice is still in the beginning stages. However, the application of this concept can influence positively the nursing profession, especially clinical practice. The information revealed by my study can serve as a guide to implementing educational and training activities that enhance the use of emotional intelligence abilities among registered nurses. Additionally, this information can be utilized to conduct emotional intelligence screening sessions with the intent to organize and direct educational resources. Evidently, the utilization of these programs is the start to a positive social change movement by not only improving the clinical nursing practice but also developing emotionally intelligent emergency room nurses. Reflective activities, simulations, as well as role play have been identified as useful strategies to promote emotional intelligence in acute care settings (Parnell, & Onge, 2015).

Moreover, the findings of the study can be instrumental in the modification of current organizational policies and guidelines to incorporate emotional intelligence as core competencies for emergency care providers. The use of this concept as an essential skill can transform the overall culture of health care organizations. It is essential to note that the regular use of emotional intelligence will positively change the care provided to

both emergency room patients as well as local communities. This potential transformation in the nursing practice is the significant contribution when striving for positive social changes.

Summary

Delivering high-quality care to health care consumers continues to be a goal for the health care industry. Substantial scientific evidence has demonstrated strong correlations between the emotional intelligence of health care providers and their ability to make adequate clinical decisions, communicate effectively, as well as establish caring relationships with both patients and family members. The skills to employ adequate conflict management skills and work collaboratively are not only essential to provide high-quality care but also have been associated with the provider's emotional intelligence abilities (Adams & Iseler, 2014; Codier et al., 2009; Quoidbach & Hansenne, 2007; Rakin, 2013). Mayer, Salovey, and Caruso (2000) define emotional intelligence as a group of abilities necessary to identify emotions in self and others, use emotions to enhance critical thinking, manage emotions, as well as understand emotions.

Although emotional intelligence is imperative to deliver quality care, emerging studies have identified opportunities to enhance this concept in high-risk units such as the emergency department (Bailey et al., 2011; Holbery, 2014). Moreover, this limited use of emotional intelligence in the practice of emergency room nurses is a topic that needs scientific investigation. This qualitative inquiry aimed to provide clarity to the inadequate use of emotional intelligence with the intent to deliver high-quality care to patient and families in the emergency departments.

A phenomenological research approach was used in this study. The participants consisted of eight emergency room nurses from two acute care community hospitals. The data was collected through face-to-face in-depth interview sessions and analyzed for common themes and categories. The study includes some limitations such as the similarities of both facilities, the exclusion of the participant's age, gender, educational, and cultural background, as well as the inclusion of only one specialty area of the clinical nursing practice. It is important to consider that the findings and recommendations of the study can add original contributions to the body of knowledge associated with the application of emotional intelligence in the nursing practice as well as its implication to positive social change

Chapter 2: Literature Review

Introduction

The delivery of high-quality care to health care consumers has been the priority of the health care industry. Researchers have identified the use of emotional intelligence skills crucial to the provision of high-quality care (Joshi et al., 2014). Goleman et al. (2013) defined emotional intelligence as a set of abilities necessary to identify and understand emotions in self and others, control, and express emotions, as well as manage relationships. Furthermore, positive correlations have been established between the levels of emotional intelligence and the clinical decision-making skills of health care professionals, the therapeutic approach utilized by clinical teams, as well as the overall clinical performance (Codier et al., 2009; Smith et al., 2009; Winship, 2010; Carmona-Navarro & Pichardo-Martine, 2012).

Additionally, teamwork, conflict management strategies, as well as long-term group cohesiveness, have been correlated with the clinical professional's levels of emotional intelligence (Codier & Codier, 2015; Holbery, 2015; Quoidbach, & Hansenne, 2007; Winship, 2010). It is essential to note that although the role that emotional intelligence plays in the clinical practices of health care providers have been confirmed, Bailey et al. (2011), as well as Codie et al. (2013), identified the need to enhance the use of this concept in high-risk environment such as the emergency department. A descriptive phenomenological research approach was used to determine the emergency room nurse's perception of emotional intelligence to gain an understanding of the limited use of emotional intelligence skills in the emergency rooms.

Relevance

Research evidence indicates that emotional intelligence is a predictor of job performance, leadership effectiveness, and organizational success. Unlike intelligence quotient (IQ) which predicts the cognitive capacity of an individual, emotional intelligence refers to the skills necessary to interpret and manage emotions. It is essential to note that when emotions are not controlled, the cognitive abilities to perform effectively are affected (Rankin, 2013). Goleman et al. (2013) described the concept of emotional intelligence based on four competencies: self-awareness, self-control, social awareness, and relationship management. They went on to define self- awareness as the ability to be aware of one's feelings and recognize how these feelings affect one's performance. The authors defined self-control as the capacity to manage one's emotions and impulses (Goleman et al., 2013). According to these researchers, social-awareness is manifested when people can attune to a broad range of emotional signals, letting them sense the felt but unspoken emotions of the environment. The fourth competency of emotional intelligence identified by Goleman et al. (2013) is called relationship management. This competency is evident when people can collaborate with each other and build relationships through influence as well as motivation. There is no doubt that these four competencies are critical to the clinical practice of health care providers. To deliver quality care, especially in high-risk environments such as the emergency department it is important for the clinical teams to recognize their feelings and identify how their emotions affect their performances as well as the performances of others. Furthermore, it is essential for these teams to learn how to control their feelings and also

manage their relationships efficiently to work collaboratively with multidisciplinary professionals, patients, and family members.

Furthermore, the work of Adams and Iseler (2014) are additional scientific evidence that supports the importance of this concept in the nursing practice. The authors identified relationships between all four components of emotional intelligence and the quality of care delivered to patients in acute care settings. The quality of care was assessed through four nursing quality indicators consisting of Clostridium difficile infections, MRSA infections, patient falls with injury, and patient ulcer screenings. The results of the study revealed positive correlations between the nurse's levels of emotional intelligence and all four quality care indicators.

Similar results were demonstrated by Codier et al. (2013). The authors utilized a mixed method approach to explore the impact of an emotional intelligence development program on the clinical nursing staff and patient care. After providing one round of education about emotional intelligence, the authors discovered an increase in the nurses' documentation related to the emotional care of their patients and an improvement of the nurses' emotional care planning (Codier et al., 2013). Interestingly, the researchers argued that although there was evidence indicating that the clinical teams were able to identify emotions in self and others, the habit of utilizing the components and attributes of emotional intelligence was not apparent. Interestingly, the work of Codier et al. (2013) supports two essential assumptions of my study. One assumption states that the clinical care can be improved with the use of the emotional intelligence skills of health care

providers. The other assumption validated by the work of these authors is that educational programs are useful tools to enhance emotional intelligence among clinical teams.

Moreover, the studies conducted by Winship (2010) and Codier et al., as well as Shoultz (2009) confirmed the important role of emotional intelligence from a different perspective. The authors indicated positive correlations between this concept and the levels of clinical performance, organizational commitment, as well as staff retention.

New themes have evolved with the study of emotional intelligence in the clinical practices of health care professionals. Bailey et al. (2011) has exposed not only the importance of emotional intelligence in emergency nursing but also the need to enhance and promote the use of this concept. Additionally, the researchers identified the lack of evidence explaining the emergency room nurse's understanding of this concept. Similar findings were demonstrated in the qualitative inquiry conducted by Hogan et al. (2015). Three major themes resulted from the analysis of the data collected from semi-structured interview sessions. Eleven emergency room nurses participated in the interviews. The results confirmed positive associations between the emergency room nurse's level of emotional intelligence and their abilities to engage in meaningful relationships with patients and families, to empathy with their patient's experiences, and to meet the emotional needs of their patients despite heavy workloads (Hogan et al., 2005). Comparable outcomes were identified by Codier and Codier (2015). The authors not only supported the need for emotional intelligence in the practice of emergency room clinical nurses but also suggested the consideration of this concept as a core competency for emergency care professionals (Codier, & Codier, 2015). It is important to note that these

emerging themes not only verify the gap being addressed by my study but also support the urgency to explore the limited use of emotional intelligence skills among emergency care professionals. These authors have exposed the lack of evidence describing the emergency room nurses' perception of emotional intelligence.

Emergency rooms are perceived as stressful, high risk, and chaotic clinical environments where multitask, speed, and protocol-based practices are critical. Holbery (2014) explained how emergency nursing is a task-based practice; however, it lacks caring touch components essential to patients and family members. The author identified emotional intelligence as an element vital to the practice of emergency room nurses (Holbery, 2014). She concluded that empathy, self-awareness, and managing of emotions are critical and exposed the need to develop emergency room training programs that enhance the use of emotional intelligence skills. Self-reflection, storytelling, and simulation were recognized as useful tools to incorporate emotional intelligence into the curriculum of educational activities (Holbery, 2014). It is essential to note that the findings of my qualitative study can serve as a foundation and a guide for the development of educational programs to enhance the use of emotional intelligence skills in acute clinical environments.

The practice of emergency care professionals highly depends on the teamwork abilities of the emergency care teams. Quoidback and Hansenne (2007) explored the impact of emotional intelligence on the performance and cohesiveness of teams. The researchers reported positive correlations between health care provider's level of

emotional intelligence and both team performance as well as the long-term cohesiveness of nursing teams (Quoidback, & Hansenne, 2007).

The care for patients experiencing behavioral crisis has increased significantly. Carmona-Navarro and Pichardo-Martinez (2012) reported that for every suicide case, suicide attempts have led to not only five hospitalizations but also approximately twenty-two visits to the emergency department. Emergency care professionals, especially the nursing personnel, have been identified as the first medical contact for patients experiencing both suicidal and homicidal ideations. Appropriate assessment and managing of these patients in the emergency department are vital to prevent imminent suicidal attempts and enhance the use of health services. A descriptive and cross-sectional research study conducted by Carmona-Navarro and Pichardo-Martinez (2012) indicated that the emergency room nurses who demonstrated high levels of emotional intelligence were able to employ positive approaches towards patients suffering from behavioral emergencies such as suicidal ideations. Evidently, the work of these researchers validates how the quality of care delivered to patients experiencing psychiatric emergencies can improve by enhancing the emotional intelligence skills of health care providers. Interestingly, the results of my qualitative inquiry provided new insights into the phenomenon associated with the insufficient use of emotional intelligence skills by identifying the emergency room nurse' understanding of this concept.

Literature Search Strategies

Multiple sources of information were utilized to search the literature. A comprehensive search was conducted in several Walden University Library databases. Some of these data bases consisted of ProQuest, CINAHL plus, as well as several ESCOhost databases such as Academic Search Complete, and SAGE Premier. Other data sources included national organization websites such as the Emergency Nurses Associations, Google Scholar, and books obtained from local libraries. Emphasis was given to the studies that were published within the past five years. Different terms were utilized during the search of the literature. For example, *emotional intelligence, nursing practice,* and *quality of care* were used to explore the role of this concept in the nursing profession. *Conceptual models of emotional intelligence, Ability Model of Emotional Intelligence, Personality Trait Model of Emotional Intelligence, as well as Mixed Model of Emotional Intelligence* were some of the search term used to gain understanding of the background and theories of emotional intelligence. Once I identified the gap in my study, exploring research methodologies that could potentially address my research problem became the focus of my search. Term employed in this section were *phenomenological research approaches, lived clinical experiences, as well as interpretation of lived experiences.*

Theoretical Framework

The concept of emotional intelligence has captivated the interest of researchers for several decades, and its application has expanded the scientific knowledge of multiple disciplines. A comprehensive search of the literature has demonstrated the utilization of

three fundamental approaches during the evolution of this concept. The Ability Model of Emotional Intelligence, The Personality Model of Emotional Intelligence, as well as The Mixed Model of Emotional Intelligence are three popular frameworks used in the study of emotional intelligence. Although strong similarities have been found in the analysis of the three models, there are differences related to the context in which the concept is being explored.

Principles of Emotional Intelligence

The Ability Model of Emotional Intelligence was first proposed in the early 1990s by Mayer, Caruso, and Salovey (2016). This model was developed based on seven essential principles that described emotional intelligence as emotional abilities. The first principle perceived emotional intelligence as a mental ability which refers to the capacity of an individual to comprehend meaning, understand concepts, and develop generalizations. Mayer, Caruso, and Salovey (2016) believed that to measure emotional intelligence accurately, it must be evaluated as a group of emotional abilities not personality traits. In other words, presenting problems for people to solve give researchers the opportunity to explore the foundation of people's thinking (Mayer et. al., 2016).

The distinction between intelligence and behavior was another critical principle that guided the thinking of the authors. The authors believed that although intelligence influences some behaviors, predicting people behaviors can be inaccurate due to the interaction among variables such as society and personality (Follesdal & Hagvet, 2009; Rivers, Brackett, Reyes, 2012; Mayer, Caruso, & Salovey, 2012). Another essential

principle utilized in the Ability Model of Emotional Intelligence was related to the accuracy of measuring people's mental abilities. Mayer, Salovey, and Caruso (2002) indicated that the content of the test, the problem-solving area, and what is being tested must be incongruent. Furthermore, the researchers strongly felt that a practical test must expose important human mental abilities (Mayer et al., 2016). It is essential to mention that the authors not only identified emotional intelligence as a broad intelligence but also the type of intelligence that influences the hot information processing also known as any type of reasoning that involves emotions (Mayer et al., 2016). As a general intelligence, emotional intelligence is associated with the fluidity of thinking, comprehension-knowledge, long-term storage and retrieval of information as well as the speed in which the information can be retrieved (Mayer et al., 2016). According to the authors, intelligence can be grouped into two sets: cool and hot. Cool intelligence deals with concrete knowledge while hot intelligence contains reasoning with information involving emotions (Mayer et al., 2016).

The Four-Branches Model of Emotional Intelligence

Guided by these principles, Mayer, Caruso, and Salovey developed the Four-branch Model of Emotional Intelligence also known as the Ability Model of Emotional Intelligence (Salovey & Grewal, 2005). In this model, the authors provided a comprehensive theoretical definition of the concept based on four essential assumptions. The first assumption or branch recognizes emotional intelligence as the ability to perceive emotions. It refers to the ability to read and identify feelings on facial expressions, verbal and nonverbal expressions, language, behaviors, as well as pictures. It includes the ability

to distinguish between deceptive or dishonest emotional appearances, accurate versus inaccurate emotions while considering cultural differences (Mayer et al., 2016); Mayer, Salovey, & Caruso 2004; Salovey & Grewal, 2005). It essential to note that although all four branches are crucial components of emotional intelligence, the ability to perceive emotions in self and others has been considered vital making possible other elements of the concept (Salovey & Grewal, 2005).

The second branch of this model is associated with the ability to use emotions to facilitate cognitive activities such as problem-solving, reasoning, and critical thinking. In other words, this branch consists of the ability to generate emotions to assist in judgment and memory and to prioritize thinking by directing attention based on present feelings. It also includes the selection of problems based on how emotions can facilitate cognition, as well as the ability to use mood swings with the intent to consider different points of views (Mayer et al., 2016; Caruso, Mayer & Salovey, 2002). The third branch is related to the capacity of understanding emotions. According to Caruso, Mayer, and Salovey (2002), this branch consists of the ability to interpret not only complex and mixed feelings but also emotional chains. The authors associated this branch with the capability to comprehend how emotions move from one phase to the next such as from anger to satisfaction, understand the roots of emotions, as well as the associations among emotions. Additional assumptions related to this branch include the ability to recognize cultural differences when evaluating feelings, identity how someone might feel under specific circumstance, differentiate between mood and emotions, and assess situations that can produce emotions (Mayer et al., 2016). It is essential to mention that to

understand emotions completely, the identification of antecedents, meanings, and consequences of emotions are critical.

The fourth branch of this model is the capability to manage emotions in self and others. The authors explained how to control emotions, some degree of self-awareness and social awareness is necessary (Mayer et al., 2004). The ability to manage emotions in self and others involves the use of strategies to preserve, reduce, or increase emotional reactions and enhance emotions that are positive or productive (Mayer et al., 2016).

The Mayer-Salovey-Caruso Emotional Intelligence Test known as the MSCEIT was the operation definition developed by the authors to demonstrate the validity and reliability of the Four-Branch Model of Emotional Intelligence. The MSCEIT is composed of eight tasks where two tasks measure each of the four branches (Follesdal & Hagtvet, 2009). For instance, the first branch of the model: perceiving emotions; is measured by having the respondent identify the emotion presented in a picture of a face and by detecting the type of feelings that are conveyed though images of landscapes and designs (Mayer et al., 2004). The second branch called the use of emotions to facilitate cognitive activities is evaluated by both sensations and the identification of emotions that would best facilitate a specific type of thinking. Branch number three; understanding emotions is measured through change and blends (Mayer et al., 2004). In this case, the participant's abilities to recognize under what circumstances one emotional state changes into another as well as what emotions are involved in complex affective states. The fourth branch: managing emotions is evaluated by given hypothetical scenarios to the participants and asking them ways to change or maintain their feelings. The second

element of this task is associated with emotional relationships. For this question, the respondents are asked to identify methods to manage other's emotional state to accomplish desired goals (Mayer et al., 2004). It is important to note that this instrument utilizes an objective approach and the results of the eight tasks are determined using consensus scoring.

The Four-branch Model is the theoretical framework utilized in this study. The principles, assumptions, and conceptual components of this model guided the development of the interview guide, interview process, data collection, as well as data analysis methods.

Personality Model of Emotional Intelligence

The Personality Model of Emotional Intelligence originated from the community mental health arena and was developed by Dr. Reuven Bar-On. Dr. Bar-On identified a phenomenon called Emotional Quotient later called emotional intelligence. He defined this phenomenon as a set of emotional, personal, and social abilities that have a direct impact on people's capabilities to cope and manage the stress of life (Ahmad, 2010; Winship, 2010). To measure emotional intelligence based on these principles, Dr. Bar-On developed the EQ-i instrument. This tool is a self-report instrument that determines not only the total emotional intelligence score but also eighteen sub-scores (Winship, 2010). Researchers have argued the accuracy of the EQ-i tool since the results depends on the self-assessment abilities of the individuals (Ahmad, 2010).

Mixed Model of Emotional Intelligence

Dr. Daniel Goleman has played an essential role in the evolution of emotional intelligence, and his work has provided outstanding contributions to the study of this concept. Dr. Goleman proposed the Mixed Model of Emotional Intelligence which consists of a combination of both personality traits and emotional abilities (Winship, 2010). Though this model Goleman et al., (2013) defied this concept based on four fundamental competencies. The work of Dr. Goleman not only illustrates emotional intelligence as something that can be learned, developed, and improved but also a combination of self-awareness, self-management, social awareness, and relationship management competencies (Christie, Jordan, Troth, & Lawrence, 2007; Goleman et al., 2013). Self-awareness includes knowing one's emotions, being able to assess one's feeling accurately, identifying one's strengths and limitations. Self-management refers to the ability to have control of one's emotions, impulses, and being able to use them in a productive way (Goleman et al., 2013). Another competency identified in this model is social-awareness that includes the ability to empathize and serve others. Relationship management is the fourth competency involved in the Mixed Model of Emotional Intelligence. This element consists of the capability to manage conflict, work collaboratively, influence, inspire, and develop others (Goleman et al., 2013).

Table 1

Models of Emotional Intelligence

Components	Four-branch model	Personality model	Mixed model
Definition	Emotional abilities	Personality traits	Emotional abilities and

	perceive emotions in self and others understand emotions manage emotions use emotions to enhance reasoning		personality traits self-awareness social awareness self-management relationship management
Authors	Mayer, Salovey, Caruso	Bar-On	Goleman
Origen	Cognitive-psychology	Community health	Organizational development
Instrument	MSCEIT	EQ-i	Emotional competency inventory

Review of Literature

Emotional Intelligence Background

Emotional intelligence has been a growing topic in the literature. Researchers continue to explore this concept since it has been associated with not only academic but also the professional success. A search of the literature revealed an increased in the scientific study of emotional intelligence since 1990s. The work of Mayer, Salovey, and Caruso (2016) has been recognized as the beginning stages of the evolution of emotional intelligence. These researchers identified emotional intelligence as a group of emotional abilities. In the mid-nineties, Reuven Bar-On introduced a new phenomenon called Emotional Quotient that defined emotional intelligence as personality traits (Ahmad, 2010). The work of Goleman advanced this concept by taking emotional intelligence to a

new level. Dr. Goleman identified emotional intelligence as a combination of both emotional abilities and personality characteristics (Christie et al., 2007).

Leadership

The value of emotional intelligence has become apparent through scientific knowledge. It is essential to note that an abundant amount of research has explored the application of emotional intelligence into the role and responsibilities of effective leaders. Emerging studies have recognized emotional intelligence as critical component in the practice of active and influential leaders (Boyatzis, 2011; Brett, Behfar, & Kern, 2006; Clawson, 2012; Goleman, 2000; Lam & O'Higgins, 2012; Pierro, Raven, Amato, & Belanger, 2012; Sadri, 2012). The work of Goleman et al. (2013) has established positive correlations between the neuroanatomy of effective leaders and the four competencies of emotional intelligence. These researchers demonstrated that leaders with high levels of self-awareness are in tune with their values, goals, dreams, motivations, and think things through instead of acting impulsively. Furthermore, they can enhance positive moods, suppress negative emotions such as frustration, and trust their gut feeling. Goleman et al. (2013) associated these qualities with the proper functioning of areas of the left prefrontal lobe of the brain as well as the basal ganglia and amygdala where memories related to emotions are saved.

Self-management consists of the ability to control one's emotions and not let emotions, especially negative ones such as anger, anxiety, frustration or panic control our actions (Goleman, 2000). According to the neuroanatomy analysis of leadership, the abilities associated with self-management are controlled by the activities of the left side

pre-frontal cortex and the amygdala. A brain scan of someone unable to control negative emotions was utilized to validate this principle (Goleman et al., 2013). The images illustrated an abnormal overactivity between the right prefrontal cortex and the amygdala. The authors further expanded on how this overactivity interferes with the ability to focus and resonate positive energy. (Goleman et al., 2013). Social awareness also identified by Goleman et al., (2013) as empathy and relationship management are the last two competencies of emotional intelligence associated with the neuroanatomy of leadership phenomenon. These competencies refer to the ability to establish an interpersonal open loop for emotions and the art of managing relationships stems from neurons in extended circuitry connected to and in the amygdala, which read people's facial expressions, voices, as well as body languages (Goleman et al., 2013). These neurons fire messages continuously that allow us to interpret not only the feelings of others but also guide our next actions (Goleman et al., 2013). Evidently, this neural attunement is vital to the role of effective leaders.

Similarities have been found in the behaviors of both emergency room nurses and effective leaders. Montague, Wright, Harlin, & Hughes (2010) indicated that prioritization, critical thinking, and conflict management are essential skills observed in successful leaders. Because of the extensive workloads and extensive responsibilities of emergency care providers, prioritization of tasks, collaboration with other health care care professionals, coordination of care, and negotiation with patients and families are critical to the emergency nursing practice. It is apparent that the practice of emergency room nurses can be associated with the neuroanatomy analysis of effective leaders and

the four competencies of emotional intelligence identified by Goleman et al., (2013). Therefore, the self-awareness, social awareness, self-management and relationship management of the emergency room nurses can influence the leadership component of the emergency nursing practice.

Academic and Professional Success

Substantial evidence has demonstrated the relationship between levels of emotional intelligence and academic as well as professional success. Romanelli et al. (2006) conducted a meta-analysis to explore this correlation. A total of eight emotional intelligence traits were included in this meta-analysis. The authors concluded that despite the potential limitations associated with the different operational definitions of emotional intelligence the positive correlations between these variables were apparent (Romanelli et al., 2006). They identified essentials components of emotional intelligence including trustful relationships, empathy, management of emotions, adaptability to change, as well as self-awareness critical to both academic and professional success.

Similar findings resulted from the work of Benson, Ploeg, and Brown (2010) as well as Parnell and Onge (2015). These researchers examined the associations of this concept and the academic success of baccalaureate nursing students as well as safe clinical practices. The authors found statistically significant results in the emotional intelligence scores and the student's interpersonal skills, stress coping skills, conflict management abilities, and their overall clinical performance (Benson, Ploeg, & Brown, 2010; Parnell & Onge, 2015). Furthermore, these research inquiries supported the need to incorporate the concept of emotional intelligence into the undergraduate nursing

curriculums as well as into the practices of clinical nurses. Additionally, Rankin (2013) conducted a quantitative inquiry to examine predictive relationships between emotional intelligence and three outcomes on an undergraduate nursing program. Although the author reported some limitations associated with the self-assessment tool of emotional intelligence, the results of the study validated associations between this concept and the clinical practice performance, student retention, as well as student's academic success (Rankin, 2013).

Emotional Intelligence and Nursing Practice

Nursing is a profession that continues to advance based on the application of new scientific evidence. The Institute of Medicine (2010) revealed in one of their consensus reports the importance of evolving the role of the registered nurse to meet the demands of a complex health care system (2010). Improving patient safety by promoting high-quality nursing care is still a priority for the nursing profession. Different variables including nursing quality indicators, nurse/patient relationship, patient satisfaction, and the overall patient outcomes have been utilized by researchers to define high-quality nursing care. These variables have also been used to explore the concept of emotional intelligence in the nursing practice. It is clear how scientific researchers have established positive correlations between the quality of nursing practice and the nurse's levels of emotional intelligence (Adams & Isleler, 2014; Codier et al., 2013; Hess & Baciagalupo, 2011; Kooker, Shoultz, & Codier, 2007; Winship, 2010). Kooker, Shoultz, and Codier (2007) argued that essential elements of high-quality nursing practice such as autonomy,

accountability, mentoring, collegiality, and activisms are also attributes associated with the concept of emotional intelligence.

Codier, Frietas, and Muneno (2013), as well as Hogan et al. (2015), described the importance of the relationship between nurses and patients as well as how this connection can influence the overall patient care. The authors supported their point of views by explaining how the nurse/ patient relationship relies heavily on the nurse's ability to perceive emotions in self and others, understand feelings, manage emotions, as well as the use of emotions to facilitate reasoning (Codier et al., 2013; Hogan et al., 2015). Parallel findings were reported in a research study conducted by Codier et al. (2009). The authors illustrated how the clinical performance of the nurses and staff retention depend on the health care professional's capabilities to identify emotions, comprehend emotions, control their emotions, as well as to use feelings in a way that enhances critical thinking (Codier et al., 2009). It is essential to note that the conceptual components utilized in all these studies correlate with those employed in the Four-Branch Model of Emotional Intelligence (Mayer et al., 2016). Additional elements essential to the nursing practice include teamwork, effective conflict and stress management skills, problem-solving skills, critical thinking, job satisfaction, as well as staff retentions. Researchers have identified strong connections between these components and the provider's emotional intelligence (Quoidbach & Hansenne, 2007; Winship, 2010).

Emotional intelligence and emergency nursing. It is apparent that substantial scientific evidence has validated the significant role that emotional intelligence plays in the clinical practice of professional nurses; however, researchers continue to argue the

need to enhance and promote this concept, especially in complex clinical settings (Holbery, 2015). Hogan et al., (2015) and Bailey et al., (2011) utilized a descriptive interpretative approach to expose the emergency room nurse's perception of their clinical experiences and management of emotions when caring for patients at the end of life. The authors described not only the level of complexity involved in emergency nursing and the expectations of the role but also the importance and necessity to utilize emotional intelligence skills in this clinical environment (Hogan et al., 2015; Bailey et al., 2011).

A similar study was conducted by Matney, Staggers, and Clark (2016) to understand the meaning of practicing with wisdom in the emergency nursing practice. New insights into the study of emotional intelligence resulted from this research inquiry. The authors recognized emotional intelligence as a vital element in the practice of emergency room nurses as well as the opportunities to increase the use of this concept (Matney, Staggers, & Clark, 2016). The appropriate management of behavioral health patient in the emergency department has been associated with the nurse's levels of emotional intelligence. The work of Carmona-Navarro and Pichardo-Martinez (2012) confirmed not only the limited use of emotional intelligence skills among emergency care professionals when caring for patients with psychiatric emergencies but also the negative impact that inadequate emergency care has on the overall outcome of these patients. Additionally, the researchers identified the lack of evidence investigating the need to promote emotional intelligence among emergency care professionals (Carmona-Navarro & Pichardo-Martinez, 2012).

Although the application of emotional intelligence in emergency nursing is an evolving topic, a significant body of research had established strong correlations between this concept and the clinical performance of emergency care professionals. Codier and Codier (2015) utilized a qualitative approach to demonstrate the positive influence that the four branches of emotional intelligence developed by Mayer, Salovey, and Caruso has in the emergency nursing practice. The different themes resulted from the data analysis process validated how the patient care can be improved using emotional intelligence and the need to incorporate this concept as a core competency for the clinical staff of the emergency department. Furthermore, the researchers recognized that understanding the emergency room nurses' perception of emotional intelligence is critical; however, they validated the lack of scientific evidence exploring this phenomenon (Codier & Codier, 2015).

Summary and Conclusions

Emotional intelligence is a concept that has been recently examined; nevertheless, it has captivated the interest of researchers from several disciplines. This concept has been perceived in the literature as the predictor of academic as well as professional success (Ploeg, & Brown, 2010; Parnell & Onge, 2015; Rankin, 2013; Romanelli et al., 2006). The study of emotional intelligence started with the work of Mayer, Salovey, and Caruso in the early 1990s. The authors defined emotional intelligence as a group of emotional abilities. The Ability Model of Emotional Intelligence also known as the Four-branch Model of Emotional Intelligence was developed to expand further this definition (Mayer et al., 2002). A few years later, Dr. Bar-On presented a new phenomenon called

Emotional Quotient which was also associated with the concept of emotional intelligence (Winship, 2010). Dr. Bar-On viewed emotional intelligence as a set of personality traits essential to the physiological and psychological wellness. In the mid-1990s, Goleman advanced the concept of emotional intelligence a step further. He presented this concept as a combination of both emotional abilities and personality traits (Goleman, 2000). Goleman believed that emotional intelligence could be learned, developed, and refined with practice (Goleman et al., 2013). It is essential to note that Goleman's view of emotional intelligence has been explored at the organizational or cooperate level while the Four-branch Model of Emotional Intelligence has been effectively employed to examine this concept in acute care settings extensively (Mayer et al., 2016).

A significant body of evidence has demonstrated the role of emotional intelligence in the nursing practice. High levels of emotional intelligence have been associated with the clinical team's abilities to work collaboratively and to manage conflicts effectively (Codier & Codier, 2015; Holbery, 2015; Quoidbach, & Hansenne, 2007; Winship, 2010). Other themes that link this concept with good nursing practices have emerged recently. Researchers have found that the clinical nurses who demonstrated some level of emotional intelligence were able to influence the nursing quality indicators positively, engage in meaningful relationships with patients and families, as well as assume leadership roles to assure patient safety (Adams & Iseler, 2014; Bailey et al., 2011; Hogan et al., 2015; Parnell & Onge, 2015). Furthermore, additional scientific data has correlated emotional intelligence with job satisfaction, high rate of clinical staff retention, and low level of staff burnout (Quoidbach & Hansenne, 2007; Winship, 2010).

Despite the substantial body of evidence supporting the role of emotional intelligence in the delivery of high quality nursing care, researchers have found opportunities to promote and enhance the use of this concept, particularly in highly complex clinical setting such as the emergency departments (Bailey et al., Carmona-Navarro & Pichardo-Martinez, 2012; Codier & Codier, 2015; Hogan et al., 2015; Holbery, 2015). Codier & Codier (2015) suggested incorporating this concept as a core competency for emergency care providers through educational activities and training programs. The authors explain that to effectively integrate the concept of emotional intelligence into the emergency room educational curriculums, assessing the emergency room nurse's understanding of this concept is critical. Interesting, a comprehensive evaluation of the literature demonstrates insufficient scientific research explaining the emergency room nurse's perception of emotional intelligence (Bailey et al., Carmona-Navarro & Pichardo-Martinez, 2012; Codier & Codier, 2015; Hogan et al., 2015; Holbery, 2015). It is essential to know that this gap in knowledge has been identified as a priority for future research to develop appropriate and meaningful training programs (Bailey et al., 2011; Codier & Codier, 2015; Hogan et al., 2015; Holbery, 2015, Scott, 2015).

This qualitative study addresses the lack of research exposing the emergency room nurse's perception of emotional intelligence with the intent to improve the quality of care delivered to patients in the emergency department and improve the satisfaction of emergency room nurses. The data was collected through semi-structured interview sessions giving the emergency room nurses time to reflect on the meaning of emotional

intelligence through their clinical experiences. The results from this qualitative inquiry can have a potential impact on the quality of nursing care with emotional intelligence skills and can also provide new insights into the overall scientific application of this concept to evolve the nursing profession.

Chapter 3: Research Method

This qualitative study aimed to identify the emergency room nurses' understanding of the concept of emotional intelligence. The data was collected utilizing face-to-face standardized open-ended interview sessions with no more than twenty-five participants or until saturation of the data is achieved. Emergency room nurses from two facilities that work thirty-six hours per week or more served as the participants in the study. The study was conducted following the parameters and requirements of Walden University Institution Review Board as well as the Institutional Review Board of the partner organizations to assure an ethical research inquiry and to guarantee the protection of the participants. Chapter three is divided into five main sections including the research design and rationale, the role of the researchers, methodology, issues of trustworthiness, and summary.

Research Design and Rationale

This section is structured following two components: research questions and phenomenological research design rationale.

Research Questions

The purpose of this study was to identify the emergency room nurse’s perception of emotional intelligence with the intent to provide an understanding of the limited use of this concept among health care professionals working in the emergency department. A central research question and four subquestions were addressed using a phenomenological research approach. It is essential to note that the four subquestions were constructed following the Four-branch Model of Emotional Intelligence by Mayer,

Salovey, and Caruso. The general question is: What is the emergency room nurse's understanding of emotional intelligence?

1.According to the emergency room nurses' interpretation of their clinical experiences, what evidence demonstrates the existence of emotional intelligence based on the nurse's ability to perceive emotions in self and others?

2.According to the emergency room nurses' interpretation of their clinical experiences, what evidence demonstrates the existence of emotional intelligence based on the nurses' ability to understand emotions?

3.According to the emergency room nurses' interpretation of their clinical experiences, what evidence demonstrates the existence of emotional intelligence based on the nurses' ability to control or manage emotions?

4.According to the emergency room nurses' interpretation of their clinical experiences, what evidence demonstrates the existence of emotional intelligence based on the nurses' ability to use emotions to enhance reasoning?

Phenomenological Research Design and Rationales

Multiple research designs were considered to address the research questions. The decision of the research design used in this inquiry was based on the relationship among the different research components such as the purpose of the study, phenomenon of interest, research questions, as well as my philosophical standpoint. The use of a quantitative approach was the first research design considered for this study. Creswell (2009) explained that a quantitative research inquiry uses an objective approach to examine relationships among variables. These variables can be measured using

instruments, and the numerical data is typically analyzed utilizing statistical procedures (Creswell, 2009). It is important to note that this type of study uses a deductive method to test theories, validate assumptions, and prove hypotheses. Furthermore, quantitative researchers use a positivism/ post-positivism lens to develop and conduct quantitative studies (Creswell, 2009). The mixed method was another research design considered in this research. This type of inquiry uses a combination of both quantitative and qualitative forms. Researchers include subjective and objective data to explore research questions (Creswell, 2009).

On the other hand, a qualitative research approach uses a subjective strategy to identify and explore the meaning that people provide to the world based on lived experiences, social interactions, and relationships (Patton, 2015). The work of Ravitch and Carl (2016) explained how qualitative research is a set of sophisticated interpretative practices that provide meaning to numeric data or statistical analysis. Therefore, to answer my research questions accurately, the use of a qualitative research approach was necessary. Qualitative researchers, as the primary investigator in the study, have the opportunity to collect the data through the interpretation of documents, observations, and the analysis of open-ended interview questions. This approach allows qualitative investigators to capture the essence of people's experiences while utilizing an inductive method to provide clarity to the unexplored phenomenon (Patton, 2015). Furthermore, qualitative researchers demonstrate a constructivist perspective which supports their assumptions about understanding the uniqueness of individuals and how the meaning that

people provide to the world is shaped by multiple factors such as society and traditional construction (Creswell, 2009).

Clearly, a qualitative inquiry is the research design that explicitly provided answers to my research questions. Besides, it was congruent with the research components of my study including the purpose, research problem, the population of interest, conceptual framework, as well as the identified gaps (Maxwell, 2005). Seemingly, a subjective approach was necessary to determine the emergency room nurse's perception of emotional intelligence. The information revealed by qualitative data illuminated and exposed the meaning that the emergency room nurses attach to their clinical experiences. The analysis and reflection of the nurses' stories gave me the opportunity to understand their perspectives on not only the meaning of emotional intelligence but also the importance and connection of this concept to the emergency nursing practice (Patton, 2015). Another critical contribution of this qualitative inquiry included the identification of unanticipated consequences. For instance, the open-ended field work of the qualitative data sources such as interview sessions gave me the opportunity to recognize unintended information that provided clarity to the limited use of emotional intelligence skills in the practice of registered nurses working in the emergency department.

A total of five qualitative inquiry paradigms were examined for this study. Ethnography was the first method of qualitative inquiry considered. Ethnographic research studies focus on the study of cultural groups in their natural settings over a period of time. The work of ethnographic researchers assumes that any group of people

that work together, over time evolve to a culture (Creswell, 2009; Patton, 2015). This qualitative strategy is employed when the lived reality of cultural groups is the topic of research. Grounded theory was the next approach considered for my qualitative study. This type of paradigm is utilized when the goal of the researcher is to generate theories from the data rather than test theory (Patton, 2015). The case study paradigm was also analyzed as a potential strategy to conduct this qualitative inquiry. Creswell (2009) explained that in this type of approach the researchers explore a program, an event, or an activity over a sustained period of time. The narrative research approach was also measured as one of the five qualitative strategies for the study. Patton (2015) explained that narrative studies center on individual's storied experiences. In this type of paradigm, the researchers focus on examining humans lived experiences through stories. It is essential to note that in this particular qualitative inquiry, the researcher values people's stories as a central and valid data source. The final product of narrative research is the combination of both the participant's point of views and the researcher interpretation of the stories (Creswell, 2009).

The phenomenological paradigm was not only the last qualitative tactics considered in the study, but the approach used in this research. This qualitative technique concentrates on providing a comprehensive description of phenomena based on the participant's interpretations of lived experiences (Creswell, 2009; Ravitch & Carl, 2016). The interest of phenomenological researchers is to identify and understand phenomena through how individuals perceive them. In this case, the researchers compare the essences of shared experiences while staying as close to the data as possible (Ravitch & Carl,

2016). Patton (2015) attributed the origin of the phenomenological research paradigm to the work of Edmund H. Husserl in the early ninety-hundreds. This German philosopher intended to determine how people perceive and describe things through their senses (Patton, 2015, p. 116). His philosophical assumption stated that people make sense of the world based on the essence and meaning constructed from their interpretation of lived experiences. The concept of transcendental phenomenological reduction, a key epistemological strategy of phenomenology, was one of the contributions of Dr. Husserl to the world of qualitative research (Dowling, 2007).

Transcendental phenomenological reduction

This type of phenomenological strategy has served as a rigorous framework for numerous phenomenological studies. It values the concrete thinking behind every lived experience. Dr. Husserl believed in the importance of separating any ideology that is influenced by factors such as personal biases, perceptions, assumptions, past skills, as well as cultural context to uncover the true meaning of the experience or the phenomena being explored (Gros, 2017). In other words, he believed in the immediate pre-reflective consciousness of life (Dowling, 2007). It is apparent that the principles behind the transcendental phenomenology indicate that before explanations and assumptions are formed of a phenomenon, understanding the event from within is critical.

As stated previously, my study intended to identify the emergency room nurse's perception of emotional intelligence. To gain a deeper understanding of the nature and the essential features of the limited use of emotional intelligence, the emergency nurse's clinical experiences were explored to capture how these professionals describe their

understanding of this concept through their nursing practices. Emphasis was provided to the participants' positive and negative emotions, how they managed their emotions, used their emotions to enhance reasoning, as well as relationships. It is essential to note that the essences of these experiences were bracketed, studied, and compared to find commonalities. A phenomenological reduction process free from variation was followed. This process consists of allowing the concrete essences of the participant's experiences to reveal the meaning of the stories by withholding or separating both the participants as well as my presuppositions, assumptions, theories, and previous experiences from the collection and interpretation of the data (Dowling, 2007).

Role of the Researcher

As the primary investigators in qualitative studies, the role of the researchers is critical. Qualitative researchers are responsible for the construction, understanding, and implementation of the investigation (Ravitch & Carl, 2016). In other words, they identify the research problem, select an appropriate research methodology, collect, and analyze the data. The selection of a qualitative research design and a conceptual framework that are consistent with the research components are also part of the role of qualitative researchers (Patton, 2015; Ravitch & Carl, 2016). It is essential to note that the researchers' positionality, experiences, beliefs, assumptions, working epistemologies, biases, and their overall viewpoints have a direct influence on how they visualize and plan their study. Maxwell (2005) identified two components essential to the role of the researchers. These components include the researcher's positionality and social location. Positionality consists of the researcher's roles and relationships that occur between the

investigator and the participants that can influence any aspect of the research process. The researcher social location refers to the researcher's identifier markers such as gender, race, culture, as well as the national origin that can potentially impact the overall study (Ravitch & Carl, 2016).

In my study, as the primary investigator, I served as the observer-participant during the in-depth interviews. I not only designed and conducted the investigation, but also, I was responsible for analyzing, interpreting the data, as well as reporting the results including the recommendations for future inquiries. The principle of epoche guided my role as the primary investigator to adhere to the epistemological assumptions of transcendental phenomenology analysis. Patton (2015) identified epoche as a fundamental step of the phenomenological research. Epoche is a Greek word that indicates to refrain from judgment or preconceived perceptions (Patton, 2015, p. 575). Gaining clarity of my presumptions, becoming aware of my prejudices, and controlling my biases to eliminate personal involvement in the subjective materials of my study gave me the opportunity to prevent premature or imposed meaning to the data as well as conduct the research with open viewpoints (Patton, 2015). Strategies that was employed to achieve epoche include a systematic reflection of my subjectivities using analytical or reflective memos as well as dialogic engagement sessions with members of my dissertation committee (Ravitch & Carl, 2016).

I do not have a personal or professional relationship with the participants that may involve power over them to influence their decision to participate in the study. The participants were recruited according to the inclusion criteria of my research. Two

strategies were prosed in the original plan. One was to have centralized scheduling send an email to the emergency room nurses from both facilities. The other strategy was to use the snowball sampling method to recruit the rest of my population.

Methodology

The methodology section of this chapter is organized based on the following subcategories: participant selection logic, sampling strategy, instrumentation, procedures for recruitment, participation, and data collection, as well as the data analysis plan.

Participant Selection

The plan for the study was to include six to twelve emergency room nurses from two community hospitals in a suburban area of South Jersey. The inclusion and exclusion criteria were guided by the recommendations of the Emergency Nurses Associations. The emergency departments are divided into several clinical sections to optimize not only the clinical resources but also to assure the delivery of high-quality care to patients and families. It is essential to note that variables such as the patient's acuity level, chief complain, symptomatology, the number of resources required to safely treat the patient's medical emergencies, as well as the age and developmental stages influence their flow through these areas. Examples of the clinical zones within the emergency department include behavioral health or crisis division, pediatrics, FastTrack also known as prompt care or express care, cardiac, gerontology, triage, as well as critical zone or code area (Emergency Nurses Associations, 2011). Various set of skills are necessary to practice effectively in all areas of the emergency department. It is essential to note that these clinical divisions can vary based on the clinical services offered by the facilities.

According to the Emergency Nursing Scope and Standards of Practice developed by the Emergency Nurses Associations (2011) to assure safe practices in the emergency department, a combination of both training and clinical experience is essential. This organization recommends a minimum of one year of practice before emergency room nurses get to rotate through all clinical areas within the department. This recommendation guided both the inclusion and exclusion criteria of my study. With the intent to capture diversity in the clinical experiences among the emergency room nurses, my inclusion criteria consist of registered nurses working thirty-six hours or more per week in direct patient care, a minimum of one year and up to ten years of practice in the emergency care environment. I did not consider the participant's gender, age, race, or cultural differences since this could potentially limit the size of my population. My exclusion criteria include nurses with less than one year of experience, those who work less than thirty-six hours per week, and nurses who have any type of leadership responsibilities such as nurse managers, assistant nurse managers, as well as clinical educators. According to the Emergency Nurses Association (2011), emergency nurse leaders are required to receive numerous of leadership training programs. It is important to note that substantial scientific evidence supports the use of emotional intelligence principles in the training programs of nurse leaders (Akila & Thangavel, 2013; Boyatzis, 2011; Hess & Bacigalupo, 2011; Lam & Higgins, 2012; Sadri, 2012).

Sampling Strategy

A purposive sampling technique was used to select the participants that could provide information-rich stories with the intent to answer my research questions. Ravitch

and Carl (2016) defined purposive sampling as a useful sampling method that gives qualitative researchers the opportunity to choose interviewees purposefully based on specific reasons such as living in a particular geographical location, having specific knowledge of a phenomenon, or an absolute experience. The original plan for the study include the use of snowball or chain sampling to select most of my participants. This strategy starts by asking the first few interviewees for recommendations about who has different or similar point of views that could be a good source given the focus of inquiry (Patton, 2015). Two referrals were going to be asked to the first two interviewees and four in my second interview session. The references were going to be multiplied by two until reaching six to twelve participants or saturation of the data.

Scientific studies have identified reaching saturation of the data as a definitive point in the sample size of qualitative inquiries. Different definitions of data saturation have been utilized through the years by qualitative researchers. Mason (2010) examined a wide range of qualitative investigations to not only define data saturation but also identify factors that influence this concept. The author concluded that data saturation is obtained when new information fails to provide contributions to the overall story, model, or theory (Mason, 2010). According to Mason's work, phenomenological researchers reach data saturation between the fifth and twenty-fifth interview. He concluded that factors such as the complexity of the research questions, the researcher's understanding of data saturation, as well as the time allotted for the study influence the saturation of the data. Similar results were reported by Bunce and Johnson (2006) who suggested that data saturation is reached in a phenomenological study usually between the sixth and the

twelve interviews. The authors explained that qualitative researchers reach data saturation when the information revealed by the interview sessions fails to continue to demonstrate recurring patterns and concepts or when the data is sufficient to answer all components of the research questions (Bunce & Johnson, 2006).

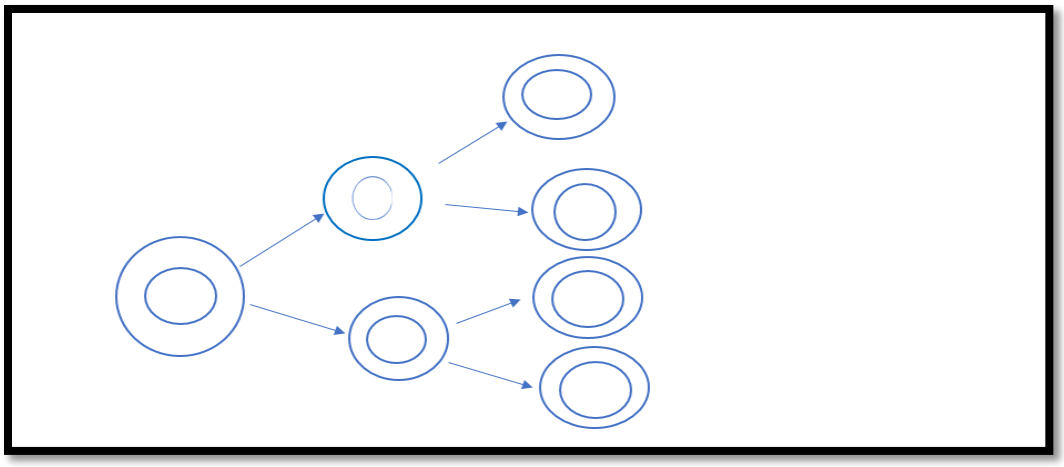

Figure 1. Snowball sampling strategy.

Instrumentation

The primary instrument of data collection consisted of in-depth semi-structured interviews. Semi-structured interviews are utilized when the researcher has a specific topic of inquiry, prepares a set of questions in advance, as well as follow-up questions (Rubin & Rubin, 2012). The standardized open-ended interview approach was employed in the semi-structured interview sessions. According to Patton (2015), this interview design consists of a group of well-structured questions strategically developed by the investigator with the intent to take each interviewee through the same sequence of items and the same experience. Although the flexibility with the use of probing is somewhat limited in this approach, the researchers utilize open-ended questions to allow the

participants express as many details as desired when describing their experiences (Turner, 2010). The interviews were recorded for transcription and data analysis. Field notes and reflective memos supplemented the information provided by the participants.

An interview guide containing six questions and the interview protocol were utilized in each session (Appendix D). The interview protocol included the interview process, purpose, duration, closing statement, informed consent, my contact information, as well as an explanation of the member checking part of the data analysis. The participant's privacy, as well as the confidentiality of the data, were also part of the interview protocol. The six interview questions were developed to answer the central research question as well as the four subquestions. It is essential to note that the questions included in the interview guide were in alignment with the theoretical framework of the study. In other words, every question represented a different branch or conceptual principle included in the Four-branch Model of Emotional Intelligence (Mayer et al., 2016).

Procedure for Recruitment, Participation, and Data Collection

After receiving the approval from the Intuitional Review Board of both the health care care organizations with the number (201805312JX-RMC) and Walden University with the number (06-14-18-0657391), the recruitment process was initiated. The names and email addresses of the potential participants were obtained from the centralized staffing department. The original plan was to have the centralized staffing department of both organizations send an email containing three screening questions, a brief explanation of the purpose of the study, as well as my contact information to two nurses from the

emergency department of each facility. The nurses who would like to participate in the study were going to reply to this email with the answers to the three screening questions. It is important to note that this email recruiting the first two participants was going to be sent until the participation of two interviewees was secured. If a response from a potential participant who did not meet the inclusion criteria was received, a message recognizing their interest and time was going to be conveyed. Once a response from the participant is received, an email confirming their participation was going to be sent. In this email, I would ask for their contact information to arrange the interview session, verify their answers to the three screening questions, and answer any questions that might raise. Chapter four describe the variation to this original plan.

The interviews took place in a meeting room of each facility. The rooms were reserved for two hours for every interview session to assure not only the privacy and confidentiality of the participants but also prevent interruptions or distractions during the interviews. The potential participants were given the opportunity to select the time of the meeting. All participant's point of view and experiences were included without discrimination or biases.

The interviews took approximately thirty to forty-five minutes. During the first five minutes of the interview, I explained the purpose, process, and permission to record the interview. Information associated with the privacy and confidentially of the study such as the potential use of pseudonym names was also included. Also, I restated that the participation in the study is voluntary and no consequences or penalties will be applied if the participant decides to terminate their participation in the study at any point. The

informed consent was explained, and a copy of this signed document was provided to the participants (Appendix C). All information related to the interview sessions is kept in a locked cabinet located in my personal office. It is important to note that a combination code which I created and maintain privately to open this cabinet is needed. The interview session proceeded with a fundamental question with the intent to build a trustful relationship with the participant (Jacob & Furgerson, 2012). The following questions requested information associated with the four subquestions of my study based on the theoretical framework (Jacob & Furgerson, 2012). Each question asked the nurses to describe an element of emotional intelligence based on their clinical experiences while working in the emergency department. Probes and follow-up questions were used throughout the interview when appropriate.

At the conclusion of the interview, I thanked the interviewee for their participation. I asked for permission to contact them if clarification of the data is needed Furthermore, I provided a brief explanation about the member checking component of the data analysis and the role of the participants when reviewing the finding for accuracy. Finally, I offered to answer any questions, explain the transcription process, and volunteered to share a copy of the transcription if desired by the participants.

Data Analysis Plan

A professional transcriptionist transcribed the recorded interviews. A signed confidentiality agreement was completed before the professional transcriptionist had access to the recorded data (Appendix D). A meeting with the transcriptionist was arranged to complete this step. Thematic analysis was utilized to examine the data. The

Colaizzi's Method of data analysis served as a guide to complete the data analysis plan. It is essential to note that this type of data analysis method relies on the manual coding abilities of the researcher (Valle & King, 1978). Although manual coding is a vigorous and time-consuming process that requires dedication and commitment from the researcher, it provides a significant contribution to the data analysis process. The continuous revision, interpretation, and reflection of the data give the investigator the opportunity to construct new insights into the phenomenon under investigation (Saldana, 2016). Furthermore, the constant manipulation of repeated phrases and words allowed me to have control and ownership of my work. I conducted several cycles of manual coding while using the Microsoft Word program. The different codes and emerged themes were color-coded to facilitate both the organization and interpretation of findings. The final themes were placed in a matrix or table to allow clear visualization of the analyzed data. The interview guide was utilized to help organize the different manual coding cycles.

The seven steps identified in Colaizzi's Analytical Method will was utilized to evaluate the data. As previously stated these steps depend on the manual coding abilities of the researcher (Curtis, Hook, Davis, Van Tongeren, Shannonhouse, DeBlaere, Ranter, & Cuthbert, 2017; Valle & King, 1978). The first step of Colaizzi's Data Analysis process includes a meticulous review of all interview transcripts and protocols to gain an idea of the participant's narratives (Valle & King, 1978). The second step involves rereading each transcript to extract significant statements. Curtis et al., (2017) define significant statements as sentences or phrases related to the phenomenon of interest. In

my study, this step focused on the organization of the comments made by the emergency room nurses that were associated with the concept of emotional intelligence.

The third step of Colaizzi's method involves the transformation of significant statements into formulated meaning units (Abalos, Rivera, Locsin, & Schoenhofer, 2016). To complete this section an in-depth description of each significant statement was included with the intent to identify the hidden meanings in the data. In this step is when the researcher utilizes creative insights to go beyond what is provided in the original data and at the same time maintain the connection with the original transcription (Valle & King, 1978). Each formulated meaning received a number and a color to facilitate the next step. The fourth step consisted of organizing the formulated meanings into clusters of themes that were frequently used in the transcriptions of every interview (Dimer & Ercan, 2017). The principles of emotional intelligence identify in the Fourth-branch Model of Emotional Intelligence was utilized as a guide to group the clusters of themes. These principles include the nurses' ability to identify emotions, understand emotions, use emotions to enhance reasoning, as well as manage emotions (Mayer et al., 2016). It is essential to note that the clusters of themes were utilized as the central themes of the study. The fifth and six steps of Colaizzi's method consisted of integrating the results into a thorough explanation of the phenomenon being explored and developing an exhaustive description with the intent to identify its fundamental structures (Abalos et al., 2016). The final step was associated with the validation of the findings. To complete this step, a copy of the descriptions of the clusters and themes was email to the participants for verification. Also, I asked the participants to include any idea or statement if necessary.

Valley and King (1978) explained that to validate the findings the inclusion of every participant is not required. Therefore, the feedback from one or two participants could be sufficient.

Issues of Trustworthiness

Positivistic researchers have questioned the validity of qualitative inquiries. The quality of qualitative research depends on the researcher's ability to achieve trustworthiness of the data. Ravitch & Carl, (2016) defined trustworthiness as the researcher's way to maintain the data as faithful as possible to the participant's experiences. Four strategies were employed to demonstrate the trustworthiness of this study. These strategies include credibility, transferability, dependability, as well as confirmability (Shelton, 2004).

Credibility

Credibility has been defined as the ability to demonstrate in the study what the study is intended to illustrate. It compares the accuracy of the results with reality (Patton, 2015). Qualitative researchers have employed different techniques to achieve credibility. My study will include three of these strategies. Member checking which consists of a quality control process where the participants are given the opportunity to check the data (Shelton, 2004). The participants in my study received a copy of the themes emerged from the interviews to be reviewed for accuracy. They were asked to compare the words in the document to what they intended to express. The strategy of triangulation was also utilized in my study. This technique consists of the use of different methods to collect the data or the use of a wide range of data sources (Shelton, 2004). To achieve the

triangulation of the data, the information of my study was collected from nurses with different level of experiences, expertise, and from two separate facilities. This approach was utilized with the intent to obtain a variety of perspectives. Another component employed in my study to achieve credibility was the researcher's development of an early familiarity with the culture of both the participants as well as the organizations. To assure my familiarity with these elements, I completed frequent visits to the emergency departments before the data collection process began. I contacted the managers of the departments to schedule my visits at a convenient time.

Transferability

Shelton (2004) described transferability or external validity as the degree to which the study can be applied or transferred to other situations. Transferability can be achieved by providing a thick description of the data. Information crucial to a detailed description of the data includes the number of participants involved in the study, the type of data sources, and data collection methods, as well as the time period that will be used to collect the data (Shelton, 2004). It is apparent that a thick description of the data allows the readers to apply both the data collection source and method used in my study to explore similar phenomena in other clinical environments including but not limited to intensive care units, medical-surgical floors, as well as ambulatory clinical settings.

Dependability

Dependability refers to the stability of the data over time. It focuses on the process of inquiry to assure that the process is logic, documented, and in alignment with the arguments made by the researcher to answer the research questions with the intent to

allow future replications of the study (Pattor, 2015). In my study dependability was reached through a detail description of the research design, implementation, data gathering process, and how these elements were utilized to answer the research questions (Ravitch &Carl, 2016).

Confirmability

According to Patton (2015), the confirmability of the study is reached when the researcher demonstrates that the data and the interpretation of the inquiry are not part of the researcher's imagination rather the actual results of the experiences and ideas of the participants. Shenton (2004) identified strategies such as triangulation, researcher reflexivity processes and external audits as ways to assure the conformability of the data. To guarantee the confirmability of my study, I focused on two strategies: triangulation and reflexivity processes. Reflective memos were completed right after every interview session. These documents included not only detailed documentation of my biases and perceptions but also how these components were controlled in a way that did not influence my data collection and interpretation.

Ethical Procedures

My study required the approval of two Institutional Review Boards. These departments include the health care facilities IRB and Walden University. Once both approvals were granted, I initiated the recruitment process for my participants. The participants were selected in an ethical manner. An email including three screening questions, explanation of the purpose of my study, and my contact information were sent to the nurses from each facility. The original plan was to send this email continuously

until the first two participants form each facility were confirmed. The use of the snowball sampling strategy was also included into the original plan to select the rest of the nurses. The participants were made aware that their involvement in the study was voluntarily, and that they had the option to withdraw from the research or interview at any time with no penalties or consequences. In the case where the participants terminated their cooperation in the study, a card with my contact information was going to be offered as needed. If the participants were noted to be on any emotional discomfort during the interview, an immediate break or termination of the interview session was going to be suggested. The informed consent was obtained before each meeting following the recommendations from both Walden University's Institutional Review Board as well as the Institutional Review Board from the partner organizations.

To assure the privacy of the participants and the confidentiality of the data all information was included and reported anonymously. The participants received pseudonym names during the interview sessions. Identifiers that could potentially reveal the identity of the participants such as name, last name, the name of the institution, as well as details of the participant's clinical experiences were omitted at all times. All items associated with the data including the recording devices and the transcriptions of the interviews were stored inside a lacked cabinet located in my office. Information in electronic form was kept on my personal computer that can only be accessed with my password. It is essential to note that this information was available to members of my dissertation committee if necessary. This data will be kept for five years after the study is completed. After five years, this information will be destroyed. It is essential to note that

although I work for the same health care system as the participants, I do not have a supervisor or instructor position over the emergency room nurses that could influence their participation in the study.

Summary

My study focused on identifying the emergency room nurse's perception of emotional intelligence. A phenomenological research approach was utilized to address my central research question and four subquestions. Researchers have identified this type of strategy as a way to provide a comprehensive description of phenomena based on the participant's interpretations of lived experiences (Creswell, 2009; Ravitch & Carl, 2016). The snowball sampling method also known as chain sampling strategy was included in the original plan of the study to select the participants in my study. The participants consisted of registered nurses working over thirty-six hours or more per week with at least one year of clinical experience and up to ten years in the emergency department. Two community hospitals located in the South East region of the state of New Jersey were used in my study. The participants were recruited until the saturation of the data was reached. According to Bunce and Johnson (2006), data saturation is achieved in phenomenological studies between the six and twelve interview sessions.

Once the IRB approval from Walden University and the health care facilities were received, the selection of the participants, data collection, and analysis process was initiated. The data was collected through in-depth semi-structured interviews while following a standardized open-ended interview approach. The interview sessions consisted of six questions and lasted approximately thirty to forty-five minutes. Ethical

considerations were followed to assure the protection of the participant's privacy and confidentiality. The interviews were recorded for transcription purposes. Manual coding cycles while following the Colaizzi's Method of data analysis was employed. The trustworthiness of the study was validated through the use of four strategies such as credibility, transformability, dependability, as well as conformability. Evidence of the settings, demographics, data collection, data analysis, as well as a detailed description of the results are presented in the following chapter.

Chapter 4: Results

Introduction

This phenomenological research study aims to identify the emergency room nurse's perception of emotional intelligence to gain an understanding of the limited use of this concept in high-risk clinical environments, such as emergency departments. The nurses' understanding of this concept is essential to promote and enhance the use of emotional intelligence with the intent to improve the quality of care provided to patients in emergency rooms. The study addresses one research question and four subquestions. It is essential to note that the research question, as well as the four subquestions, were created based on the theoretical framework of the study. Each subquestion represents one of the four principles of emotional intelligence presented in the Four-branch Model of Emotional Intelligence also known as the Ability Model of Emotional Intelligence.

RQ: What is the emergency room nurse's perception of emotional intelligence?

SQ 1. According to the emergency room nurses' description of their clinical experiences, what evidence demonstrates their ability to perceive emotions in self and others?

SQ 2. According to the emergency room nurses' interpretation of their clinical experiences, what evidence demonstrates their ability to understand emotions?

SQ 3. According to the emergency room nurses' interpretation of their clinical experiences, what evidence demonstrates their ability to control or manage emotions?

SQ 4. According to the emergency room nurses' interpretation of their clinical experiences, what evidence demonstrates their ability to use emotions to enhance reasoning?

Chapter four focused on revealing the results of the study. This chapter is organized based on the following sessions; settings, demographics, data collection and analysis, as well as the trustworthiness of the data.

Setting

The study took place in two acute care facilities located in the Central and South regions of New Jersey. One facility is a 476-bed acute care community hospital located in Red Bank, New Jersey. Red Bank has an estimated population of 12, 206 people as stated in the 2010 United States Census with a median household income of $74,538 a year (2010, United States Census Bureau). The other facility is a 147-bed community hospital located in a town called Holmdel in the central region of the state of New Jersey. According to the United States Census in 2010 the estimated population of Holmdel is 16,773 people with an average annual family income is $159, 633(United States Census Bureau, 2010). It is essential to note that although this town has one of the highest average annual family income in the country, it is surrounded by impoverished communities. Therefore, in addition to serving a wealthy population, this facility serves a high number of vulnerable and financially challenged health care consumers.

Emergency room nurses from both facilities participated in the study. Although the inclusion criteria for all participants were the same, there were some differences among both emergency departments. Some of these differences include the number of emergency room visits, the patient's acuity levels, as well as specialized services available in both facilities. In other words, one emergency room receives over forty-thousand annual patient visits while the other receives twenty-five thousand. One of the

facilities offers multiple specialized services such as neurosurgery, cardiac catheterization, psychiatric care, as well as pediatric care twenty-four hours a day, seven days a week. Therefore, patients experiencing these types of emergencies are often transferred to the hospital that provides those services. It is essential to mention that the patient volume, as well as the services or resources available, have a direct impact on the emergency room nurse's assignments, workload, as well as workflow.

Demographics

Eight emergency room nurses from two different acute care community hospitals participated in the study. Three of the eight participants work in the emergency department of one facility and five in the other. To maintain confidentiality as well as to protect the privacy of the participants, the facilities will be named A and B throughout the study. The letter A represents the facility with higher number of visits and B the other. The study included both males and female participants between the ages of twenty and forty-nine years of age. The participants had different levels of experience as emergency room nurses and as health care providers (Table 2). The data was collected until saturation was apparent including a total of eight interviews over a period of ten weeks.

Table 2

Demographic Data of Sample

Participant	Facility	Gender	Age (years)	Years of experience as ED-RN	Prior clinical experience
1	A	Male	40-49	10 years	10 years
2	A	Female	30-39	6 years	3 years
3	B	Female	40-49	8 years	2 years
4	B	Male	30-39	7 years	2 years
5	A	Female	30-39	5 years	0 years
6	A	Female	30-39	4 years	0 years
7	A	Female	20-29	4 years	2 years
8	B	Male	20-29	3 years	0 years

Population

This phenomenological research study includes eight emergency room registered nurses from two different facilities. Five emergency room nurses work in the community hospital A, and three nurses work in B (Figure 2). The participants were different ages ranging from mid-twenty to forty-nine years old (Figure 3). Although the female nurses dominated the study, three participants were male (Figure 4). The participants had different levels of experience as emergency room nurses. Their experience as registered nurses in the emergency room ranged from three to ten years (Figure 5). The clinical background of the participants before becoming emergency department registered nurses was considered during the data analysis process. Their experiences ranged from none to ten years of clinical experience (Figure 6). Some of the participants worked as patient care assistants, licensed practical nurses, and others as registered nurses in telemetry units.

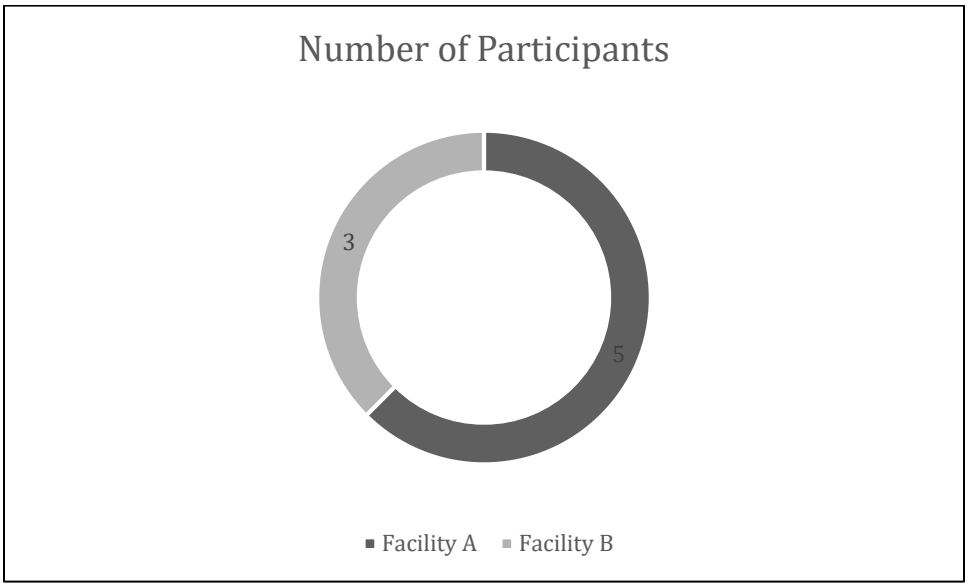

Figure 2. Demographic data: Community hospitals.

Figure 3. Demographic data: Participants' age distribution.

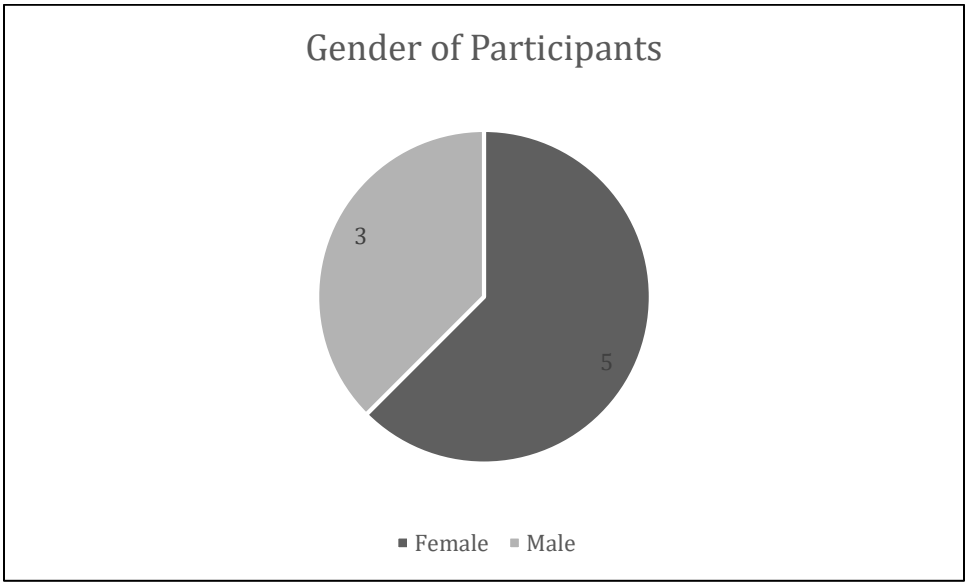

Figure 4. Demographic data: Gender.

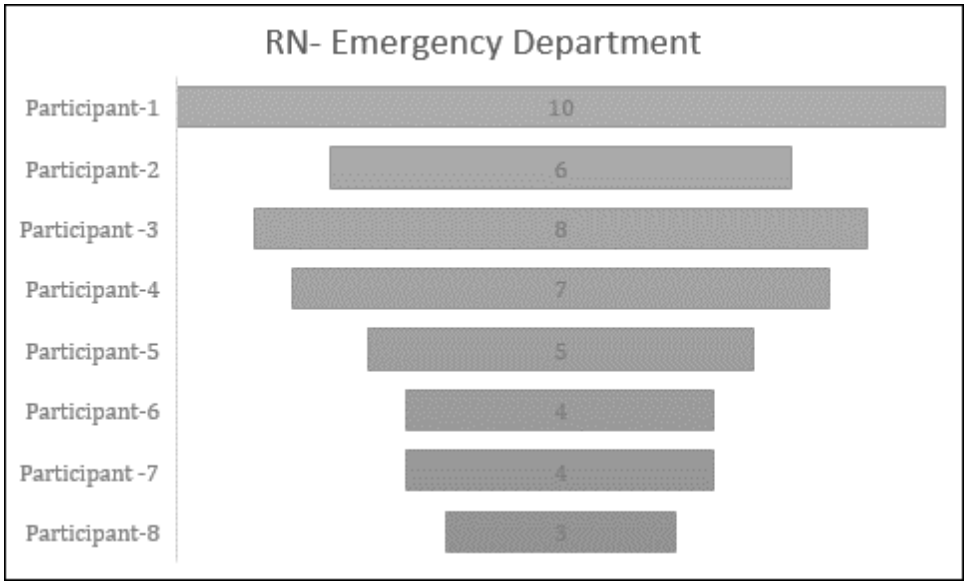

Figure 5. Demographic data: Years of experience as ED- RN.

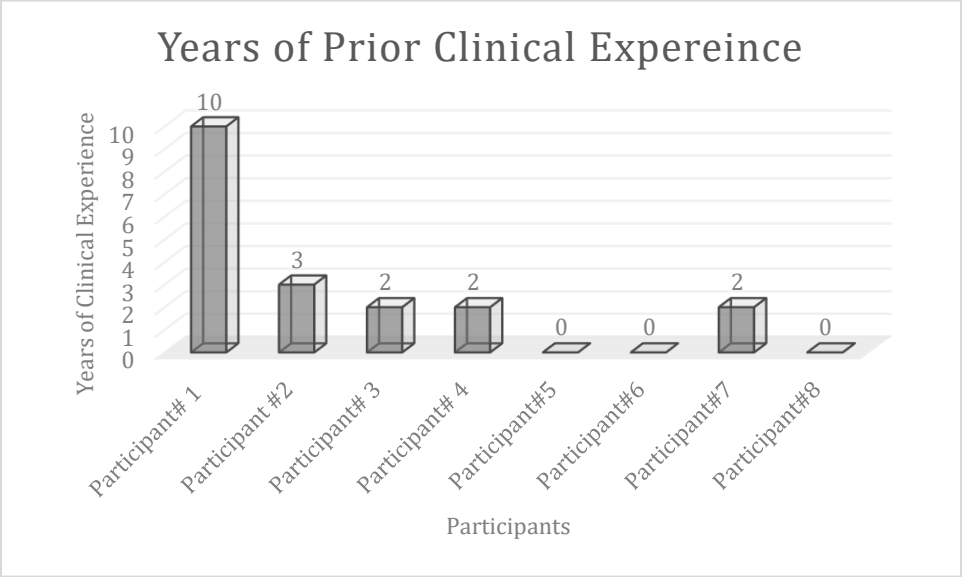

Figure 6. Demographic data: Prior clinical experience.

Data Collection

Eight emergency room registered nurses from two acute care community hospitals located in the central and south region of the state of New Jersey participated in the study. The participants were selected randomly with the purpose of obtaining variety in the data. These nurses were exposed to the same set of interview questions to identify their understanding of the concept of emotional intelligence through their clinical experiences.

Data Collection Process

The recruiting process started immediately after the research request was approved with the following IRB numbers (06-14-18-0657391) and (201805312JX-RMC). Permission to initiate the research was granted by both Walden University IRB and the IRB from the community research partner. An email inviting the emergency room nurses from both facilities was sent by the Centralized Staffing Office. The content of

this email included the purpose of the study, the role of the participants, three screening questions, as well as the researcher's contact information (Appendix A). A total of fourteen emergency room registered nurses responded to the invitation email, only eight participated in the study. Eight nurses answered the invitation email from facility A and six from facility B. Out of the eight nurses from the agency A only five participated. Two of these nurses did not meet the inclusion criteria and one cancelled the participation after rescheduling the interview session several times. A total of six nurses responded to the invitation email from facility B; however, only three participated in the study. One respondent did not meet the inclusion criteria, another did not respond to the interview email, and the third nurse had to cancel the participation due to a personal matter. A thank you email was sent to the emergency room nurses who responded; however, did not meet the inclusion criteria. The recruiting period and interview sessions took a total of ten weeks. The data was being analyzed simultaneously to determine saturation.

After confirming their participation in the study, the potential participants were contacted by the researcher via phone to schedule the face to face semi-structured interviews. During this phone conversation, the participants selected the time of the interviews. All interviews were conducted in a conference room of both facilities. Each interview sessions took between twenty to thirty minutes. The rooms were reserved the day before the interview sessions for two hours. I started each interview session with an introduction, information about the informed consent process, as well as the interview protocol (Appendix B & C). Once informed consent was signed by the participants and information about how their participation in the study was voluntary, I asked for

permission to record the interview session. Before turning on the recording device, the participants were informed that they could terminate their participation in the study at any time with no penalties.

If no questions were asked, I proceeded to the interview session by turning on the recording device. The standardized open-ended interview approach was employed in the semi-structured interview sessions. The purpose of this approach was to take each participant through the same journey of questions. It is important to note that although flexibility with the utilization of probing is limited when using the standardized open-ended interview strategy, it allows the participants express as many details as possible when describing their clinical experiences (Patton, 2015). The first question of the interview requested general information about the professional background of the participants. The purpose of this question was to establish rapport and gain the trust of the interviewee. The following questions were more complex and required some level of analysis and critical thinking. It is important to note that the Four-branch Model of Emotional Intelligence was utilized to develop the interview questions. Each question represents one of the four branches stated in this model (Appendix C). During the interviews, field notes were taken to capture every detail of the conversation. Furthermore, reflective memos were created after every interview as part of the bracketing technique.

All interviews concluded with a closing statement. This session gave me the opportunity to not only thank the participants for their time but also introduce the member check component of the data analysis process. Additionally, my contact

information was once again given to the participants with a copy of their signed informed consent. At this time, I encouraged the participants to feel free to contact me with questions or if they would like to share additional information. The recording device was turned off, and the audio was immediately transferred to my personal computer. This computer requires my own password to access it and is kept in a locked cabinet located in my place of residence.

Variation in the Data Collection

I made a variation from the original plan during the data collections process. I had initially planned to utilize the snowball sampling also known as the chain sampling strategy to recruit the participants. The snowball sampling strategy starts by asking the first interviewee for recommendations about who has a different or similar point of views that could be a good source given the focus of inquiry (Patton, 2015). During the IRB approval application process, this sampling strategy was found to potentially have some ethical issues due to the type of population needed in the study. Therefore, a different sampling strategy was recommended and used in my research. An invitation email was sent to all emergency room nurses of both facilities (Appendix A). The nurses who responded to this email and met the inclusion criteria were included in the study.

Unusual Circumstances Encountered

During the data collection process, I encountered three unexpected situations. All three situations were related to the time of the interview sessions. The interview protocol included six questions. The interview sessions were anticipated to take between thirty to forty-five minutes. This period of time consisted of the time necessary to obtain the

informed consent and conduct the six-question interview (Rubin & Ruben, 2012). Interestingly, twenty minutes was the amount of time needed for the interview sessions. Approximately twenty minutes was the amount of time needed to obtain informed consent from the participants but also go through the interview protocol.

Another unusual situation was associated with one of the participants. This interviewee was going through a family emergency and did not want to reschedule the interview session. The interviewee was waiting for a phone call from a family doctor. This interview session was interrupted six times by phone calls and text messages. I had a difficult time refocusing the interviewee and keeping the flow of the conversation. Despite this unusual circumstance the interview was completed successfully. Another unique situation was a fire alarm that was activated during the third interview. After obtaining the informed consent from the participant and right before turning on the recording device a code red was announced overhead. The sound of the alarm was significantly loud interfering with my conversation with the participant. The sound of the alarm lasted approximately four minutes before it was deactivated. I become concerned about the time that the interviewee had allotted for the interview session. I offered to reschedule the meeting several times. Fortunately, after approximately four minutes the fire alarmed was deactivated by the fire department, and I was able to proceed with the rest of the interview protocol.

Data Analysis

I initiated the data analysis process with the verbatim transcription of the recorded interviews. The Colaizzi's Method of data analysis was used to analysis eight

transcriptions inductively from coded units to categories and themes. The Colaizzi's Method of data analysis consists of seven steps which I followed strictly. It is important to note that although this method of data analysis requires the researcher to perform several coding cycles manually, the word "code" is not included in the descriptions of this method.

Step One: Reading of Protocol

This step consisted of a detailed reading of the eight transcriptions. All documents were read three times to gain a sense of the whole content. In other words, I wanted to not only acquire a feeling for them but also make sense of the information. During this process, any thought, ideas, or feelings that arose as a result of my previous work in the emergency department, were added to a bracketing memo or diary. The use of the bracketing technique helped explore the phenomenon as experienced by the participants by removing my opinion, feelings, beliefs, as well as preconceptions (Gearing, 2004).

Step Two: Significant Statements

The second step consists of the abstraction of significant- statements. The significant statements are defined as phrases or sentences directly about the phenomenon being investigated (Valle & King, 1978). To obtain these phrases I focused on the identification of the human condition as verbs, gerunds, and the participant's own words rather than selecting the topic- based nouns. The significant statements identified were highlighted on each transcription and then transferred to a separate document. The information was organized in a table format. The table consisted of three columns. One column included the significant statements. The next column had the number of the

transcription where the statement was obtained, and the last column included the line number of the transcription for easy reference. Repetitions of significant statements were found among some of the transcripts. All repeated phrases were not included in this document. For instance; some of the repeated phases include “To me, a negative experience is more impactful,” “I tend to remember sad clinical experiences,” “I always think about negative but meaningful clinical experiences.” In this case, the significant statement included in the document was, “negative experiences were identified by the participants”. One hundred and fifty significant statements were abstracted from the eight transcripts.

Step Three: Formulating Meanings

This step gives the researcher the opportunity to engage and be more involved in the data. In other words, the researcher spells out the meaning of each significant statement (Valle & King, 1978). During this step, I was able to leap from what the interviewees said to what they meant. For instances, one of the significant statement was; “When I talk about emotional intelligence, I think of leadership. Emotional intelligence is having a good mindset as a leader. A good leader needs to be aware of other’s emotions”, the meaning of which I formulated as “The concept of emotional intelligence has a direct correlation with the role and the characteristic of a leader.” I was careful while completing this step. In other words, the formulated meanings were reviewed several times to avoid the formulation of meaning that did not have a connection to the data with the intent to allow the data to speak for itself. For example, while using the same significant statement, a formulated meaning that would not relate to the data includes

"The interviewee believes that only leaders have emotional intelligence, or to have emotional intelligence, you need to be a leader." These two formulated meanings did not have a connection to the data or to what the interviewees intended to convey.

Step three was also organized in a table format. Eight tables were created representing the information from each transcript. Each table had two columns. The first column included the significant statement while the second column had the formulated meaning associated with the statement. A total of one hundred and fifteen formulated meanings were identified.

Step Four: Clusters of Themes

Step number four consisted of grouping the formulated meanings into categories to reflect clusters of themes and emergent themes. This step focused on moving from what is given in the meanings to themes given with them. Once the clusters of themes and then the emergent themes were identified, referring to the original protocol was essential. This was achieved by questioning whether there was anything contained in the original transcript that was not accounted in the themes and whether the themes revealed anything that was not proposed in the transcriptions (Valle & King, 1978). It is essential to note that, at this point, discrepancy was found among the various themes identified. For instance, "…emotional intelligence is essential in the emergency department, and it is only learned over time with experience" while another theme state "…emotional intelligence should be learned as early as during nursing schools." Evidently, one theme is contradicting the other. As a researcher, I had to rely on my tolerance for ambiguity and refused the temptation to ignore the ideas that did not fit with what I was hoping to

demonstrate. I was able to report both themes from a neutral point of view and let the data speak for itself.

Step four was completed utilizing a three-columns table format in Microsoft Word. The first column included the formulated meaning, second column consisted of the clusters of themes, and the third column contained the emergent themes. A total of eight table were completed including the information from all transcripts. Step four revealed a total of twenty clusters of themes and eight emergent themes (Appendix E). Examples of the eight emergent themes include:

1. Passionate about emergency room nursing.
2. As a result of the environment in the emergency department, emergency room nurses are not able to process their emotions in a timely manner.
3. Although a limited understanding of emotional intelligence was noted among the participants, all four branches or principles of emotional intelligence were evident in the stories shared by the interviewee.
4. The concept of emotional intelligence is essential in the practice of effective leaders.
5. Emergency room nursing lacks emotional intelligence.
6. All participants shared emotionally stressful experiences.
7. Emotional intelligence should be incorporated into undergraduate nursing curriculums.
8. Emotional intelligence is critical when caring for patients at the end of life where family members become a crucial part of the nursing assignments.

Step Five: Exhaustive Description

An exhaustive description of all emergent themes was completed at this stage of the data analysis (Valle & Kin, 1978). After merging all study themes, I provided a comprehensive description of the eight themes and their relation to the phenomenon being explored.

Step Six: Fundamental Structures of the Phenomenon

Strong similarities are between step five and six of the Colaizzi's method of data analysis. However, step six focuses on identifying the fundamental structures of the phenomenon (Valle & King, 1978). To complete this step a reduction in finding was done. I excluded from the structures any redundancy, misused, or overestimated description. Examples of fundamental structures of the phenomenon included:

Passionate about ED- nursing. All seven participants expressed their passion and love for emergency nursing. When they shared their experiences, they talked about their profession with pride and satisfaction. They spoke about emergency nursing being part of who they are. Five participants had an extensive clinical experience before becoming emergency room nurses. Besides working in a different clinical environment as registered nurses, they were all patient care associates. Two participants came from different disciplines. One was a chef for five years and the other worked in the guest relationship department for three years.

Interestingly, no significant differences were noted in their answers to the questions. The limited understanding of the concept of emotional intelligence was noted among all participants. Furthermore, no information was shared regarding the

participant's professional training; however, their stories revealed the use of similar strategies to control the negative emotions.

As a result of the working environment, emergency department nurses are not able to understand and process their emotions. The emergency department is a stressful, chaotic, and overwhelming environment where nurses often are responsible for several assignments at a time. It is important to note that emergency room nurses are expected to not only care for their patients but also for their patient's family.

Not knowing what is coming through the doors and the stress of handling several emergencies at the same time put the nurses in an autopilot mode. The fast-paced prevent nurses from stopping, thinking, and processing their emotions. During a 12hour shift, the nurse's feelings continue to build and when not handled appropriately it results in frustration, burnout, as well as job dissatisfaction. The participants reported unrealistic expectations of the role of emergency room nurses. They explained how emergency room nurses need to be there for their patients, families, and coworkers. Not being able to deal with the emotional and physical stress associated with emergency nursing trigger feelings of sadness, sorrow, and distress. These feelings can potentially interfere with the nurse's performance, therefore being perceived as a sign of weakness. Fast-paced and quick decision making are two essential principles of emergency nursing. ED nurses need EI to identify their emotions. The identification of these emotions is critical to making the right decisions.

Emotionally stressful clinical experiences. All participants shared negative and emotionally stressful experiences. They described their emotional struggles and distress

triggered by the clinical situations. In three of the stories, the participants were caring for patients at the end of life. Another story was about caring for a patient during a near-death experience, two were unexpected death, and the last story was related to an emotionally unstable patient. All experiences involved patients and family members. While sharing the experiences, all participants explained how these situations had changed their careers as emergency room nurses.

Interestingly, the interviewees described how they were able to transform these negative experiences into moments that helped them grow emotionally and professionally. The participants stated “This experience me to learn how to work under pressure”; “ I was never the same, I learned to pay attention to both the physical as well as the emotional needs of my patients and family members”; “This clinical event got me closer to my team. It gave me the tools to work collaboratively with others and support each other”.

Emotional intelligence is critical when caring for patients at the end of life. Three of the experiences shared by the participants were related to the end of life care. The participants reported having a difficult time understanding their patients' point of view when different from their owns. “I had a difficult time not judging the peace felt by my patient and family member when they decided to honor the patient’s end of life wishes.”; “My first instinct, as an ED nurse is to save lives, not just let the patient die”.

Step Seven: Validation of Findings

Member checking was the technique utilized in step number seven. The purpose of this step was to validate the accuracy of the data. An email was sent to all eight

participants. This email included an attachment with the results of the data analysis, the process to review this document, as well as the researcher's contact information (Attachment F). Four members participated in this final step. Three participants provided their feedback via phone, and one via email. All participants showed their satisfaction with these results which entirely reflect their feelings and experiences.

Interestingly, one of the participants added some ideas associated with one of the emerged themes. This member explained that although emergency nurses do not have the opportunity to learn about the concept of emotional intelligence, they are able to use this concept in their nursing practice. The interviewee concluded that to work in this clinical environment, emergency room nurses must manage their emotions and the emotions of others. Furthermore, they must understand their feelings and how their feelings affect their performance.

Discrepancy in the Data

A discrepancy was noted between two themes in step number four of the data analysis process. The participants reported a need to enhance the use of emotional intelligence in the clinical practice of emergency room nurses. On the other hand, evidence of emotional intelligence was apparent in every story shared by the participants. The interview transcripts, field notes, and the coding cycles up to step four were read numerous times to identify a way that incorporates this discrepancy into to the overall analysis process. The result of this analysis concludes that the participant's lack of understanding and unfamiliarity with the concept of emotional intelligence interferes with their ability to identify components of this concepts.

Furthermore, it is essential to note that although elements of emotional intelligence were apparent in the stories, some events shared by the participants indicated a limited use of this concept. For instance, during their experiences, some participants did not know how to process their emotions resulting in frustration, dissatisfaction, as well as emotional distress. Others expressed; "…. I could not understand what I was feeling", "I was not able to identify the correct way to ask the question because I did not want to cause more pain," "Looking back, I utilized a task-oriented process to make my decisions. I was not able to let my emotions guide my critical thinking.".

Evidence of Trustworthiness

In a qualitative study, the credibility of the findings and accurate interpretation depends on the researcher's ability to establishing trustworthiness. In this research, the trustworthiness of the data was demonstrated through the use of four strategies. These strategies include credibility, transferability, dependability, as well as confirmability.

Credibility

The strategy of credibility also called internal validity consists of the ability to demonstrate the congruency of the findings with reality (Shelton, 2004). Three techniques were employed in the study to assure the credibility of the data. Member check is a quality control measure that allows the interviewee to review the data for accuracy.

Member check. Member check was the step number seven of the data analysis process. The results of the data analysis were emailed to participants to be reviewed. The participants expressed their satisfaction with results which entirely reflect their feelings

and experiences. Another strategy utilized in the study to assure credibility is triangulation.

Triangulation. According to Shelton (2004), a form of triangulation is the use of a wide range of data sources that allow the different point of views and experiences of the participants can be verified against each other. I included in the study a wide range of data sources such as emergency room nurses with different levels of skills, expertise, and from various facilities. The levels of experience range from one and up to ten years of practice in the emergency department. These nurses had different levels of expertise such as trauma nurses, geriatric emergency room nurses, pediatric emergency room nurses, as well as emergency room behavioral health nurses. The participants work different shifts and in two separate facilities. The wide range of data sources gave me the opportunity to identify different themes and perceptions associated with the concept of emotional intelligence.

Development of an early familiarity with the culture of participating organizations. Early familiarity was established by visiting both emergency rooms before the data collection took place. These visits were arranged with the nurse managers of the units. Through these visits, I was able to understand the flow of patients through the emergency department, the nurse's assignments, ways the assignments get modified during emergency situations, as well as the culture of each unit. It is important to note that the familiarization with the environment allowed me to understand not only the nurse's experiences but also the meaning behind each story.

Transferability

In a qualitative study, transferability or external validity refers to how well the study can be replicated in different settings (Shelton, 2004). To establish transferability, the researcher must ensure that sufficient contextual information is provided. This information includes fieldwork sites, number of participants, inclusion and exclusion criteria, data collection methods, the length of the data collection sessions, as well as the techniques utilized to analyze the data (Shelton, 2004). In my study, transferability was achieved by providing thick descriptions of contextual information. The detail descriptions give the readers the opportunity to apply both the data collection sources and methods used in my study to explore similar phenomena in other clinical environments including but not limited to intensive care units, medical-surgical floors, as well as ambulatory clinical settings.

Dependability

The phenomenon of dependability is defined by qualitative researchers as the stability of the data over a period of time. It is reached through a detail description of the research design, implementation, data gathering process, and how these elements are utilized to answer the research questions (Ravitch &Carl, 2016). The detail description of the process within the study enables the reader to not only replicate the study but also obtain the same or very similar results. The dependability of my study is demonstrated by providing an abundance description of the research design, implementation process, data collection method, and analysis, as well as how all these elements are used to answers the research question.

Confirmability

Confirmability, in qualitative studies, refers to the objectivity of the results. In other words, it is how the investigators assure that the findings are the results of the participant's experiences and ideas instead of the researcher's preferences. According to Shelton (2004), three strategies can be utilized to establish the confirmability of a qualitative inquiry. These techniques include triangulation, researcher's reflexivity, as well as external audits. Confirmability has been demonstrated in my study through the use of triangulation and the researcher's reflexivity. The method of triangulation was explained at the beginning of the chapter. Researcher reflexivity is the continued assessment of the investigator's identity, positionality, and subjectivities during the process of completing a qualitative study (Ravitch & Carl, 2016). In my study, the researcher's reflexivity was achieved through the use of analytical memos after every interview session as well as through the bracketing technique utilized during the data analysis process.

Results

The Colaizzi's Method of Phenomenological Data Analysis was utilized to analyze the information obtained from eight interview sessions. This method consists of seven steps and depends on the manual coding ability of the researcher. All themes, emergent themes, and fundamental structures of the phenomenon were organized into different categories. The categories provide the answers the research question and subquestions. Furthermore, both the research question and subquestions were developed based on the Four-branch Model of Emotional Intelligence also known as the Ability

Model of Emotional Intelligence. Every category constitutes a branch or a conceptual component of the Four-branch Model of Emotional Intelligence.

Research Question: What is the emergency room nurse's perception of emotional intelligence?

Subquestions 1. According to the emergency room nurses' interpretation of their clinical experiences, what evidence demonstrates the existence of emotional intelligence based on the nurse's ability to perceive emotions in self and others?

Subquestion 2. According to the emergency room nurses' interpretation of their clinical experiences, what evidence demonstrates the existence of emotional intelligence based on the nurses' ability to understand emotions?

Subquestion 3. According to the emergency room nurses' interpretation of their clinical experiences, what evidence demonstrates the existence of emotional intelligence based on the nurses' ability to control or manage emotions?

Subquestion 4. According to the emergency room nurses' interpretation of their clinical experiences, what evidence demonstrates the existence of emotional intelligence based on the nurses' ability to use emotions to enhance reasoning?

Research Question

The focus of the study was to answer the research question which states, what is the emergency room nurse's perception of emotional intelligence? A total of eight emergency room nurses were interviewed to identify their understanding of this concept. As part of the interview protocol, the participants were asked to explain not only their perception of emotional intelligence but also share a meaningful clinical experience.

Undoubtedly, the information obtained from the interview sessions demonstrated a lack of familiarity with the concept of emotional intelligence among the emergency room nurses. Although they perceived emotional intelligence as a critical element of the clinical practice, the lack of understanding associated with all components of the concept was evident. The theoretical definitions utilized by the participants when describing emotional intelligence did not include all elements of this concept. For instance, the participant number five explained how emotional intelligence was associated with the ability to control emotions. This answer omitted other aspects of this concept such as the ability to perceive emotions in self and other, the ability to understand emotions, as well as the capacity to use emotions to enhance thinking.

The concept of leadership was also used by some participants when explaining their perceptions of emotional intelligence. The participant number three stated, "Emotional intelligence is leadership. An emotionally intelligent leader is able to support his/her team and also recognize when the team needs her/him". A similar definition of this concept was given by the participant number four when stated, "Emotional intelligence is being a leader. It is the capacity to move a team forward while assessing and meeting the needs of the group".

The analysis of the data revealed that common themes were used by participants to describe their understanding of emotional intelligence. Two participants utilized the ability to control emotions while two others associated emotional intelligence with the concept of leadership. The concept of empathy and transparency were often used by three

participants while meeting the needs of others was described by the last participant as the theoretical definition of emotional intelligence (Figure 7).

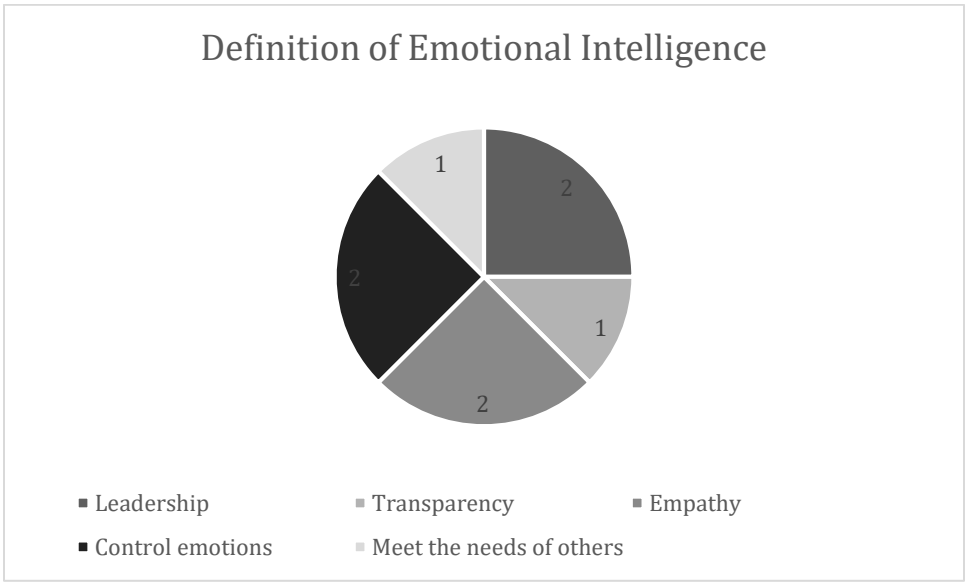

Figure 7. Definition of emotional intelligence.

It is essential to note that the information discussed during the interview sessions exposed the lack of familiarity with the concept of emotional intelligence. Although the emergency room nurses demonstrated a limited understanding of the concept of emotional intelligence, evidence of this concept was present in all stories shared by the participants. Fascinatingly, nurses did not associate their abilities to perceive and understand emotions with the concept of emotional intelligence.

Subquestion 1.

The purpose of this subquestion was to identify evidence of emotional intelligence by the nurse's ability to recognize emotions in self and others. This subquestion assesses one component of the concept of emotional intelligence, which includes the perception of emotions. To find the answer to this subquestion, the stories

shared by the nurses were assessed for information that demonstrated their capacity to recognize their feelings as well as the emotions in other through the tone of voice, facial, and postural expressions. Evidence of this component of emotional intelligence was identified in all the stories. Examples of emotions perceived by the participants include guilt, shock, happiness, frustration, disbelieve, hope, stress, sadness, and emotional pain (Figure 8). It is essential to note some participants perceived more than one emotion in their stories. The participants identified these emotions in themselves as well as those involved in the experiences.

During the interview session, participant number one explained the emotional pain that the patient's family was experiencing. The participant stated, "I could see in her eyes the emotional pain that the mom was feeling after experiencing the death of her daughter. I did not speak. I knew I needed to stay with her". Similar phrases were shared by participant number four when stated, "Initially I was in shock. Then, I felt a deep sadness knowing that the patient knew what was going to happen. In other words, that she was going to die, and she was ok with that".

I found significantly interesting the mixed emotions perceived by some of the participants. For instance, the participant number five stated, "I was angry and upset and frustrated and happy because the team did a great job. There were so many things that bothered me in that situations. Things that could have gone easier". Participant number seven stated, "I was sad because what a terrible thing had happened to this family a week before Christmas, and at the same time I was beyond happy because we were able to

bring the patient back. The family was terrified. By the tone of their voices and facial expressions, I could see the feelings of guilt, frustration, and disbelief."

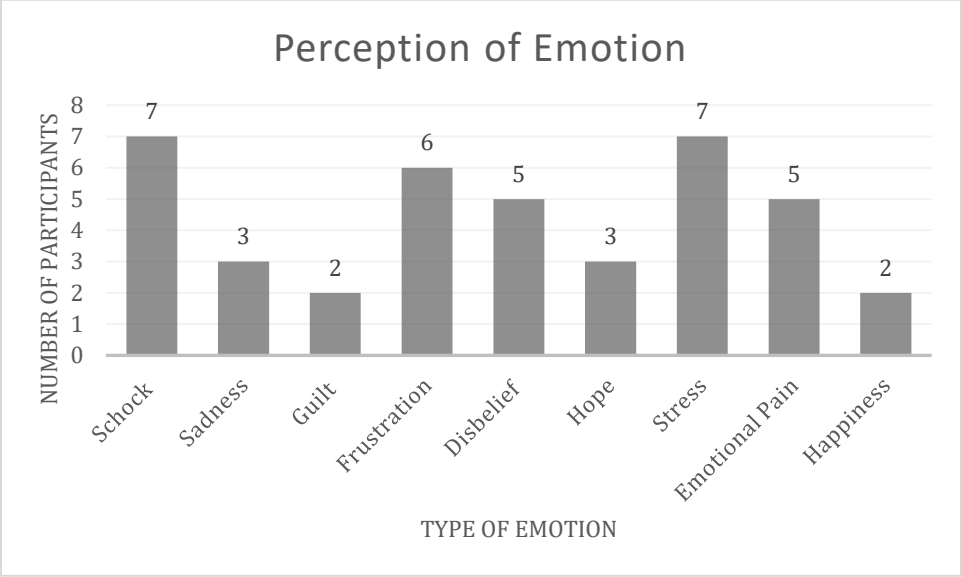

Figure 8. Perception of emotions.

Subquestion 2.

This subquestion was designed to identify a different element of the concept of emotional intelligence. This element includes the emergency room nurse's ability to understand their emotions as well as the emotions of others. Interestingly, evidence demonstrating the nurses' understanding of emotions were present in every story; however, some participants expressed having difficulties understanding their own feelings (Figure 9). Three participants were not able to understand their emotions. Five participants demonstrated a good understanding of both their emotions as well as the emotions of others. Meanwhile, all eight participants reported having no issues understanding the emotions of their patients and family members.

Participant number seven stated, “I knew I was not right. I was feeling sad; however, at first, I could not understand why. It happened later on my ride home when I started to associate the patient with my own mother. This patient was the same age as my mom and she even looked like her”. Similar responses were reported by participant number six when stated, “I did not know what I was feeling at that time. Now, thinking about it, I realized that I did not understand why the family was ok with honoring the patient’s end of life wishes and not allowing the clinical team intervene to try to save her”.

Other participants were able to understand both their emotions as well as the emotions of those involved. Participant number two stated, “I was frustrated and started to get flustered. I was doing all I could to help my patient, but she was very upset and angry. I did not take it personally. I understood that it was not me, it was the situation that we both were in”. Similar responses were given by participant number five when stated, “I understood the emotions that my patient and the family were experiencing. They had lost control of themselves as well as the situation. Nothing I could have said or done was going to change that. So, I stayed next to them listening quietly.”

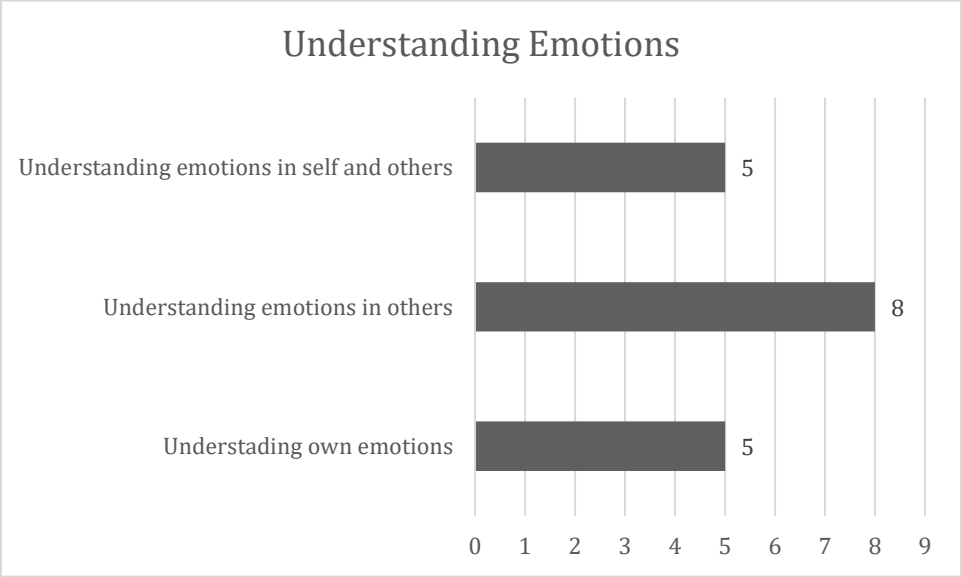

Figure 9. Understanding emotions.

Subquestion 3.

The third subquestion assess the nurses' ability to utilize their emotions in a way that enhances their critical thinking. It is essential to note that this component of emotional intelligence focuses on the knowledge necessary to connect emotions and thinking to direct one's planning (Mayer, Salovey, & Caruso, 2004). The information shared by the participants revealed that the emergency room nurses were not able to identify how their emotions influenced their ability to make decisions. However, their stories exposed how their decisions were influenced by their emotions. For some participants the feeling of fear allowed them to make quick decisions. Other explained how feeling overwhelmed helped them concentrate on what needed to get done. The feeling of stress gave them the ability to use different problems skills such as identifying potential resources during the emergency situation. Other nurses explained how the sense of sadness allowed them to see things from different perspectives and be more

understanding with their patients and families. Interestingly, one of the participants expressed how the emotional pain caused by the experience helped her collaborate with the rest of the team (Table 3).

For instance, participant number three stated, “I work very well under pressure. Feeling overwhelmed helped me concentrate on what needs to be accomplished. I’m able to isolate other problems and prioritize what is in front of me”. Participant number six explained, “Emotionally challenging clinical situations, like this one, reminded me of the good things I have in life. I was able to see things from a different point of view while going through this experience. This feeling influenced the way I treated both my patient and those involved in this situation. I was kind, patience, and more understanding”. Similar answers were reported by participant number one when stated, “While all this was happening, I could feel the fear inside of me. I was able to make quick decisions while working or collaborating with the rest of the code team”.

Table 3

Use of Emotions to Enhance Reasoning

Emotions	Actions
Fear	Quick decision making
Stress	Problem solving
Overwhelmed	Concentration
Sadness	Patience, understanding
Emotional distress	Collaboration

Subquestion 4.

I developed the fourth subquestion to identify evidence that demonstrates the emergency room nurse’s ability to control their emotions. This subquestion assesses the

element of emotional intelligence that relates to the individual's capacity to avoid feeling or to reframe appraisals to comfort oneself or achieve equanimity (Mayer, Salovey, & Caruso, 2004). Consistency was identified among the answers provided by the participants. The stories shared by the participants demonstrated how the emergency room nurses utilized similar strategies to control their emotions. A commonly utilized strategy includes the use of task-oriented techniques such as completing doctor's orders, cleaning the patient's rooms, as well as helping other nurses with their assignments. Other participants explained that taking a deep breath, going for a walk as well as removing themselves from the situations helped them manage their feeling effectively (Figure 10).

Participant number three stated, "I was able to control my feelings by focusing on the tasks that needed to be completed. I remember reading the doctor's orders over and over and cleaning the patient's room several times. These tasks kept me busy and prevented me from showing my frustration and sadness". A similar response was given by participant number seven when stated, "I just kept myself busy. When I carried out all my orders, I went around the unit and offered to help other nurses with their assignments. This kept me from going back into the room and letting my emotions show". A different approached was used by participant number six when stated, "I just continuously removed myself from the situation. I would leave the room and go for a walk around the unit. This gave me the opportunity to clear my head and not just let my emotions expose. I felt like I wanted to cry and talk to them about my feelings. Instead, I just took a walk."

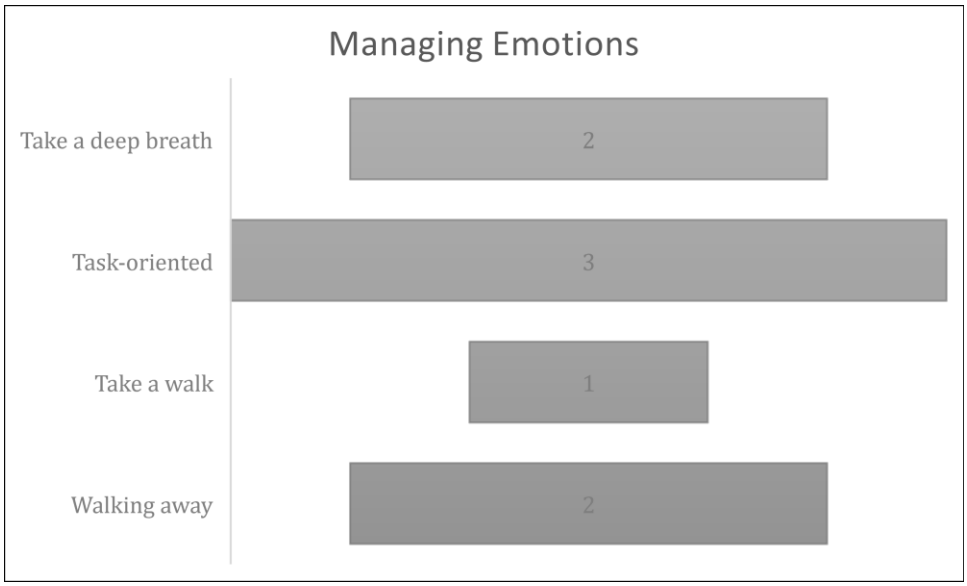

Figure 10. Controlling Emotions

The results of the study exposed seven additional themes. These themes include:

1. The participants are passionate about being emergency room nurses.
2. As a result of the environment in the emergency rooms, emergency nurses are unable to understand and process their emotions in a timely matter.
3. Emotional intelligence is a critical component of leadership.
4. There is a limited use of emotional intelligence in the clinical practice of emergency care nurses.
5. Emergency room nurses tent to remember emotionally stressful clinical experiences.
6. The concept of emotional intelligence should be incorporated into undergraduate nursing curriculums.

7. Emotional intelligence is essential when caring for patients at the end of life. Often, family members become the primary focus of the emergency nurses' assignments.

Summary

This qualitative study aimed to identify the emergency room nurses' perception of emotional intelligence. The study included one research question and four subquestions. It is essential to note that the four subquestions were developed based on the Four-branch Model of Emotional Intelligence. This model is also known as the Ability Model of Emotional Intelligence was used as the theoretical framework of the study. A total of eight emergency room registered nurses from two different facilities participated in this inquiry. The data was collected through face-to-face interview sessions. The information shared by the participants was transcribed and analyzed following the seven steps of the Colaizzi's Method of Phenomenological Data Analysis. I used four strategies to achieve the trustworthiness of the data. These strategies are credibility, transferability, dependability, and confirmability.

It is apparent that the results of the study answered the research question, as well as the four subquestions. The data analysis revealed that although emergency room nurses perceive emotional intelligence as a critical component of their clinical practice, they demonstrated a limited understanding of this concept formally. The descriptions of the concept provided by the participants did not include all elements of emotional intelligence. For instance, some participants described emotional intelligence as the

ability to control emotions. Others perceived it as the capacity to support and understand the feelings of people.

It is essential to note that although the participants demonstrated an unfamiliarity with this concept, evidence of the four elements of emotional intelligence was present in every story. The analysis of the data indicated that all participants were able to identify their feelings as well as the emotions of those involved in the stories. Evidence of how the emergency room nurses understood their emotions, as well as the feelings of others, was also revealed by the data analysis. Although the nurses employed different strategies, they were able to control their emotions successfully. The use of emotions to enhance reasoning was the four element of emotional intelligence present in the clinical experiences shared by the participants. Interestingly, although emotional intelligence was present in all clinical experiences reported by the emergency room nurses, they were not able to connect these components with the concept of emotional intelligence.

Chapter five is the next section of the study. This chapter focus on the detail explanation of the findings, conclusions, as well as recommendations. Chapter five in organized as follow: detail interpretation of findings, the limitations of the study, recommendations, as well as implications.

Chapter 5: Discussion, Conclusions, and Recommendations

Emotional intelligence has been identified as an essential component of the clinical practice of health care professionals. Researchers have established positive correlations between the clinical nurses' level of emotional intelligence and care quality indicators, nurse/patient relationships, staff retention, job satisfaction, as well as team cohesiveness (Adams & Iseler, 2014; Codier et al., 2009; Quoidbach & Hansenne, 2007; Rakin, 2013). Amusingly, a need to enhance the use of this concept, especially in the emergency departments, continues to be a topic of concern for the health care industry (Bailey et al., 2011). The purpose of this phenomenological inquiry was to identify the emergency nurse's perception of emotional intelligence with the intent to gain an understanding of the limited use of this concept in their clinical practices.

I used a transcendental phenomenological approach to assess the nurses' understanding of this concept and identify the existence of emotional intelligence in the emergency nursing practice as well as how these nurses make sense of the world through lived clinical experiences (Patton, 2015). The study was guided by one research question and a total of four subquestions. I designed the research question with the intent to recognize the emergency room nurse's perception of emotional intelligence. The purpose of the four subquestions was to assess additional information related to the emergency nursing practice and the concept of emotional intelligence.

After obtaining the IRB approval from Walden University with the number (06-14-18-0657391) and the IRB approval from the partner organization with the number (201805312JX-RMC), I initiated the recruiting process. A total of eight emergency room

nurses from two different facilities participated in the study. The data was collected over a period of ten weeks through face-to-face interview sessions. The interviews were recorded and transcribed for analysis purpose.

The Colaizzi's Method of Phenomenological Data Analysis was utilized to analyze the information. This method consists of seven steps that were followed strictly. Eight themes were identified once the data analysis was complete. The themes demonstrated the emergency room nurse's perceptions of emotional intelligence and added interesting insights that illuminate the essence of this phenomenon further. It is essential to note that although the emergency room nurses were not familiar with the concept of emotional intelligence, evidence of this concept was present in the stories shared by all participants.

Interpretation of the Findings

A total of eight themes emerged from the data analysis. These themes not only answered the research question and subquestions but also confirmed what has been researched about the concept of emotional intelligence in the literature and extended the knowledge of the nursing profession. The relationship between emotional intelligence and leadership was one of the themes revealed in the results of the study. The participants explained that emotional intelligence is an essential quality of good leaders. Sadri (2012) describes that leaders with high levels of emotional intelligence have the ability to recognize, appraise, predict, and manage emotions in a way that allows them to work and motive others.

Furthermore, Boyatzis (2011) not only links the competencies of emotional intelligence and the role of leaders but also describes how the levels of emotional intelligence predict the effectiveness of both leaders and managers. Lam and O'Higgins (2012) demonstrated similar findings. The authors reported strong correlations between this concept and leadership styles. They explained how the leader's level of emotional intelligence has a direct influence on their leadership style. Leaders with high levels of emotional intelligence often use transformational leadership approaches achieving better outcomes. A more in-depth analysis that confirmed the participants' perception of the relationship between emotional intelligence and leadership was performed by Goleman et al. (2013). The authors examined the neuroscience of a leader and validated how their level of emotional intelligence influences the leader's behaviors.

The need to incorporate the concept of emotional intelligence into undergraduate nursing curriculums was another finding revealed by the data analysis. The participants expressed the importance of being familiar with this concept to overcome emotionally challenging clinical situations. It is essential to note that this theme confirms the work of Rankin (2013). The author conducted a research study to predict the relationship between emotional intelligence and practice performance, academic success, as well as student retention. Interestingly, the results of the study demonstrated the positive correlation between the student levels of emotional intelligence and academic performance, retentions, as well as their success in the clinical practice. Similar results were revealed by the work of Benson, Ploeg, and Brown (2009) as well as Bulmer, Profetto-McGrath, and Cummings (2009). The authors not only explained the role that the concept of

emotional intelligence plays in the clinical practice of nurses but also described the importance of including this concept into the curriculums of undergraduate nursing programs.

It is worth mention that conflict was noted during the analysis of this theme. Although both the stories shared by the emergency room nurses and the literature review demonstrated the need to incorporate the concept of emotional intelligence into the undergraduate nursing curriculums, interesting arguments were made by two participants. These participants believed that although being familiar with this concept is essential, only going through emotionally difficult experiences can help develop emotional intelligence. They explained that it is significantly challenging to simulate emotionally stressful situations in academic settings. In other words, the emotional and physical stress caused by the environment of the emergency room can only be experienced when working as emergency care professionals.

Additionally, the participants argued that the way individuals perceive stressful situations influences how they learn from these experiences. They also stated that there is a difference between how nursing students see emotionally challenging circumstances when compared to the perception of emergency room nurses. They further indicated that although simulation learning has demonstrated to be an excellent teaching strategy, it is different from the learning that occurs with real-life experiences. Future research is needed to expand the scientific knowledge related to the use of effective strategies to teach and learn emotional intelligence.

The end of life care in the emergency department has been a topic of interest for professional researchers. Bailey, Roger, and Porock (2011) have done exceptional work evolving two concepts emotional intelligence and end of life care. The researchers have demonstrated how the use of emotional intelligence skills can improve the quality of end of life care, especially in emergency rooms. Hogan et al. (2015) not only validated the results of Bailey, Roger, and Porock (2011) but also identified the need to enhance the use of emotional intelligence in the emergency care settings. It is important to note that the participants in my study have confirmed these research findings. In other words, many of the participants shared stories related to their experiences while proving the end of life care. An interesting theme emerged from the analysis of the stories. Emergency room nurses perceive emotional intelligence as a critical skill when caring for patients at the end of life because of the emotional stress that is often associated in these types of situations.

Moreover, this emerged theme revealed a new insight that extends the knowledge of emotional intelligence in the nursing profession. According to the participant's point of view, the patient's family members should become the focus of care when caring for patients at the end of life. Emotional intelligence competencies such as identification and the understanding of emotions, the management of emotions, as well as the use of emotions to influence thinking should be directed to the support of the family through the end of life process. The participants also identified opportunities for improvement related to family support at the end of life in the emergency department.

It is vital to consider that the analysis of this theme revealed an interesting observation which has not been addressed in the literature. Some of the participants who shared end of life clinical experiences had a difficult time understanding and meeting the emotional needs of the patients and families especially when these needs were incongruent with the nurse's values and beliefs. For instance, one of the participants explained how difficult it was to support the patient's family emotionally when both the patient and family members refused to receive or consider medical treatment. This participant wanted to intervene and do what emergency professionals do best, save lives. This nurse explained how she struggled to meet the emotional needs of her patient and family since they refused medical treatment. The participant could not understand the peace experienced by the patient and family associated with this decision. Additional scientific evidence is needed to explore this phenomenon further.

The limited use of emotional intelligence in the clinical practice of emergency room nurses was another theme emerged from the data analysis. It is important to note that this theme confirmed the findings of the study performed by Carmona-Navarro and Pichardo-Martinez (2012). The authors identified the need to increase the use of emotional intelligence in the emergency department, especially when treating patients experiencing psychiatric emergencies. Codier and Codier (2015) as well as Holvery (2014), also argued for the need to enhance emotional intelligence in the practice of emergency care professionals. The authors explained how teamwork, team cohesiveness, conflict management, and effective communication are not only critical elements of the

emergency nursing practice but also are profoundly influenced by the nurses' levels of emotional intelligence.

The emergency nurse's inability to understand and process emotions in a timely manner as a result of the stressful clinical environment is another theme identified by the participants that confirm the knowledge found in the literature review. Holbery (2014), as well as Codier and Codier (2015), define emergency rooms as chaotic, stressful, and fast-moving clinical environments. The authors further explain that emergency nursing is a protocol-driven practice that depends on the critical thinking and quick decision-making abilities of the nurses. According to Holbery 's description of the emergency nursing practice, as a result of the nurses' heavy assignments, the care delivered to emergency room patients often lacks a caring touch. The author argues that the environment of the emergency departments does not give nurses the opportunity to meet both their emotional needs as well as the need of their patients.

Theoretical Framework and Findings

The Ability Model of Emotional Intelligence also known as the Four-branch Model of Emotional Intelligence by Mayer, Salovey, and Caruso was the theoretical framework utilized in the study. In this model, the authors define emotional intelligence as a set of cognitive abilities necessary to perceive emotions, understand emotions, the use of emotions to facilitate thoughts, as well as manage emotions (Mayer, Salovey, & Caruso, 2016, p. 294). These abilities go from basic to more cognitively complex areas. The Four-branch Model of Emotional Intelligence has been instrumental when studying the application of this concept in acute clinical settings.

With the intent to answer the research question, the participants were asked to share not only their understanding of emotional intelligence but also meaningful clinical experiences. It was apparent that all participants demonstrated a limited understanding of this concept; however, evidence of all four branches of emotional intelligence was present in every story. The descriptions of emotional intelligence provided by the participants did not include all the elements of this concept according to the definition of Mayer, Salovey, and Caruso. For instance, some participants described emotional intelligence as the ability to manage emotions and meet people's needs, while others used the concept of leadership to define emotional intelligence.

It is essential to note that the analysis of the stories shared by the emergency room nurses demonstrated the application of emotional intelligence in the clinical practice of these professionals. The Four-branch Model of Emotional Intelligence guided this analysis. Although the participants did not link their cognitive abilities to this concept, to some degree, they were able to apply all four branches of emotional intelligence.

Branch number one: ability to perceive emotions. Evidence that demonstrates branch number one, the perception of emotions, include the different feelings perceived by the participants in self and those involved in the situation. The different emotions were perceived through facial expression, the tone of voice, as well as nonverbal clues (Mayer, Salovey, & Caruso, 2016). Examples include the feelings guilt, frustration, happiness, disbelieve, hope, stress, sadness, as well as emotional pain.

Branch number two: ability to understand emotions. The branch number two of the ability model of emotional intelligence consists of the ability to understand

emotions in self and others. This branch was assessed through evidence that demonstrated the participant's capacity to examine feelings and anticipate potential outcomes (Mayer, Salovey, & Caruso, 2004). Although some participants had difficulties understanding their emotions evidence that suggests the application of this branch was apparent in the stories. For instance, some participants verbalized how the behaviors exhibited by their patients and families were related to their lack of control. Another participant explained that the emotions she was feeling were the results of her past experiences.

Branch number three: use of emotions to facilitate reasoning. The third branch of the Four-branch Model of Emotional Intelligence relates to the individual's ability to connect emotions with thinking in a way that will effectively direct one's planning (Mayer, Salovey, & Caruso, 2004). The stories were evaluated to identify how the nurse's emotions generated judgment as well as how their feelings guided their actions. Evidence of this branch was apparent when the participants explained how being overwhelmed kept them focuses on what needed to be accomplished, while the feeling of sadness helped them be patience and understanding towards their patients and family members. Other examples include the feeling of fear resulting in quick decision-making as well as the emotion of stress enabling problem-solving.

Branch number four: manage emotions. According to the stories described by the participants, different strategies were utilized to control emotions with the intent to achieve desired outcomes. The participants were able to engage with feelings that would help them and disengage with those that would not. Some of the strategies include

keeping themselves occupied and following doctor's orders with the intent to suppress unhelpful emotions. The use of breathing techniques and going for a walk were other successful strategies utilized by the nurses.

Significance of Findings

The results of the study not only offer significant contributions to the body of knowledge that evolves the nursing profession but also influence the quality of care delivered to health care consumers positively. This information can be utilized by nurse leaders and stakeholders of health care organizations to modify policies and guidelines with the intent to include the concept of emotional intelligence into the daily operations of the facilities. For instance, screening for emotional intelligence can be included in the recruitment, hiring, and annual performance assessment process of registered nurses. Elements of emotional intelligence can be incorporated into the daily nursing assignments such as patient assessments, plan of care, handoff communication, patient discharge processes, as well as patient- family meetings, and education.

Furthermore, leaders of health care organizations can use the components of emotional intelligence as a tool to not only perform clinical rounds but also built emotionally intelligent relationships with members of the health care teams. The four areas of emotional intelligence can also be used as part of the leaders' annual appraisals. Additionally, emotional intelligence can become a core competency for registered nurses including a required number of continue education credits related to this concept, especially in the emergency departments.

It is essential to point out that the findings of the study are instrumental to the work of clinical nurse educators. The unfamiliarity of the nurses with emotional intelligence evident by the incomplete definitions of this concept can be used as a tool to develop educational and training programs to not only raise awareness but enhance the utilization of emotional intelligence skills in the clinical practices of these professionals. Additionally, emotional intelligence can be incorporated into the curriculum of nursing residency programs as well as the new hire's orientation process. Nurse educators can utilize the four branches of this concept as a framework to design and conduct in-services, educational meetings, as well as during the annual competency assessment activities.

It is important to consider that the result of my study can influence the role of academic educators positively. On other words, educators can include the concept of emotional intelligence into the undergraduate nursing curriculums to impact both the academic and clinical performance of nursing students. The development and application of emotional intelligence skills can be used as one of the students' clinical requirements to continue in the program. Furthermore, the four branches of this concept can serve as a tool to assess the students' levels of emotional intelligence during the admission process and the final stages of the nursing program.

Limitations of the Study

The study was conducted with rigor to facilitate the trustworthiness of the data; however, it includes several limitations. The sample size is considered a limitation of the study. It is essential to note that although the saturation of the data was achieved, the

study includes eight participants. According to Mason (2010), the appropriate sample size in a qualitative varies, and it is determined according to the data saturation. On the other hand, some qualitative researchers argue that good sample sizes are multiples of ten (Guest, Bunce, & Johnson, 2006). Another limitation of the study is related to the population. Several factors including the participant's age, gender differences, educational, as well as cultural background were not taken into consideration during the recruitment, data collection, and data analysis process. Studies have demonstrated that although emotional intelligence is not often associated with gender differences, age, educational, as well as cultural background these factors can influence both the perception and application of this concept (Benson, Ploeg, & Brown, 2009; McNulty et al., 2016).

Another limitation of the study includes the type of agencies. Although differences exist between the two facilities included in the study such as the size, the number of inpatients and outpatient visits, as well as the availability of services, they are both considered acute care community hospitals. Therefore, no significant differences were noted among the information shared by the participants. All participants demonstrated a similar understanding of the concept and disclosed the same types of clinical experiences. It is essential to note that exploring the emergency room nurse's perceptions of emotional intelligence in university hospitals or trauma-level facilities where the complexity of the patients is higher and specialized services are available can add new insights into the study of this concept.

Another limitation of the study is the clinical setting where the concept of emotional intelligence was examined. The study only includes nurses from the emergency department. Clinical professionals from other clinical areas such as intensive care units, operating room, oncology, and medical-surgical were not contemplated for the study. It is worth considering that registered nurses from other clinical practices who have had different types of clinical experiences with patients and family might provide different perspectives related to not only the limited use of emotional intelligence but also the overall understanding of this concept.

Recommendations

The results of the study have contributed to the existing knowledge of descriptive research associated with the concept of emotional intelligence. In other words, the findings of the study demonstrate the emergency nurses' perception of emotional intelligence and how this concept is applied in their clinical practices. Recommendations have emerged from the results of the study, limitations, as well as the literature review. One of the recommendations includes extending the study to nurses from various clinical settings with the intent to capture not only different point of views but also expand the sample size. Nurses from other clinical backgrounds might have a different perception regarding the concept of emotional intelligence.

It is essential to note that the data analysis demonstrates not only the importance of emotional intelligence but also the need to enhance this concept in the clinical practices of emergency care professionals. Suggestions for future research studies that substantiate the need to incorporate emotional intelligence as a core competency for

emergency care professionals are necessary. Consequently, additional scientific evidence is needed to determine and to validate effective teaching strategies that facilitate the learning and application of emotional intelligence in the nursing practice.

Implications for Positive Social Change

Social change is the use of knowledge to influence others positively at different levels. It consists of the identification of a problem, collaborating with others to be part of the solutions, and actively implementing changes to positively transform individuals, families, organizations communities, and societies across the nation. Although a significant amount of research has been conducted to explore the concept of emotional intelligence, the application of this concept in the nursing profession is still in the beginning stages. However, the results of this study have potential impact for positive social change at the organizational as well as professional level. In other words, the information revealed in the interview sessions such as the emergency room nurses' understanding of emotional intelligence can serve as a guide to implementing educational and training activities that enhance the use of emotional intelligence abilities among, registered nurses.

Furthermore, the emergency room nurse's application of this concept demonstrates the presence of the four branches of emotional intelligence. The way the participants employed the four elements of this concept can be utilized as a tool to conduct emotional intelligence screening sessions with the intent to organize and direct educational resources. The utilization of both educational activities, as well as emotional intelligence screening programs, is the start of a positive social change movement by not

only improving the clinical nursing practice but also developing emotionally intelligent registered nurses.

The modification of current organizational policies and guidelines to incorporate emotional intelligence as core competencies for emergency care providers is another potential implication when striving for positive social changes. The use of this concept as an essential skill can transform the overall culture of health care organizations (Goleman, Boyatzis, & McKee, 2013). It is essential to note that the regular use of emotional intelligence will positively change the care provided to both emergency room patients and local communities.

Theoretical Implications

A related point to consider is the fact that the theoretical framework used in the study has made an essential contribution to the positive social change influence of this qualitative inquiry. I assessed the emergency room nurse's perception of emotional intelligence through the ability model of emotional intelligence, also known as the four-branch model of emotional intelligence. In this model Mayer, Salovey, and Caruso define emotional intelligence as a group of cognitive abilities necessary to identify emotions, understand emotions, use emotions to enhance reasoning, and to control emotions (Mayer, Salovey, Caruso, 2016, p. 294). I used these four principles in the study to evaluate the presence of emotional intelligence in the clinical practice of emergency room nurses. The findings of the study validate the existence of the four components of emotional intelligence in the clinical practices of all participants. Therefore, the ability model of emotional intelligence can be used by stakeholders, recruitment personnel,

nurse managers, and leaders of health care organizations as a mechanism to assess and evaluates the presence of emotional intelligence among clinical teams.

Conclusion

The delivery of a high-quality care has been a priority of the health care industry. The concept of emotional intelligence plays a vital role in the type of care delivered by clinical professionals. Nevertheless, researchers have identified a need to increase emotional intelligence in the clinical practice of emergency care providers. To understand the limited use of this concept, recognizing the emergency room nurse's perception of emotional intelligence is critical.

A total of eight emergency room nurses from two different facilities participated in this qualitative study. The Ability Model of Emotional Intelligence was the theoretical framework that guided the study. The data were collected through face-to-face interview sessions and analyzed following the Colaizzi's Method of data analysis. During the interviews, the participants were asked to explain their understanding of emotional intelligence as well as to share meaningful clinical experiences. The information revealed by the participants demonstrated a lack of knowledge regarding the concept of emotional intelligence; however, evidence of emotional intelligence was present in the stories shared by the nurses. The participants were not able to connect their abilities to identify emotions, understand emotions, the use of emotions to enhance thinking, and how they managed their emotions with emotional intelligence.

It is essential to mention that the results of the study not only illustrate the emergency room nurses understand of this concept but can be instrumental to a positive

social change movement at the organizational as well as professional level. The findings of the study can serve as a guide to implementing educational and training activities that improve the use of emotional intelligence abilities among registered nurses. Furthermore, the emergency room nurse's application of this concept demonstrated by the presence of the four branches of emotional intelligence can be utilized as a tool to conduct emotional intelligence screening sessions with the intent to organize and direct educational resources. The modification of current organizational policies and guidelines to incorporate emotional intelligence as core competencies for emergency care providers is another potential implication when striving for positive social changes. The use of this concept as an essential principle of nursing practice can transform the overall culture of health care organizations.

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Appendix A: Invitation to Participate in the Study

Dear, ***Name will be inserted here,***

This email is sent on behalf of Ingrid Astralaga, a doctoral student from Walden University. The focus of her dissertation project is to identify the emergency room nurses' perception of the concept of emotional intelligence. Your participation in the study would be much appreciated. Your involvement in the study would entail participating in a face-to-face interview session that would last approximately thirty to forty-five minutes and the review of the final document for accuracy which could take approximately fifteen to thirty minutes. The interview will take place in a conference room of your facility.

Your participation is entirely voluntary. Your privacy will be protected at all times, and the information from the interviews will be kept confidential. If you have any questions regarding the study, please feel free to contact the researchers at "XXXXXX" or call the following number "XXXXXX".

If you are interested in being part of this study, please take a few minutes to answer the following screening questions. If your answer is yes to all three questions, please email Ingrid Astralaga at "XXXXXX" or call the following number "XXXXXX" with your contact information.

1- Do you have more than a year and less than ten years of experience as an emergency room nurse?

Yes No

2- Do you work thirty-six hours or more per week as a registered nurse in the emergency department?

Yes No

3- Is your role in the department considered staff nurse with no administrative responsibilities such as nurse manager, assistant nurse manager, or clinical educator?

Yes No

Thank you very much in advance for your consideration.

Sincerely,
Ingrid Astralaga.

Appendix B: Informed Consent

You have been invited to participate in a research study that focuses on identifying the emergency room nurses' understanding of emotional intelligence. The participants consist of emergency room nurses with one to ten years of experience in an emergency care setting, work thirty-six hours per week or more, and are not in a managerial role such as manager, assistant nurse manager, or clinical educator. This form is part of a process called “informed consent” to allow you to understand this study before deciding whether to take part.

This study is being conducted by a researcher named Ingrid Astralaga, who is a doctoral student at Walden University. You might already know the researcher as the Diagnostic OP Imaging Business Manager, but this study is separate from that role.

Background Information:

The purpose of this study is to explore the emergency room nurses’ perception of emotional intelligence with the intent to understand the limited use of this concept in the clinical practice of emergency care providers.

Procedure:

I am requesting that you permit me to conduct an audio-recorded interview for approximately thirty to forty-five minutes. The interviews will be transcribed for analysis purposes. The transcriptions of your interview will be available to you. During the interview you will be asked to share a meaningful clinical experience and respond questions such as:

- Tell me about how you were able to identify your feelings as well as the emotions of others involved.
- Based on this clinical experience, how would you describe your understanding of your emotions and the feelings of others?
- Was there a moment during this experience where you needed to make a decision? If so, tell me if the emotions that you were experiencing influenced your decision-making ability and in what way?

The transcription of your interview will be analyzed to identify common categories and themes. Once the data analysis is finalized, copies of categories and themes will be emailed to you to verify the accuracy of the information. This step is called member checking and will take approximately fifteen to thirty minutes.

Voluntary Nature of the Interview:

This interview is voluntary. If you decide to take part now, you can still change your mind later or at any time during the interview process with no penalty. No one at facility A or facility B will treat you differently if you decide not to be in the study.

Risks and Benefits of Being Interviewed:

Being in this interview would not pose any risks beyond those of typical daily life. An example of a risk of the minor discomfort include becoming upset after remembering an unpleasant experience. Being in this study would not pose risk to your safety or wellbeing. You will not receive direct benefits by participating in the study. However, the results of the study will not only impact the clinical practice of emergency

care nurses but also will add essential contribution to the nursing profession body of knowledge.

Payment:

No payment or financial compensation will be provided.

Privacy:

Reports coming out of this study will not share the identities of individual participants. Details that might identify participants, such as the location of the study, also will not be shared. The researcher will not use your personal information for any purpose outside of this research project. Data will be kept secure in a locked cabinet located in my personal office at my place of residency. Interview recordings and full transcripts will be shared with you upon request. The interview recordings, and transcripts will be kept for five years. After this period of time this information will be destroyed as recommended by the Walden Institutional Review Board.

Confidentiality:

All information shared in the interview session and during the study will remain confidential.

Reporting Obligations:

The research procedures are not intended to reveal any information related to criminal activity or child/elderly abuse. If any information related to child abuse is shared in the study, this information will be reported to the New Jersey Department of Children Protection and Permanency. If any information related to elderly abuse is shared in my study, it will be reported to the New Jersey Adult/Elderly Protective Services.

Contacts and Questions:

If you have any questions you may share them now. If you think of any questions later, you can contact me by phone at "XXXXXX" or email; "XXXXXX". If you would like to discuss your rights as a participant in the research study, you can call the Research Participant Advocate at my university at 612-312-1210. or email irb@waldenu.edu. I will provide you with a copy of the signed consent form for your records. If you feel you understand the study well enough to make a decision about it, please indicate your consent by signing below:

Printed Name of Participant _____

Date of consent _____

Participant's Signature _____

Researcher's Signature _____

Appendix C: Interview Guide

Interview Guide

Introduction

Welcome the participants and introduce myself.

Explanation of General Purpose

Emotional intelligence is a concept that has been explored significantly through the years. Researchers have established positive correlations between levels of emotional intelligence and the clinical performance of registered nurses, team cohesiveness, job satisfaction, as well as the overall patient outcomes. On the other hand, emerging research has indicated a need to enhance the use of emotional intelligence in the clinical practice of emergency room nurses. To explore this phenomenon further with the intent to promote the use of emotional intelligence among emergency room nurses, identifying the emergency room understanding of this concept is critical. The purpose of this interview is to determine the emergency room nurse's knowledge of emotional intelligence.

Emotional intelligence has been defined as the ability necessary to identify emotions in self and others, understand emotions, use emotions to enhance critical thinking, as well as manage or control emotions.

General Instructions

Your participation is entirely voluntary. You can choose to end this interview at any time. This conversation will take between thirty to forty-five minutes. You can take breaks at any point during the interview. The interview will be recorded for analysis

purposes. I will take notes occasionally during the interview. The purpose of taking random notes is so that I can get all the details and at the same time be able to carry on an attentive conversation with you. All information will be kept confidential, and all data related to the interview will be stored in a locked cabinet located in my personal office at my place of residence. No information that reveals your identity such as names, last name, the name of the institution, as well as details of your experiences will be disclosed in this study.

It is recommended for you to keep a copy of the signed informed consent document.

If you have no further questions and allow me to record the session, let's start the interview.

Turn on the recording device

Interview Questions

- Let's begin the interview talking about your professional background. What can you tell me about your professional practices?
- In your own words, what is your understanding of emotional intelligence?
- I would like you to think about and describe a meaningful clinical experience that you have had while working in the emergency room. Tell me about how you were able to identify your feelings as well as the emotions of others involved.
- Based on this clinical experience, how would you describe your understanding of your emotions and the feelings of others?
- Was there a moment during this experience where you needed to make a decision? If so, tell me if the emotions that you were experiencing influenced your decision-

making ability and in what way?

- If at some point during this experience you needed to control your emotions, what can you tell me about the strategies that you used to manage your emotions.
- Is there anything else that you would like to share with me?

Conclusion

Thank you very much for your time. This information provides valuable contributions to my study. The recorded interview will be transcribed for analysis purposes. The transcript will then be submitted through several coding cycles to identify essential themes. A copy of the transcribed interviews will be available in a few days. Once the data is analyzed, you will receive a copy of the themes via email to be checked for accuracy. Please do not hesitate to contact me if you would like to share additional information or if you have any questions or concerns.

Phone number “XXXXXX”

Email: “XXXXXX”

Thank you very much again.

Appendix D: Confidentiality Agreement

Name of Signer:

During the course of my activity in collecting data for this research: "----insert study name-----" I will have access to information, which is confidential and should not be disclosed. I acknowledge that the information must remain confidential, and that improper disclosure of confidential information can be damaging to the participant.

By signing this Confidentiality Agreement I acknowledge and agree that:

I will not disclose or discuss any confidential information with others, including friends or family.

I will not in any way divulge, copy, release, sell, loan, alter or destroy any confidential information except as properly authorized.

I will not discuss confidential information where others can overhear the conversation. I understand that it is not acceptable to discuss confidential information even if the participant's name is not used.

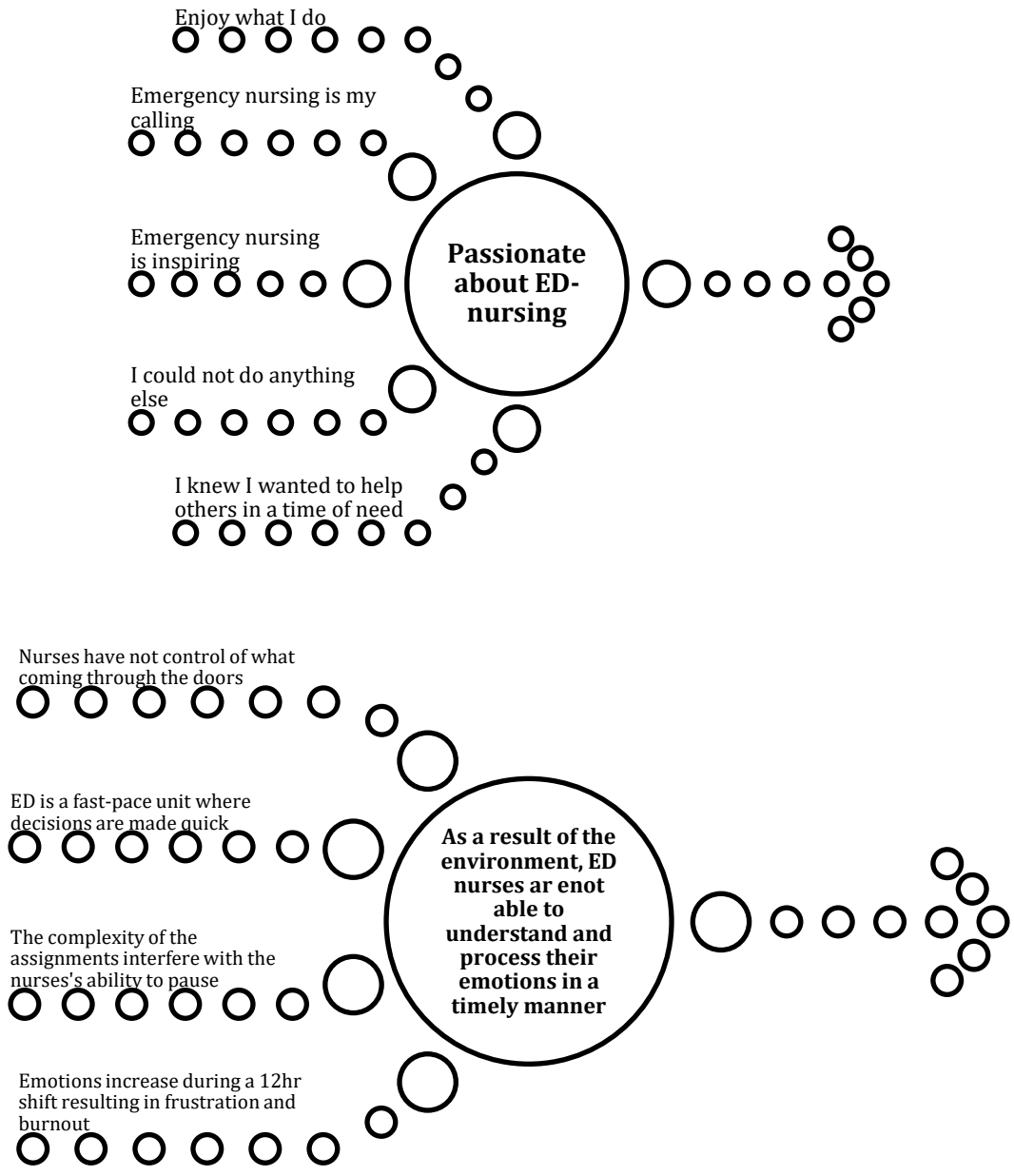
I will not make any unauthorized transmissions, inquiries, modification or purging of confidential information.

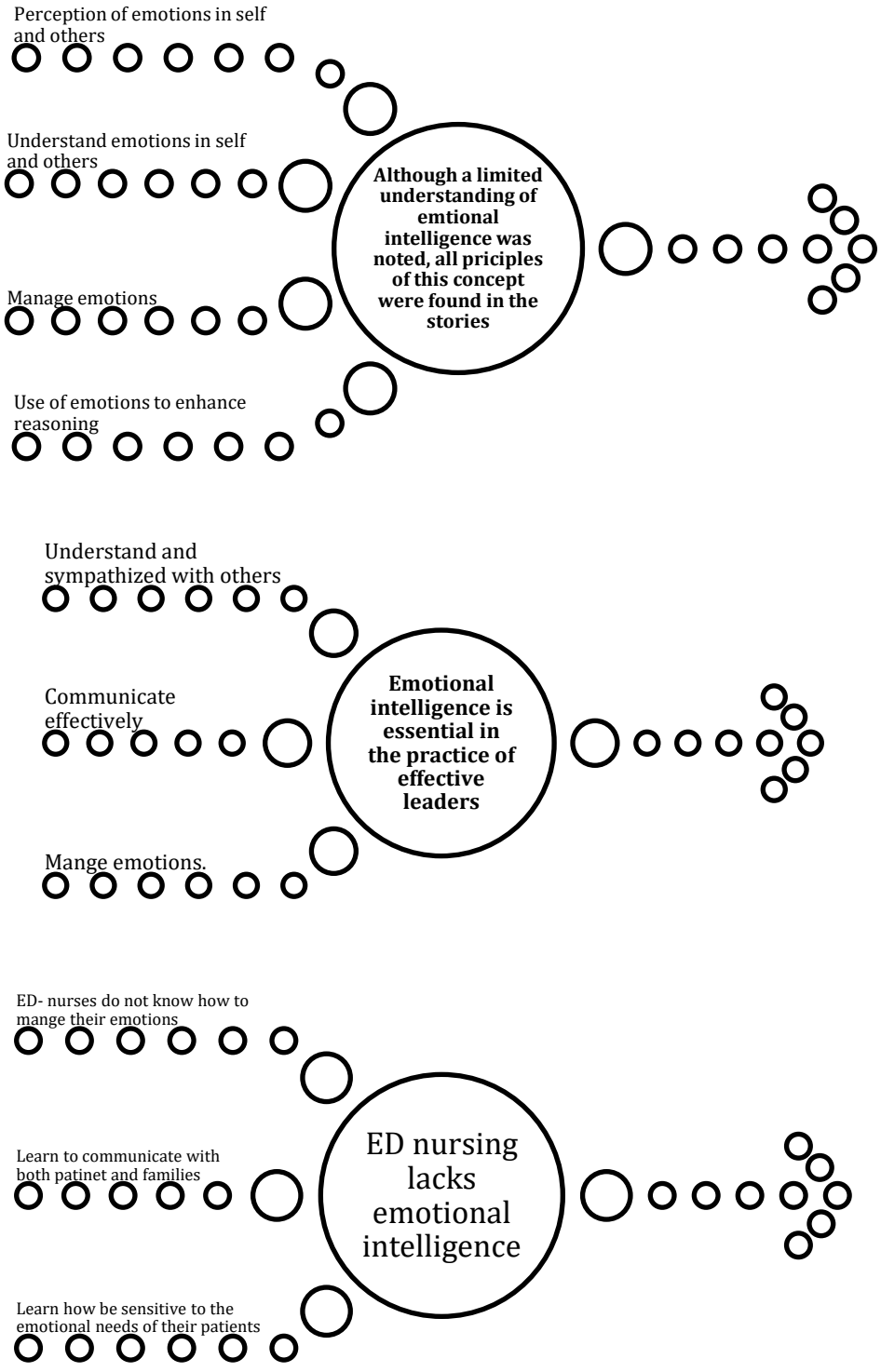
I agree that my obligations under this agreement will continue after termination of the job that I will perform. I understand that violation of this agreement will have legal implications. I will only access or use systems or devices I'm officially authorized to access, and I will not demonstrate the operation or function of systems or devices to unauthorized individuals.

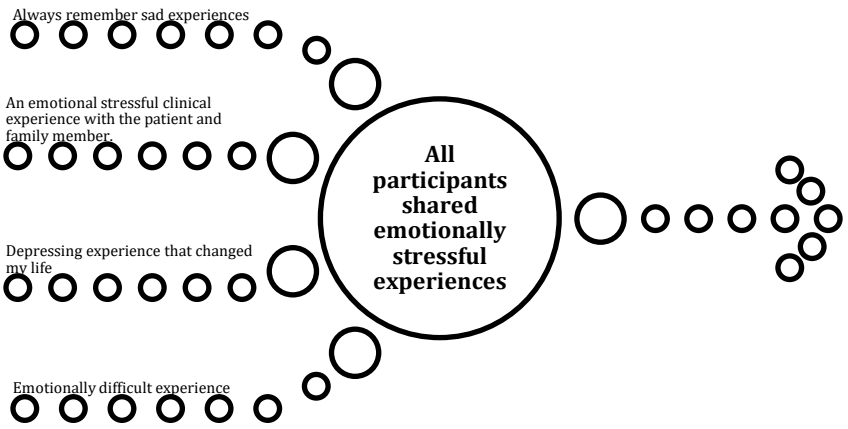
Signing this document, I acknowledge that I have read the agreement and I agree to comply with all the terms and conditions stated above.

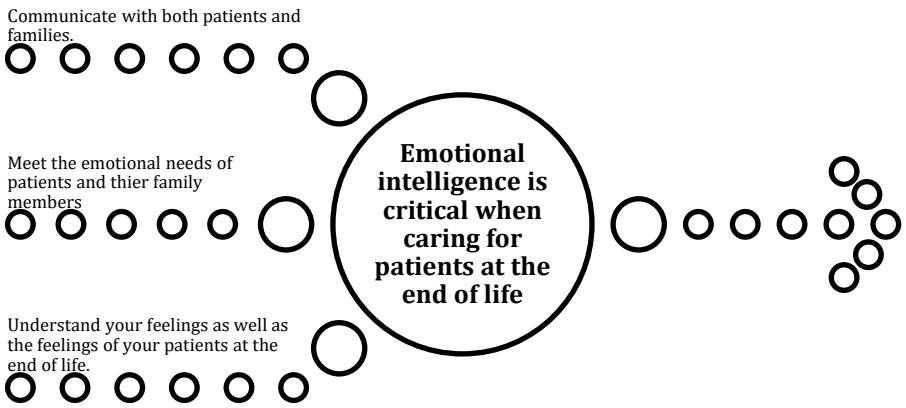
Signature: Date

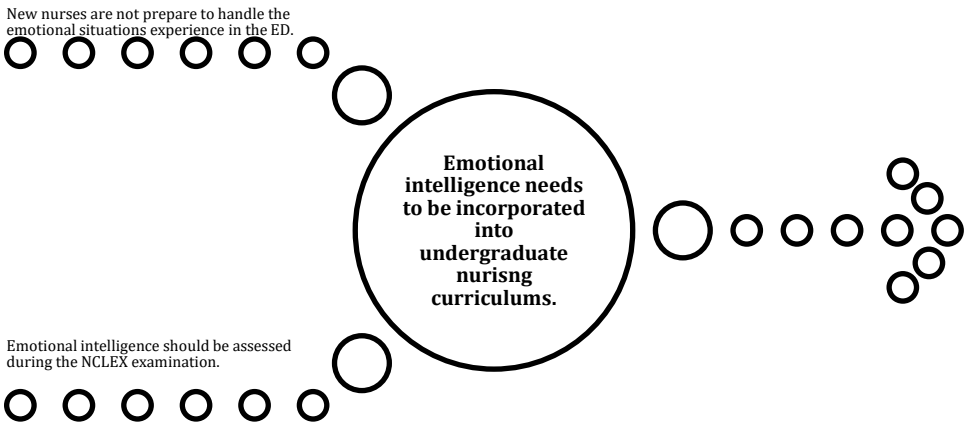
Appendix E: Colaizzi's Method of Data Analysis (Clusters of Themes and Emergent Themes)




Perception of emotions in self and others
Understand emotions in self and others
Manage emotions
Use of emotions to enhance reasoning
Although a limited understanding of emtional intelligence was noted, all priciples of this concept were found in the stories
Understand and sympathized with others
Communicate effectively
Mange emotions.
Emotional intelligence is essential in the practice of effective leaders
ED- nurses do not know how to mange their emotions
Learn to communicate with both patinet and families
Learn how be sensitive to the emotional needs of their patients
ED nursing lacks emotional intelligence


Always remember sad experiences
An emotional stressful clinical experience with the patient and family member.
Depressing experience that changed my life
Emotionally difficult experience
All participants shared emotionally stressful experiences


Communicate with both patients and families.
Meet the emotional needs of patients and thier family members
Understand your feelings as well as the feelings of your patients at the end of life.
Emotional intelligence is critical when caring for patients at the end of life


New nurses are not prepare to handle the emotional situations experience in the ED.
Emotional intelligence should be assessed during the NCLEX examination.
Emotional intelligence needs to be incorporated into undergraduate nurisng curriculums.

Appendix F: Member Checking Email

Dear; _____

My name is Ingrid Astralaga, and I'm a doctoral student from Walden University. As I had mentioned, the focus of my dissertation project is to identify the emergency room nurses' perception of the concept of emotional intelligence. As explained during the interview process, the recorded interviews were transcribed and submitted to several coding cycles to identify categories and themes. A total of eight interviews were included in this analysis. The attached document contains a detailed description of eight themes emerged from the information obtained during the interviews. This email is an invitation to participate in the member checking stage of the data analysis process.

Your participation is entirely voluntary, and your privacy will be protected at all times. Your involvement in the member checking stage will take approximately ten to fifteen minutes. It will consist of reviewing the information included in the attached document for accuracy by responding to the following questions:

1- How do my descriptive results compare with your experiences?

2- What aspects of your experience have I omitted?

3- Would you like to add anything else?

If you do not have questions, please feel free provide the answers to these questions by emailing Ingrid Astralaga at "XXXXXX", calling or texting Ingrid Astralaga at "XXXXXX", or through a face-to-face conversation. Your participation would be much appreciated.

Thank you very much for your time.