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DO MY FEELINGS COUNT? Caring for people who present with alcohol related illness or injury to a small rural coastal hospital - the emergency nurse's experience.

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Abbreviations

BDH	Byron District Hospital	HSA	Health Security Assistant
BI	Brief intervention	KT	Knowledge Transfer
CBD	Central Business District	NSW	New South Wales
ED	Emergency Department	NNSWLHD	Northern NSW Local Health District
EL	Emotional labour		

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Abstract

Do my feelings count? Caring for people who present with alcohol related illness or injury to a small rural coastal hospital - the emergency nurse's experience.

Aim
This exploratory research study sought to understand the experience of Emergency Department (ED) registered nurses who deliver care to patients presenting with alcohol related injury or illness.

Background
The northern NSW coastal town of Byron Bay is a major Australian tourist destination for all age groups. There is an above New South Wales state average incidence of violent behaviour, some of which being associated with alcohol misuse and requiring attendance at the ED. Community meetings have been held, seeking proactive solutions and have included a variety of business, police and Licencing & Gaming official stakeholders.

Methods
Hermeneutic phenomenology informed this interpretive research project. Data was collected from nineteen participants divided into three focus groups and two participants who were interviewed in-depth. Data analysis sought thematic interpretations, with a view to transforming personal experience into disciplinary understanding.

Findings
Participants expressed frustration and concern in the providing safe, effective care to this patient cohort. They experienced fear at times, both in relation to their own physical safety and that of other patients and staff in the ED. However, they also had a degree of tolerance for the misbehaviour, particularly in the younger age groups. The participants noted that they often did not have the time or staff to address associated issues such the health risks of excessive alcohol consumption with this patient group.

Conclusion
Emergency nurses recognise harmful alcohol consumption as a risky activity. While acknowledging time and staffing constraints and knowledge deficits, most participants acknowledged the public health benefits of acquiring education that will assist in the provision of alcohol brief interventions in the ED.

Implications for health care
Workplace stress related to caring for alcohol-intoxicated patients needs to be acknowledged by managers, and practices to allow for discussion and debriefing implemented and supported. Education that enhances both the knowledge and confidence of emergency nurses will assist in developing alcohol brief intervention education in the ED. Additionally, the electronic medical record used in the ED requires systems redesign to incorporate a distinct prompt to prompt emergency nurses to obtain a substance use history from all patients presenting to the ED.

Key words:
Emergency nurses, alcohol intoxication, emotions

Implications

Potential system improvements and practice changes can be made to improve care for alcohol-intoxicated patients in the Byron District Hospital (BDH) Emergency Department (ED).

Emergency nurses experience stress and fear when caring for some patients presenting with alcohol related illness or injury. Managerial and educational support systems currently available for emergency nurses both psychologically and professionally, while excellent for critical incidents, need to be enhanced to recognise ongoing stress that occurs on a regular basis, particularly with this patient subset.

Some emergency nurses find it challenging to care for patients who present to the ED with alcohol related injury or illness due to fear, anxiety and their own personal frailties and beliefs. Utilising knowledge about emergency nurses' feelings when designing capacity building programs and education delivery systems to provide alcohol brief intervention in the ED is imperative to ensure the best fit between the needs of patients and emergency nurses.

The electronic medical record First Net, used in New South Wales (NSW) public hospital EDs does not have inbuilt software or prompts for emergency nurses to complete a substance use history, despite government guidelines suggesting assessment for all patient presentations would be beneficial. It is possible that some patients who would benefit from education regarding alcohol consumption will not have an adequate substance use assessment due to the lack of electronic prompts to collect a substance use history. Additionally, data collected electronically will continue to be inaccurate and inefficient as it is not possible to access any distinct alcohol related data sets from the present electronic system. Therefore implementation of any new practice initiatives, such as alcohol brief intervention education, will be flawed at the outset, as the best available evidence will not inform them.

Recommendations

This research recommends that local senior managers and NNSWLHD encourage the planning and delivery of programs that support emergency nurses and provide necessary public health initiatives in the ED.

1. Psychological support for emergency nurses can be strengthen by:
    a. managers acknowledging the psychological stress of caring for alcohol intoxicated patients by talking to staff at ED meetings
    b. managers and clinical leaders developing opportunities to discuss confronting shifts and patients on a regular basis as a standing agenda item at ED meetings
    c. clinical leaders including challenging alcohol related presentations on the agendas of ED clinical review meetings to encourage discussion of the psychological and clinical issues when caring for this patient subset in recognition of presentation numbers.
2. Emergency nurses require the following to implement alcohol brief intervention education in the ED:
    a. managerial and educational understanding and encouraging support for the concepts and effectiveness of alcohol brief interventions as a public health initiative
    b. provision of appropriate alcohol BI education for staff coordinated by the clinical nurse educator and delivered by a NNSWLHD Drug and Alcohol Clinical Nurse Consultant (CNC) to ensure staff knowledge and confidence
    c. adequate staff levels in ED, quarantined time and a quiet, discreet environment to provide patient education.
3. The Northern NSW Local Health District Chief Executive will need to petition the NSW Ministry of Health eHealth Department regarding necessary clinical redesign Systems redesign of the ED electronic medical record First Net to include a distinct icon built into the patient assessment. This would immediately prompt emergency nurses to take an accurate substance use history and guide any required education.
4. This system redesign would –
    a. ensure that health professionals are adequately equipped for their roles and that patients do not 'fall through the gaps' due to inadequate electronic software.
    b. provide contemporaneous, cost effective and accurate alcohol-related data sets that can support future health initiatives.

5. Research to further develop findings of this study could comprise:
    a. additional studies in different settings to assess the experiences of other emergency nurses, acknowledging the exploratory nature of the study, and given the dynamic nature of the methodology.
    b. a cost benefit analysis regarding the costs involved with the recommendations and the overall savings made by the potential decrease in alcohol misuse and subsequent financial imposts on the health system and society.

Context

Byron Bay is a small coastal rural township of 9,000 people with a high visitor population and a wide socio-economic spectrum. The latest crime statistics show alcohol-related assaults in Byron Bay have risen by 20 per cent since 2009-10. Over the same time period the number of alcohol-related assaults in NSW has fallen. Alcohol-related violence in NSW was highlighted in 2013 by policy groups and in the media. A recent national survey cited alcohol consumption in young people being of major concern. NSW government measures introduced in early 2014 to address alcohol-related violence in the Sydney central business district (CBD) may not assist with issues experienced in rural areas if these measures are confined to the metropolitan area.

Currently the Byron District Hospital (BDH) emergency nurses do not routinely undertake substance use history for ED patients and there is no provision for any formal education to patients regarding safe alcohol use. There are many benefits to such interventions such as the intrinsic health benefits to the patient, the flow on benefits to friends, family and the social and economic benefits to the community.

Approach

A constructivist approach was chosen for this study. The study design was qualitative, data being collected from focus groups and in-depth interviews at one small rural hospital in the Northern NSW Local Health District. Thematic analysis of the data generated understanding of the participants' experiences.

Twenty-one emergency nurses participated in the study, nineteen attending one of three focus groups and the two in-depth interviews. Participants were recruited by way of a written invitation. They were requested to write or type three words on separate pieces of paper, regarding their feelings about caring for people who present to the ED with an alcohol related illness or injury and bring these words to the focus group meeting or interview. These words were used as prompts to elicit information without group members feeling vulnerable and to generate discussion.

Findings

A phenomenological methodology was used to discuss the findings. Analysis of the data indicated that the participants constantly experienced dissonant and dichotomous feelings regarding patients presenting with alcohol related misadventure, sometimes within one interaction or shift. While passionately asserting a wish to be compassionate, competent and knowledgeable, they honestly acknowledged that these aspirations were not always achievable owing to both system factors such as staffing and skill mix issues through to personal frailties and beliefs. This caused them significant anxiety at times, although they relied on collegial support to manage work-related stress. This in itself was concerning as the impact of stress on professional wellbeing is well documented and can have adverse effects, particularly with less experienced staff.

An ancillary finding has been that there is no inbuilt substance history code set embedded in the ED electronic medical record First Net used in NSW Emergency Departments. Therefore, emergency nurses and medical officers do not have any distinct prompts to document either alcohol or drug use either at triage or in later electronic documentation. They are therefore put at a disadvantage in alcohol assessment right at the start of the ED presentation, with the potential that if the right questions are not asked, appropriate education may not be provided.

Introduction

Rising alcohol-related presentations to Australian hospital emergency departments (EDs) has been attributed to an increase in alcohol consumption in Australian society that has been accepted as a societal norm until recently [1, 2]. The New South Wales (NSW) government heeded community concerns in early 2014 and introduced measures to combat alcohol-related violence in the Sydney central business district (CBD) [3]. However, elsewhere in NSW problems continue. Emergency nurses bear the brunt of associated verbal and physical abuse when alcohol-intoxicated patients present to the ED [4]. They experience frustration, fear and anxiety when faced with ongoing threats of violence in the workplace.

This research study explores the experiences of emergency nurses and presents the methodology used, research findings and discussion and makes recommendations that will support emergency nurses in their work and promote alcohol-related public health initiatives in the ED.

Rationale and background information

Byron Bay is a small coastal rural township of 9,000 people, with a high visitor population and a wide socio-economic spectrum. The latest crime statistics indicate that alcohol-related assaults in Byron Bay have risen by 20 per cent since 2009-10 [5]. These statistics were exemplified by a media observation following New Year's Eve 2012 that described a town given over to alcohol driven anarchy [6]. Over the same time period the number of alcohol-related assaults in NSW has fallen [7, 3, 8].

Concerns regarding alcohol-related violence state wide were highlighted in 2013 by policy groups and in reported on in the media [9, 10]. A recent national survey [11] cited alcohol consumption in young people being of major concern in the community [10]. NSW government measures introduced in early 2014 to address alcohol-related violence in the Sydney CBD [3] may not assist with issues experienced in rural areas if these measures are confined to the metropolitan area. Local community meetings have been held, seeking proactive solutions and have included a variety of business, police and Licencing & Gaming official stake-holders.

It would seem that alcohol misuse is increasing, at least within some western countries [12, 13]. Differences in the ways alcohol is consumed in Australian and Europe have previously noted that in Mediterranean countries, as the drinking of alcohol accompanies meals, whereas in western countries binge drinking (drinking large amounts of alcohol in the absence of a meal) [12, 13]. This belies researcher investigation in two tourist destinations in France of comparable size and tourist mix to Byron Bay where there were anecdotal reports from local accommodation providers and staff at the local Town Halls that there was an increasing problem with excessive alcohol intake by young people and associated misbehaviour and violence [14].

The findings from this research project will assist in informing future research directions and quality improvement initiatives regarding support for emergency nurses, the implementation of appropriate education and systems improvements to build capacity to provide brief alcohol interventions.

Literature review

An ongoing search of web based databases that were updated monthly used combinations of key words: brief intervention, capacity building, nurses, emergency departments, alcohol, misuse, intoxication, attitudes, experiences and knowledge translation and was confined to literature post 2005 to ensure that the literature cited was contemporary. Limited literature was found about the phenomenon in question. The researcher therefore identified distinct topics from the extant literature that could impact on the emergency nurses, with a view to exploring the key determinants of care delivery for the specific patient subset. Analysis of the identified topics indicated that many were interrelated, and therefore had the possibility to influence, alter or transform other topics, supporting the possibility that both nurses' feelings and practice are shaped by every changing circumstances.

Alcohol as a public health issue

A public health approach to addressing associated injury and illness issues is supported internationally [15], [16], [17], [18], [19]. To ensure that public health focused education is implemented, careful attention must be paid to individual knowledge, attitudes and perceptions, as well as the local health infrastructure [20], as barriers are best overcome at a local level [20] so that effective change can be achieved.

The number of treatment episodes for alcohol has steadily increased over the past six years in Australia and represents a greater proportion of all treatment episodes in public hospitals [1], with a significant rise in the 15-17 years and 18-24 years age groups in both males and females to 2011 [21]. Overall increases were noted in alcohol-related physical abuse between 2007 and 2010 [2], [22]. Alcohol-related violence is exacerbated by the increasingly prevalent habit of purchasing cheaper alcohol at supermarkets and off-licence outlets, inducing intoxication before going out, an action known as 'pre-loading' [23]. Recent statistics indicate that two thirds of the 18-29 years age group deliberately drink to achieve an intoxicated state [10]. Some parental attitudes and behaviours regarding alcohol can contribute to adolescent alcohol misuse [24].

The above findings echo statements by an award winning Australian artist [25], who has freely admitted his risky alcohol consumption and associated misbehaviour in his youth. He stated that "drinking excessively with his mates was a 'rite of passage' and 'the place where boys confront death' ". Support for this notion came from an Australian fiction writer drawing from his own experiences when he stated that "drinking is flirting with anarchy" [26]. It has been suggested that depictions from the creative arts can support and explicate hermeneutic data analysis [27] and would seem that these behaviours describe some current Australian social mores.

Costs to the individual and the wider community.

There are major health and societal costs related to alcohol misuse. Alcohol accounts for 13 per cent of all deaths among 14–17 year-old Australians and it has been estimated that one Australian teenager died and more than 60 were hospitalised each week from alcohol-related causes in 2004 – the latest statistics available [28].

Social and economic costs encompass more than just the costs to health services. Alcohol cost the Australian community about $15.3 billion in 2004–05, when factors such as crime and violence, treatment costs, loss of productivity and premature death were taken into account [2]. The cost of alcohol related absenteeism alone has recently been estimated at $1.2 billion per year [29], the consumption of alcohol being estimated to cost Australian society $15.3 billion [21]. The Australian Government spent $41.2 million on alcohol awareness and prevention programs to 2005 [2].

Emergency nurses' attitudes

The majority of studies have focused on nursing attitudes and most research has portrayed emergency nurses in a negative light, suggesting that negative attitudes toward intoxicated patients may lead to reduced capacity for compassion thereby creating a barrier to care for this patient group [29], [30]. While emergency nurses generally acknowledge their role in alcohol misuse education, personal attitudes toward alcohol use, nurse confusion regarding recommended amounts, training deficits and other ED priorities may impinge on this role [31]. Literature has indicated that organisational support must accompany any expectation for emergency nurses to examine and change their belief systems and enhance their knowledge and confidence, to ensure continued engagement with patients [17], [32], [33], [34].

Emergency nurses express frustration with the re-presentation of some intoxicated patients (commonly known as 'frequent flyers') [46] and some perceive these patients as confronting and threatening [34]. Other emergency nurses believe that alcohol-intoxicated or dependent patients do not deserve care as they have chosen to drink alcohol to excess [32], and they may overlook injury or illness that requires treatment [34]. Importantly, there is also the risk that some nurses may over identify with the certain patients due to their own personal and familial experiences [35] and that may then lead to a lack of sensitivity toward the patient, due to associating their own issues and experiences with those of the patients.

ED nurses experience of abuse and violence.
Although little is known about the phenomena of abuse and violence [36], nursing is recognised as an occupation with an high risk of regular exposure to all forms of violence [4], [37]. The predominant forms of violence are found to female biased insults and threats, often containing sexual innuendo or connotation [22], [38]. Emergency nurses bear the brunt of intoxicated patients' abusive, violent and inappropriate behaviours and managing their feelings and behaviour may drain their energy and patience [4]. As alcohol intoxicated people are more likely to be involved in violent incidents [2], [22], it is therefore important to understand how the exposure to violence on a regular basis can shape emergency nurses' feelings and influence their attitudes and practice.

Implications of nurses' attitudes for practice.
Emergency nurses have been found to be fearful at times in the workplace [29], [4] and are most vulnerable when they are exposed to harm [35]. Therefore, it follows that nurses' attitudes may, in part, be related to experiences of vulnerability and the possibility of physical or psychological harm.

Unfortunately, the offshoot of fear is a risk that, in these circumstances, some nurses may withdraw the provision care if there is a possibility of harm [40]. The vulnerability alluded to above may be a key to acting ethically with this patient sub-set if nurses can generate sensitivity and openness toward the vulnerability of others [35]. Again, it is therefore important to gain a fuller understanding of emergency nurses' experiences.

The toll of emotional labour
Emotional labour (EL) is an invisible part of nurses' work [39], defined as any effort of an employee to display behaviour expected by patients that may conflict with their own emotional state [40]. Using EL therefore has human costs, and nurses unwittingly put themselves at risk by using necessary but adaptive communication that does not truly reflect what they are feeling [41].

Various interpersonal strategies used to manage frustration, fear and knowledge deficits and deflect unmanageable emotions often involve humour [42], [41], [43]. This can be adaptive or maladaptive, according to the context and particularly if used consistently over time [43], [44]. It may masked unexpressed, unmanageable emotions [41], [45] sending feelings underground. Disparaging humour, commonly known as 'black' humour [46], may disrupt engagement with patients [43] if nurses do not recognise the humanity of this patient subset. This leaves nurses with a paradox of using humour as a way to alleviate stress, while risking the diminution of compassion for their patients [43]. Active planning (to remove the stress) and positive reframing (thinking about the situation in a different way) have been found to be more helpful coping mechanisms than the use of humour [44].

Emergency nurses may also block painful feelings about intoxicated patients and their situations that then prevents establishing a therapeutic relationship [39], [47] [48], because they find it too distressing to put themselves in the patient's shoes [47]. When EL is utilised to manage the dissonances of caring for patients whose lifestyle choices manifest in violent behaviours toward others [40], [48], [49] emergency nurses run the risk of stress related illness. They therefore need support and education to use EL concepts judiciously [40], [48] so that they can manage the fear and stress associated with the provision of care for this patient subset.

Translation of knowledge between settings.
Emergency nurses need to have the ability to transfer pertinent knowledge and skills between settings to allay professional worry regarding their practice. Knowledge translation (KT) is defined as 'the methods for closing the gaps from knowledge to practice' [50] and in this case, it is the ability to transfer nursing knowledge from one setting to another that is explored [51]. It is helpful if multi-skilled nurses have the intellectual ability to transfer knowledge sets from one area of practice to another where appropriate. To do this, nurses need to be able to analyse the contextual and individual determinants of the knowledge to be utilised [52]. Knowing when to use acquired knowledge [53] may prove difficult for nurses, and individuals may also have decreased decision making skills when there is a high level of emotional or physical exhaustion [53] as is the case in a busy, fraught ED.

Knowledge translation may be mediated by professional experience and expertise. Contemporary thought considers that analytical ability, educational level and lower nurse-patient ratios have as much a part to play

as determinants of expertise, particularly in challenging clinical situations [57], [54], [55] where deliberate practice is used rather than being on automatic. To maximise the use of knowledge it is recommended that there is collaboration and support between clinical nurses, educators and managers [56], [54] so that knowledge can be transferred between settings where appropriate to enhance nursing skills.

Professional worry

Knowledge translation flows on to the justifiable concern that emergency nurses' experience regarding the knowledge deficit when a patient presents to the ED either unconscious or with a deteriorating level of consciousness, and it is not possible to access an accurate history of preceding events. It is possible that head injury and other significant trauma or illness may be overlooked if alcohol intoxication is suspected [57], [58], a decreased level of consciousness being attributed completely to alcohol intoxication particularly if the ED is busy, understaffed or there is an inadequate skill staff skill mix.

Alcohol Brief Interventions.

An emergency nurses' ability and confidence to provide alcohol brief interventions is dependent on the ability to translate and utilise knowledge. Brief interventions (BI) are short education sessions delivered prior to patient discharge. Although acknowledged to be effective [17], [18], [59] , moderators to the success of any BI education include the amount of alcohol generally consumed by the patient and whether the reason for the ED presentation was related to their alcohol use [18]. Further research is required to determine the ED patients most likely to benefit from intervention [17], [60], [61], [62].

Computer based BI for young people in the ED have had beneficial effects in two United States (US) randomised control trial studies [63], [64]. It has been noted however that the second study was exclusively completed with university students [64] and therefore may not be able to be as easily generalised as the first study [63], whose participants came from a variety of societal groups. Similarly, the use of an iPad for BI delivery in the ED in an Australia study [65] has indicated favourable findings, although the researchers have acknowledged limitations due to follow up constraints. The long term success of different interventions methods such as face to face, or technology assisted remains contentious however, and it is recommended that 'future research efforts incorporate measures of fidelity to the intervention' [18] so that the most effective modalities can be ascertained.

While it has been advocated for nurses to be at the forefront of BI implementation as they spend so much time with patients, it is acknowledged that the workplace challenges of dedicated time, dedicated space in electronic medical records and additional staff are all barriers to successful implementation Baird [66]. This is certainly exemplified by the incapacity of the electronic medical record system used in NSW EDs to provide a prompt for ED nurses to initiate a substance use history Deloitte [67]. Interestingly, this lack of inclusion has also been recognised in other States of Australia and the United States [66], [68], [69].

Study aim

This study sought to develop an insight into the experiences of registered nurses working with patients presenting with an alcohol related illness or injury at a small rural coastal hospital. As the stress and fear involved in caring for this patient subset is quite often unacknowledged, both by the nurses themselves and by their managers, the main aim was to document the feelings of emergency nurses to gain a better understanding of the day-to-day challenges emergency nurses may encounter with alcohol-intoxicated patients. More explicitly, the study purpose was to encourage discussion of the positives and pitfalls, and to explore strategies for practice and system change. By doing so, a greater understanding of what it is like to care for alcohol-intoxicated patients, and what emergency nurses need to enhance their practice could be gained. These gains have the possibility of benefiting both emergency nurses and this subset of patients into the future.

Method

Study design

A constructivist approach was chosen in order to investigate, document and analyse the lived experience through the multiple lens of both participants and researcher [70], [71] derived from the data. The research was grounded in an inductive epistemology [72] and a hermeneutic phenomenological methodology was selected as most appropriate as it addressed how participants acted in everyday situations [73]. The intent of the research was to disclose what means [74] to work with patients who present to the ED with an alcohol related illness or injury as nursing is a multifaceted, dynamic practice [74].

A saturation sample of all the hospital emergency nurses (N=28) was invited to attend either one of three scheduled focus groups or an interview by way of a written invitation which provided information regarding the study (Appendix A) and separate consent forms (Appendices B & C) were provided for the focus groups and interviews. To lessen coercion it was clearly stated that all participation was voluntary and that the participants would be able to withdraw from the study at any time. It was also made clear that there would be no penalty for refusing to participate or to answer particular questions during the focus group process.

All focus groups and interviews were held at the workplace and for the vast majority of participants, in work time. There were a total of twenty-one participants, two of whom were invited to in-depth interviews, the remaining nineteen participating in one of the three focus groups. Seven registered nurses who met the inclusion criteria did not participate due to leave or roster clashes that meant they were unavailable at the scheduled dates. The three focus groups ranged from 60 to 80 minutes, time being built in at the start and debriefing at the conclusion to allow for introductions and explanations and to establishing a sense of connection between the researcher, participants and 'scribe' in the case of the focus groups.

The two interviews lasted for 45 and 60 minutes respectively and were conducted with key informants from the overall set of participants as nested sampling sub-sets [72], [75] who did not participate in the focus groups. These two participants were chosen using a maximum variation sampling technique [72] to limit key informant bias [75]. One expert and one novice emergency nurse were selected at random to maximise diversity of opinion, the categories of expert and novice having been defined by the level of experience, analytical ability, educational level and the ability to practice independently [54], [55], [57], [76] in the ED within the accredited emergency nurse scope of practice.

Data Collection

Focus groups were selected as an appropriate data collection method that was congruent with phenomenological theory. Three focus groups comprising six to eight participants were used for data collection, the number of participants providing sufficient data to ensure saturation [72], [75]. The intent was to explore the opinions, perspectives and group dynamics [72] of the registered nurses working in the Emergency Department, the advantage being the 'recording and observation of the dynamic quality of group interaction' [77] by audio recording and written notes.

Participants brought with them to the focus group or interview three typed words on three separate sheets of paper regarding their feelings about caring for people who present with alcohol related illness or injury. At the focus group meetings, a focus group member was then invited to draw the words out of a hat one at a time and read them out so that group members did not have to put forward their own point of view in the first instance. This assisted in eliciting anonymous information without group members feeling vulnerable at the beginning, and to generate discussion. The focus groups were facilitated by the researcher who used the key words, (Appendix D) in conjunction with the minimal use of semi-structured questions only if necessary. An audio recorder was used to record the focus group discussion. A health service employee volunteered as a note-taker to transcribe written observations utilising a digital 'SmartPen' [78] that provided an additional layer of data for analysis and another set of eyes and ears to capture nuances of verbal and body language [72], [79].

The more lengthy and descriptive nature [72] of the key informant data collected from the interviews provided added complexity [72] to the data analysis as it allowed for exploration of the lived experience of the registered nurses interviewed in greater depth and breadth. These data were compared to the data

collected in the focus group meetings to discover whether these experiences exemplified the experiences of the larger groups. Numbers were allocated to all participants to maintain confidentiality.

The researcher is a female, novice researcher with a passion for supporting nurses in the workplace and the provision of evidence based patient care. She is the direct supervisor of the participants when they work in the ward area; however she is not their direct line manager when they work in the ED. She has a Master of Health Science degree and has worked as a clinical midwifery specialist and then manager of clinical care at BDH for over twenty years. Participants knew the researcher well and her longstanding interest in nursing innovation, particularly in the area of alcohol issues and practice. A reflective journal incorporating field notes was kept for the entirety of the research project, salient thoughts, feelings and reflections being recorded contemporaneously where possible and utilised to add depth to the analysis. Depictions from the creative arts were used to add another dimension to and support for the analysis [27]**.** An in-depth knowledge of, and empathy for the participants' working life contributed to the researcher's ability to write, analyse and interpret as an 'insider' [80].

Data Analysis

Interpretation of the data was within a hermeneutic phenomenological framework, the focus being to 'illuminate details and seemingly trivial aspects within experience that may be taken for granted in our lives' [27]. The many phases of interpretation that allowed 'patterns to emerge, and the interpretive process itself' [27] were critical to substantiating the rigor of the study. In particular, van Manen's [73], [79] work was utilised to distil the feelings of the participants [74] and selectively uncover themes and sub-themes [81] with a view to 'creating new ideas and lines of action that can change a culture' [82] by stimulating reflection and action. The researcher took care to safeguard the integrity of the data by being attentive to nuances of language during the actual writing process [27], [79] in order to observe the essence of the hermeneutic circle [27], [82]. This involved a process of reading, reflective writing and interpretation utilising the research data, the researcher's reflective journal and contemporary literature pertinent to the phenomena to find tentative understanding.

The aim of the data analysis was to create a narrative of how life is perceived for the participants [82], [79], [83], [84].The data were transcribed precisely to ensure verisimilitude, and direct quotes from the participants, including forthright colloquialisms, were included to safeguard veracity [79], [85]. Prior to commencing analysis the recordings were listened to repeatedly to ensure immersion in the data to add texture and depth [86].

The data were read multiple times to uncover emerging themes [87] that seemed particularly insightful into the phenomenon of interest [87]. Analysis progressed from 'naïve' first interpretation where the data were read in their entirety to obtain a sense of the experience of the participants [82] .This was useful as it encouraged reflexivity and ensured that the researcher was intimately involved and acknowledged as an 'insider writing about their own culture' [27], [80]. It also caused questioning about assumptions and pre – understanding [27], [74], [79], [82] all vital in ensuring that the fidelity of the participants' experiences was preserved.

Narayan [80] considered that *'those of us who study societies in which we have pre-existing experience absorb analytic categories that rename and reframe what is already known. The reframing essentially involves locating vivid particulars'*. This appropriation is the aim of hermeneutics - to interpret is to 'appropriate here and now' [82]. This was adopted as a maxim for the analysis as the researcher believed, like Margaret Drabble, a noted English writer, that '*Appropriation is what novelists do. Whatever we write, knowingly or unknowingly, is a borrowing*. *Nothing comes from nowhere'* [88]. These preceding observations resonated with the researcher as a way to find and interpret meaning that would respect and value the worldviews of the participants [89] distilling the essence of their experiences.

Structural analysis was then undertaken in two stages. Firstly, the researcher used a coding system to thematically analyse the data and elicit themes that provided a brief description, researcher reflections and examples from the transcript [82], [86] (Appendix E & F) and no research computer software was used during the analysis. Interpretative themes were then generated from a second level analysis to articulate a deeper understanding of the phenomenon [82], [86] before coming to a tentative understanding of the data that could be utilised to transform nursing practice [79], [89]. While no feedback was sought from the participants, the

validity, reliability and rigor of the analysis were reinforced by a data review by my academic mentor and ongoing discussion with my primary supervisor.

Ethical approval and considerations
The Northern NSW Local Health District (NNSWLHD) approved the study on 18th December 2012 (NCNSW HREC No: LNR 044). Site Specific Assessment approval was granted on 19th December 2012 NNSWLHD Gov. No: G084). Ethical principles of informed consent, no deception, right to withdraw without penalty and the maintenance of confidentiality were all maintained [90].

Conflict of interest
No conflict of interest was declared.

Findings

The research findings and discussion were integrated to ensure that the all the multiplicity of experiences[27] that is explicated by the stories of the participants was preserved, recognising that the experiences were required to be seen through the eyes of each participant and the researcher. In both the focus groups and interviews, the participants displayed eagerness to share and compare their stories and did so with great candour in the knowledge that confidentiality would be maintained. Presentation of the findings sought to encapsulate the myriad of feelings related to the phenomenon in order to acknowledge and honour the participant contributions [73].

I can't do this much longer
This theme explored the relentless aspect of alcohol-related presentations to the ED, and the frustration that this elicited. The commonality of this theme across all the focus group and interview participants and this finding was consistent with recent research that discussed workload and staffing issues in EDs [34] :

'I get that feeling of – I must be burnt out – I can't do this much longer and I do that hour by hour. The first couple of hours - it's yeah – I can cope - then bang – no – I can't anymore' (F2 4).

The underlying current of frustration was particularly noticeable when the participants told of feeling worn out and exhausted as there seemed to be no let up and this was exemplified by the exasperated or resigned tone where the participants' voices were either raised in volume or there was a noticeable change in timbre. One participant actually gave voice to her frustrating as she moaned:

'You hear the ambulance pull in again and you just feel like crying 'What am I going to do now … and you've got people sitting in chairs because you've got no more beds' (F2 1).

Some participants used humour as a way to cope with this unremitting workload and the recent research about ways of managing emotion certainly supports this observation [74]. One participant commented laughingly that:

'We do such a good job they spring out of ED and I often say to them –'have you got a headache – "no - I feel great". 'They haven't learnt anything!' (F2 2).

The use of humour was consistent across all groups and interviews and this adaptive device as a way of coping will be discussed in a separate section as it has distinct ramifications for nurses' wellbeing.

The inordinate amount of time required to maintain patient safety and curb alcohol affected patient misbehaviour [34] fed into participant exasperation:

'And the staff you need to provide when there's alcohol involved … you don't know whether they're going to become violent. So it usually takes up one if not two nursing staff plus a Health Security Assistant (HSA) and on numerous occasions the police' (F3 4).

The fact that some alcohol affected patients seemingly gave no thought to how their actions may impact on the care of other patients troubled many participants, and again, this is congruent with research findings that indicate that health care staff have disapprove of this subset of patients [32] :

' But yeah – just no thought for what the consequences of their actions might be and who, or how it might impact on other people … you've got other clinically ill people … and potentially that presentation didn't need to happen…(1 2).

The characteristics of many of these presentations meant that jealously guarded time, while necessarily expended on alcohol affected patients often had repercussions [34]. Participants worried that other patients were missing out on needed care:

' *So they don't just present being drunk – they present with other injuries – some type of injury which means bloods, it means assessing them, it means time taken away from something that may be critical that you overlook because you're with these people' (F1 6).*

Participants were clearly often exhausted and frustrated. They spoke particularly of the thoughtless actions and the time consuming nature of the care required alcohol-intoxicated patients.

Many burdens in different directions

Thematic issues raised by the participants included economic, family and public health burdens the excessive alcohol use places on society and Australian societal mores. A broad spectrum of the participants had reflected on economic burdens on society related alcohol misuse and their observations were similar to current government statistics [2], [21]:

'I'm thinking more of the burden on the department – the cost of what the presentation may be on the person and their family - the community, the hospital. So it has a wide-ranging effect on a lot of people. So – yes – there are many burdens in different directions. And I mean – look at New Year's Eve – take out the alcohol related presentations and we had four sick people' (I 2).

Others spoke of their feelings of disquiet regarding the learned behaviours of alcohol affected patients, consistent with literature that draws links between lenient parental attitudes about alcohol, parental alcohol-related problems and adolescent alcohol misuse [24]:

'You know most of these people coming to ED – they've probably witnessed their parents and older siblings doing the same thing so it's just a tumbling cycle' (F3 1).

Many participants were cognisant of the distinct public health discourse in both Australian and international literature related to alcohol misuse [16], [15], [17]. They discussed the need to address the societal acceptance of this misuse so apparent in contemporary society vociferously:

'All we're doing is picking up pieces – there's a lot of money spent on picking up the pieces when that money could be used to put in something at the very beginning to help – I don't know – some sort of prevention' (F2 4).

The public health issues certainly fed in to feelings of hopelessness as two groups talked about the political issues of changing hotel closing hours. These particularly prescient opinions mirrored those of groups advocating earlier hotel closing hours as a way to reduce alcohol related injuries [8],[9]:

'And then I think it's shutting the gate after the horse has bolted – that becomes a political argument then … are they going to stop selling alcohol? ... But then it becomes political to close all the doors' (F2 6).

' And it doesn't help – these discos/nightclubs open til three am and that's just ridiculous. And once again that's when your staffing levels are at their lowest – when the problems occur' (F3 7).

It's all very acceptable

Participants talked about Australian mores and the comparisons with their European experiences. They were adamant that Australian culture has a large part to play in the way alcohol is consumed and again, this was consistent with current opinion and research [1], [11], [12]. One group commented on their children:

'*Well – they're sitting down at dinner with us while we're drinking wine ... it's all very acceptable isn't it? Twenty years ago when we had Schoolies week not everybody would go' (F3 2).*

Others observed that:

'That's the culture – Australia Day we all get drunk, NYE we all get drunk, birthdays we all get drunk' (F3 3).

Others extended the conversation concerning family attitudes, referencing examples of other possibly more acceptable cultural mores regarding the consumption of alcohol and enthusiastically finishing each other' sentences:

'In Europe it's a social thing - they drink and eat at the same time – it's a combination whereas I think Australians just drink. You don't feel unsafe walking down the party town/party street of Paris or Madrid or Barcelona because …' (F3 1).

'In France they do that all the time' (F3 7).

'Everybody's out – the older people are out late at night too so that's … it's a totally different culture' (F3 5).

These comments supported the contention of United Kingdom researchers [13]. However the researcher had noted a paradox in this position while travelling in Europe in 2013 and was informed on investigation at local town halls that these cultural mores are actually changing, with young people binge drinking and the associated misbehaviour becoming increasingly prevalent, particularly in holiday destinations [14]. So it maybe that cultural mores are shifting, at least in western society.

It's OK to get drunk

One group also expressed indignation that young people in particular had an expectation of treatment related to alcohol illness and injury without taking any responsibility for their behaviours, observations supported by recent research that young people lack insight in reading the dangers of consuming large amounts of alcohol and cited current harm minimisation strategies being taught[23]:

'They're actually teaching the kids … if they start vomiting or start to lose consciousness get to the hospital. The education they're taking in isn't don't do it or modify your drinking or anything like that – it's how to handle it when they're … It's OK to do it - it's OK to get drunk but this is what is what you do when things are falling apart' (F3 6).

This theme clearly emphasised the sophisticated awareness participants had regarding both the economic and societal costs of excessive alcohol consumption. They were unequivocal in their belief that changes needed to be made politically and communally to address the issues.

Conflicted and confused

This theme had definite parallels with, and links to both the unrelenting nature of the presentations and the economic and societal burdens imposed by alcohol related illness and injury. Sub-themes encompassed conflicted feelings for different patient groups and the associated anger, guilt and blame as participants bravely explored this territory.

It's like water off a duck's back

Participants in both groups and interviews voiced resignation and sadness as they pondered the helplessness they felt when patients continually re-presented to the ED. The nurses referred to them as 'frequent flyers' which was also a term noted in research exploring nurses' attitudes when caring for alcohol intoxicated patients [30]:

'And you know them – they're frequent flyers quite often … and they've done something silly and you know they've done it several times before and this is their modus operandi – this is what they normally do' (F3 5).

'*Really – nothing I do – you give a person a lecture here and there or whatever but I mean … it's like water off a duck's back in a month's time' (I 2).*

The feeling of futility and despondency was palpable as participants spoke of the sadness they feel for patients, particularly for those older people who have alcohol dependence, echoing the assertion that nurses find 'bearing witness to the patients distress unbearable' [47]:

'You're powerless to actually help the person and it's the loss of that person's life that is a grief process' (I 1).

Being 'over it'

The untenable exhaustion seemed to be a factor in the manifestation of anger and blame, supporting research data that 'patient abusive, violent and inappropriate behaviours become wearing over time' [34]:

'When you get a row of them coming in and you think – not another one – I'm over it. You're worn out from the first one that came in and all of a sudden there's another one there' (F3 3).

Some research maintains that nurses endeavour to put distance between themselves and intoxicated patients [47] and this certainly rang true for one of the participants as she disclosed her aversion to patient behaviours:

'Oooh … I'm thinking about that – that sadness thing – I don't get a lot of sadness – I think I'm a bit … (F3 2)

'Hardened?' (F3 4).

'Nooo!' (F3 1) (clearly stated with humour and obvious tongue in cheek).
There was an outcry of laughter from the entire group at this point that ties in with the use of humour to manage dissonant feelings [41]. Another group reiterated these feelings, talking over each other when discussing the messiness of some presentations:

'You're just there to … (F1 3).
'Clean up their shit' (meant metaphorically) (F1 5).
'Yeah – clean up their shit – and sometimes that what you …' (F1 3).
'*You do!' (F1 5).*

While some expressed sadness at the plight of some patients, some participants also described their exhaustion when managing challenging patient behaviours. Their exasperation with this patient subset came to the surface quite readily and with little prompting as they recounted their stories.

The clash of feelings
The discourse of the participants indicated evident dissonance as conflicting emotions of anger, blame, guilt, empathy and tolerance were debated. The blurred boundaries between these emotions were patently clear as discussion ensued in both the groups and interviews and very clear sub -themes emerged during discussion.

Oscillating between anger and empathy
Anger and blame toward patients seemed to coexist for most participants as manifestations of frustration and fear that was consistent with research findings [35] and the nurses' responses could be viewed as a reaction to patient behaviours:

'You seem to be going through oscillating between anger at them and empathy for them' (I 1).
'You start losing your caring because you're so disgusted by the situation and then – yeah – you get a little bit less compassionate' (F2 2).
Several participants expressed antipathy toward those local patients with chronic alcohol dependence, some conceding in a manner that is referred to as 'self-centring' [35] that this was linked to their own life experiences:

'My frustration is with the older or repeat presentations, whether they're Parkies or not – just the representations time and time again' (F2 6).
'So – your personal belief system comes out a bit. So I have … my personal belief system is– based on my personal experience. I probably have a lower tolerance for alcoholism' (F1 1).

It was apparent that these feelings may potentially lessen the potential for engagement with patients [35] and therefore diminish compassionate care and they were compounded by guilt for having the feelings in the first place: for some at the time, and for others, after the event, as they reflected on their behaviour and feelings. They recognised that they were losing the ability to practice with compassion. This phenomenon has been well documented in nursing literature [30], [35], [43], [47] and has clear links to a succeeding discussion regarding emotional labour:

'I did become a nurse because I care about people and then … you try and stop yourself when you think of it. … because you're meant to be compassionate' (F2 2).
'Then if you lose your compassion you feel bad about it because you feel that's its wrong …' (F2 5).
'*I start putting up a very hard shell and then I don't like me by the end of the shift' (F2 4).*

The ones that really get up my nose
The feelings voiced in the preceding section were divergent to other participants in different groups and interviews who had different tales to tell and expressed greater frustration with the younger cohort of patients rather than the local chronic alcohol dependent patients. These feelings were not mitigated by guilt at all, and could be viewed as a way of distancing themselves from intoxicated patients [47] as evidenced the following conversation:

'The ones that really get up my nose are the tourists or the thirty year olds that are blow ins for the town and they come in and they get maggotted – you know – to the point of totally losing control and they might have to stay overnight, they might need to be resuscitated and then you discharge them in the morning and there is no remorse. I feel the local guys aren't a problem at all' (F1 3).
'Yeah. These young ones; forty-seven in the last few weeks' (F1 4).

'Males from that age group – you know – 18s to the 30s and the guys that are buffed – the really buffed guys. They're working out; they're into the supplements (F1 5).

Group: 'Yeah, yeah'.

Been there, done that

However, a degree of tolerance was perceived as many participants talked about the foibles of youth. This was noted to be contrary both to the participants' overall feelings, and that of research [30] regarding a reduction in compassion. This seemed to be partly attributed to the wish to 'play mother' and indeed, two participants actually voiced this proudly, albeit with tongue in cheek:

'I get called mummy 'cos I lecture the kids as they're coming 'round …' (F2 1)

'I do too but - I wonder whether they're even listening …' (F2 3).

Others spoke of the propensities of youth to inhabit the 'wild side' and accepted this as a societal norm:

'If they're young and experimenting it's sometimes quite accidental that they've ended up ... if they're drunk and hurt themselves or just drunk. That's a totally different perspective - a lot of times that's the first time they're drunk' (F3 5).

'The young people – they're coming in, it may be experimental – there's a rock concert up the road – I can't say it's inevitable but … it's going to happen. Their experiments - they're age appropriate and that's what happens' (F2 6).

Another motive for this tolerance seemed to be the easy ability to relate to their own youthful misadventures, these stories being recounted with lightness and humour:

'Yeah – I've got more compassion for the young ones … yeah – been there, done that' (F3 2).

'I can remember when I was young. I probably have more time when they sober up – the young ones – to give a little bit of education' (F3 1).

These observations were congruent with the differing opinions the participants held regarding what they perceived as the most challenging subset of alcohol intoxicated patients presenting to the ED. This is supported by literature exploring the contradictory nature of nurses' feelings [86]. While empathising with young people, some participants noted that they observed less resilience:

'When we were young what did you do if you couldn't get a bus? You had to walk an hour and a half home because you'd lost your bus money and that's what you did and you got home late at night and you got into trouble' (F3 5).

'By the time you got home you were sober (F3 3).

This reply was greeted with great hilarity.

Sometimes I can't take my eyes off 'em

Regardless of the differing feelings toward age or type of alcohol use or the manner of their presentation, many participants communicated inexorable worry and anxiety about how to keep their patients safe. This worry is quite justified [57], [58] as head injury and other significant trauma or illness may be overlooked if alcohol intoxication is suspected. The participants were very clear that they needed to know whether the patient had any underlying injury or illness when they had an alcohol misuse presentation and that this was often very difficult to discern. During these conversations the participants repeatedly used humour, seemingly to disguise or off-set their concern [41]. This method to cope with stress will be discussed in a succeeding section as interpersonal skills to manage stress are so tied up with the emotional labour that is invested in caring for challenging patients. The embodied responses of one group exemplified this worry:

'Are you breathing – I mean I know they're breathing but I'm thinking – what am I going to do with you – I hope you're all right. I just sometimes I can't take my eyes off 'em – I'm just so - I just go through all these things in my head. So if they wake up it's such a relief – you could almost kiss them – thanks for waking up' (*F2 6).*

The researcher observed that the laughter after this comment was like sun after rain, as participants seemed to be relieved that their feelings had been exemplified, and there was a cascade of confirmatory replies.

The participants also voiced concerns about fulfilling their professional responsibilities in the ED. This worry about diagnostic confusion is borne out by research [57]. One participant eloquently explained how she felt and other participants in her group unmistakeably echoed these feelings:

'It's frustrating for me because - well if they're unconscious and you've got to keep your eye on them all the time to make sure – and be right there in case they vomit so they don't inhale. And you don't know what else they've taken as well so you don't know whether they're going to crash or whether they're going to come good or … It's frustrating not knowing how serious they actually are when they're unconscious' (F3 3).

That group then talked about how they felt regarding the professional risk to themselves, and to the patient if they weren't able to assess patient adequately. The chorus of voices was overwhelming and difficult to catch – however the body language was also descriptive with participants nodding, using hand gestures and pursing their lips. The words captured during this exchange included '*anxiety, worry, scary* and *risk to patient'*. This worry was exemplified by one comment in particular:

'… it happens at a time when there's minimal staff on and all those concerns about leaving them unattended – not having enough people to watch whether they're ok … comes in to play. It becomes risky (F3 6).

Rite or right

Participants were clearly conflicted as they spoke of the prevalence for youth binge drinking and they wondered whether young people viewed alcohol misuse as a rite of passage or a right to do as they please. These perceptive reflections echoed observations made by noted Australian writers and artists about alcohol misuse as a rite of passage [(25), (26)]:

'I don't think they understand what a rite of passage actually means – they've taken it and they use this – the Schoolies use it as - this is my rite of passage is to come and get drunk but I don't think they know the right use of the term ' (F3 1).

They spoke of being shocked about the amount of alcohol young people in particular consume:

'It's just that different culture now – yeah sure – we all went out and partied and had our hangovers but you didn't go to hospital. These kids … mixing drugs and alcohol – huge amounts' (F2 1).

*'But young kids go out purely to get drunk (*said with finality*) – which is an awful thing' (F3 1).*

This theme covered an immensity of feelings for participants. Blame and anger blurred into guilt about different age group behaviours, while inexorable worry about keeping patients safe was a constant thread in the conversations about care delivery.

Out of control

Violence as an occupational hazard in nursing is well documented [(4), (37), (38)] and it was apparent that it was always in the back of the participants' minds when caring for alcohol intoxicated patients, and in the sub-themes of protecting other patients in the ED, being comfortable about withdrawing care or not waking potentially violent patients.

Pandering to their needs

The emergency nurses discussed the anticipation of violence as a part of their daily working lives in the ED:

> *…that guy I left on the bed – he was violent the day before … often I'm just stepping around them – pandering to their needs thinking - 'there's one person here and I've got an Health Security Assistant (HSA) who's not much bigger than me'. It's just an unknown … you never know what you're going to say that's going to make them turn around and start throwing things at you. (F3 2)*

Don't worry – I'll look after you

Participants felt responsible to keep people safe in the face of violence from intoxicated patients. One participant gave a potent description of the out of control nature of violence she had experienced:

'He pushed me really hard and then I said – 'that's it – I'm not doin' anything with you anymore – I'm not' – I got straight out – I was between the wall and the bed. I had a young girl down in the corner and she was like "oh my God" and I'm like – "don't worry – I'll look after you – it's all good" and then I said "ring the police" … because we – obviously – he climbing out of bed – it was scary – I was – actually – I was a bit scared '(F1 4).

The participant was observed to almost be ashamed that she was afraid.

You are making me feel unsafe

Worries about patient safety if there was a need to withdraw care due to threatening behaviour was discussed. This was contrary to research suggesting the some emergency nurses overlooked intoxicated patients' needs [(39)] as the participants clearly could not ignore their professional responsibilities:

'Now you're going beyond the bounds of where my job and me are – I am withdrawing my services from you because you are making me feel unsafe – then I just worry about him until he's awake' (F2 3).

A bit more on edge

Other participants associated the feeling of increased vulnerability with a decrease in their ability to provide safe care and again, this has been highlighted in the literature, research having suggested that the relationship between vulnerability and a reduction in the level of care provided was entirely possible, and indeed, natural [(35)]. Again, it was a cause of professional worry:

'If someone comes in who's obviously been drinking and aggressive – if I don't have security or not knowing that security is there – then I feel more threatened and I probably will not act in the best interests of the patient as in I won't be humorous or giving and sharing. I'll be nervous and worried and maybe make the other patients a bit more on edge … (F1 6).

I don't cut the corners

Others asserted that patient misbehaviour would have no bearing of their delivery of required care. Reflecting on what may constitute expert practice [(54), (55), (57), (77)], and knowing the participants as an 'insider' [(27), (80), (84), (87),] the researcher surmised that many determinants, such as analytical ability and educational level, had a part to play the decision-making processes of one particular participant:

'*I would have just bandaged him up and said come back when you want to treat us like human beings. So … umm … I don't cut the corners 'cos they're rude and abusive. It doesn't change the quality of care that I'd give. If it impacts it's just that I refuse to treat them just because I'm not going to tolerate their language, behaviour or whatever' (I 2).*

Let sleeping dogs lie

Participants in different groups talked about the temptation not to wake patients who had arrived at the ED affected by alcohol, who are verbally or physically aggressive and have subsequently fallen asleep. They explored the dichotomy of waking the patient for assessment and possibly provoking an aggressive action [(4), (34), (37)], or not waking the patient and placing their care in jeopardy. This differed from the withdrawal of care when they were in actual danger, as participants acknowledged that they would have to provide care, even though they were fearful of the repercussions, if danger was only a potential threat:

'I think also when you think they're going to be violent, if they're asleep you don't want to wake them up – do you know what I mean? You should wake them up and you have to but it's sort of like … if you can put it off for a bit longer - letting sleeping dogs …'And they're the people that can be sweet as pie one minute and tearing the ED apart the next …' (F3 5)

The repercussions of actual and potential threats of violence reverberated throughout the participants' stories. They were obviously torn between maintaining their own safety and that of others in the ED, while honouring their professional responsibility to ensure the wellbeing of alcohol- intoxicated patients.

The real beauty of working in ED

Despite all the dissonant and dichotomous feelings, the majority of participants expressed an unequivocal wish to be compassionate, competent, and knowledgeable in recognition of patient vulnerability, desiring for their practice to be ethical. This wish echoed an ethical standpoint of being sensitive to the vulnerability of others [(35)]:

'*That's why I like working in ED is that the briefest interaction can make such a difference to someone's life – just that one word acknowledging that they're experiencing some kind of pain be it emotional, physical or whatever that someone can see that? That's the real beauty of working in ED' (F1 6).*

Sub-themes of agreement, resistance and knowledge deficits arose when the participants were asked whether they thought that increased education would assist in the acquisition of skills and confidence to initiate alcohol brief BI education in the ED.

You can put the dots together

Conflicting opinions and comments were received, some participants being receptive to the idea:

'Cos you need to feel confident to say … because otherwise they're just looking at you thinking – 'you think I'm an alcoholic'. If you had the education to say it right … (F2 6).

'You're not going to heal – you're not going to do the whole thing but you can put the dots together (F1 3).

It's not my job

Others were more resistant to the idea, stating that they did not have the knowledge to provide BI:

'I think it's not my job as an ED nurse. It's actually someone else's job – it's drug and alcohol because I'm not trained in that' (F1 3).

The researcher found these sentiments confounding. All the participants were multi-skilled registered nurses who also worked in the ward area where they routinely cared for patients undergoing alcohol withdrawal or who had been admitted for alcohol-related disease processes. As such, all had attended regular continuing education regarding alcohol withdrawal and information necessary to communicate to patients. The researcher had had assumption that this knowledge would be transferable to the ED and discussed this incomprehension with the volunteer who had 'scribed' for the focus groups. She observed that the participants seemed to treat the ward and ED areas of the hospital as two discreet entities where knowledge bases did not overlap. This gave the researcher pause for thought, as it meant her pre-understanding of this issue was obviously not correct [(27), (51) ,(73), (74), (76), (79)] and the reasons for the challenges of knowledge transfer from one area of the hospital to another needed to be questioned anew as 'every notion has to be examined in terms of its assumptions [(85)].

It would seem in this context, some participants did not have the ability to recognise the usefulness of knowledge gained in one setting and be able transfer to another and this observation was congruent with research that investigated 'the operationalization of context' [(53)]:

'Obviously we're missing some major points here (in relation to a discussion on knowledge deficits) *because we haven't done the research or the study'* (F2 4).

It was clear from this comment that some participants had not thought to apply the knowledge from other settings in the ED. It could be that the participants had difficulty in transferring their knowledge due to emotional or physical exhaustion [(53), (55)].

I don't have the time

Other participants adamant comments that they did not have the time or support to provide education is backed by research [(31)]:

'I don't have the time' (F1 3).

'It's always when you haven't got time … you don't have the staff to support …' (F3 5).

'It's just not practical in an ED' (F1 2).

Currently the Byron District Hospital (BDH) emergency nurses do not routinely undertake substance use history for ED patients despite NSW Health guidelines [(90)] that recommends such holistic assessment to gain health information and insight into issues related to their drug and alcohol use and offer on the spot education where appropriate. ED assessment for substance use tends to be ad hoc, and there is no provision for any formal education to patients regarding safe alcohol use. Consequently, there is a risk that some people may fall through the gap and drug and alcohol opportunistic education and treatment may be missed. There are many benefits to such interventions such as the intrinsic health benefits to the patient, the flow on benefits to friends, family and the community and the economic benefits to the community. An additional barrier to staff completing a substance use assessment in the ED is the First Net electronic medical record system used in NSW EDs that does not have an inbuilt substance history code set for embedded in its software. Therefore, nurses do not have access to a discreet prompt so that they can initiate a substance use history. Interestingly, this lack of inclusion has also been recognised in other states of Australia and the United States [(66), (68), (69)].

Playing the friend

'Playing the friend' and other strategies such as humour and self-talk were adaptive devices described by participants as ways to manage workplace stress related to patient misbehaviour, and some of these strategies have been noted to be more helpful coping mechanisms than others [(44)] and could be 'adaptive or maladaptive according to the context' [(43)]. The participants clearly used humour in numerous ways, one

to just have fun, and the others to defuse difficult and challenging situations. In the first instance, a small group of participants agreed that some shifts could be fun with alcohol-affected patients:

'The thing is though – we have some really, really good nights down there too. Where the drunks that we get in are hilarious and we really have some great times …' (F2 1).

The predominant use of humour however, was to both circumvent aggression and debrief and, as such, seemed to be used to manage the dissonances of caring for challenging patients and being one way of managing such situations verified by research [40], [42]:

'It's my coping mechanism and sometimes it's a very effective way to connect in some form of communication if you can … in the sense that they just drop their guard a little bit, drop the aggression … get a humorous rapport' (F1 1).

This use of humour was concerning because an adaptive mechanism to maintain professional equilibrium and ameliorate psychological tensions may become maladaptive and lead to burnout over time [43], [48].

Some participants used black humour [46] to manage difficult situations and emotions. However, there is a danger that the use of humour in this way may have diminish the ability to engage with the patient [43]. One participant provoked great mirth and shock from others in her group when she described her interaction with an alcohol affected patient:

'*I did say to one young fellow once – what can I do – what can I say – I don't know what to say anymore. What can I say to make you young fellas think about what you're doing. And this young UK fellow said – "oh – you can tell me it's going to cost a lot of money – I'll have to go back to England and work instead of staying here". And I said – "well … you've knocked a couple of teeth out so the dentist will cost quite a bit and you've broken your leg" (F3 6).*

The group then broke into boisterous laughter.

The surprising frankness of this revelatory exchange has been supported by observations that nurses are keen to explicate their emotions to justify their actions [45]**.** This participant had utilised ways to express genuine emotion when she felt it was appropriate to do so, thus preventing emotional dissonance [45] and possible professional burnout, however at the risk of decreasing her level of compassion [43], [47].

Another coping strategy identified entailed emotional labour as participants 'played the friend' to prevent or ameliorate aggressive or abusive behaviours and one group discussed how they did it:

'It's … is driven by my desire usually to personalise that person somehow and then I can relate to them and then I can … it helps me manage whatever else is happening with their behaviour. As soon as they come in that door I instantly try and be the friend …' (F1 1).

Other participants in the group agreed that this strategy worked and another participant laughingly commented:

'And then they respect you when you come down hard on them because then they know that you're not always the hard-arse – if you're funny and you muck around … and then if they do something and you say – 'mate – outta line' – then they'll know' (F1 5).

The last tactic pinpointed by one group to manage emotional dissonance was 'self' or 'group' talk where participants recognised their reactive behaviours to patients and endeavoured to self – adjust, this strategy being congruent with research on the management of emotions during professionally challenging incidents [49]:

'*I keep pulling myself up and thinking 'what in that interaction – why I am so reactive to it? Even then I feel guilty about my inability to stay disconnected from it' (F1 1).*

'I usually go into the treatment room for a while' (F1 6).

This comment elicited empathy and laughter:

'*If I am really finding it difficult I will hand it over to someone else – it doesn't often happen … we do debrief in the treatment room' (F1 2).*

This strategy has been supported as being a more helpful coping mechanism than the use of humour, in any of its forms, as it uses techniques such as 'active planning (to remove stress) and 'positive reframing' (thinking about the situation in a different way) [44] and could possibly be associated with those participants having the ability to utilise problem-focused coping strategies [44]. This ability is inter-related to professional

experience [49] and knowledge transfer [54], and therefore would be a vital component of creating training opportunities [54] to develop skills.

Participants talked honestly about how their communication styles when managing challenging patients. Some strategies, such as the use of humour and befriending patients in a bid to manage threats of violence may be counterproductive in the long term as unexpressed feelings can cause work-related stress & diminish patient empathy. The use of proactive managing fear and frustration that were used by some participants can be useful tools that do not compromise compassion care.

Summary of findings

Analysis of the data indicated that the participants constantly experienced dissonant and dichotomous feelings regarding patients presenting with alcohol related misadventure, sometimes within one interaction or shift. While passionately asserting a wish to be compassionate, competent and knowledgeable, they honestly acknowledged that these aspirations were not always achievable owing to both system factors such as staffing and skill mix issues through to personal frailties and beliefs. This caused them significant anxiety at times, although they relied on collegial support to manage work-related stress. This in itself was concerning as the impact of emotional labour on professional wellbeing is well documented and can have adverse effects, particularly with less experienced staff [49, 66]

An ancillary finding has been that there is no prompt for emergency nurses and medical officers to document either alcohol or drug use either at triage or in later electronic documentation [66], [67, 68], [69] they are put at a disadvantage in alcohol assessment right at the start of the ED presentation, with the potential that if the right questions are not asked, appropriate education may not be provided and patients will 'fall through the gaps'.

Study strengths

The strengths of this study lie in the fact that little has been documented about emergency nurses' feelings in relation to this phenomenon and this new data provide insights into emergency nurses' world views. Being an 'insider' encouraged a level of trust and honesty between the researcher and participants that assisted explication of the ebb and flow of participant feelings. Consequently this study could be of value when considering the introduction of brief intervention education for patients in the ED.

Study limitations

The major weakness of this study is that the findings would be difficult to generalise given the dynamic nature of hermeneutic analysis and the specificity of both the locale and participants and it is acknowledged that participant feelings may change over time. There may also have been limitations due to the researcher's managerial relationship with the participants, whereby salient information was not divulged, although, as all the focus group and interview participants seemed relaxed and certainly spoke from their hearts with great honesty and frankness, it is hoped that this possible constraint did not distort the findings significantly.

Implications for practice

The important findings of this study are related to potential practice change:

- Utilising knowledge about emergency nurses' feelings when designing education delivery systems
- Examining educational and managerial support systems currently available for emergency nurses both psychologically and professionally
- Investigating the possibility for ED electronic medical record system change to include a prompt to gather an alcohol and drug history when patients present to the ED

Conclusion

Using a hermeneutic phenomenological methodology to interpret the research findings has highlighted the feelings of emergency nurses who care for patients presenting with alcohol related injury or illness to the ED. The concerns regarding their own physical safety and the frustration, anxiety and worry about the provision of effective care to this patient cohort cannot be underestimated, even though these feelings are moderated by compassion, tolerance and empathy. Emergency nurses need to have strong educational and managerial support to develop confidence and skill in alcohol BI education, ensure that compassionate care is not inhibited and to prevent burnout related to suppression of negative emotions. Additionally, emergency nurses require systems support from an ED electronic medical record that provides an electronic prompt to gather the necessary history regarding alcohol use at the start of the ED presentation so that appropriate education can be provided if appropriate.

Recommendations

This research recommends that local senior managers and NNSWLHD encourage the planning and delivery of programs that support emergency nurses and provide necessary public health initiatives in the ED.

1. Psychological support for emergency nurses can be strengthen by:
    a. managers acknowledging the psychological stress of caring for alcohol intoxicated patients
    b. managers and clinical leaders developing opportunities to discuss confronting shifts and patients on a regular basis
    c. clinical leaders including challenging alcohol related presentations on the agendas of clinical review meetings to encourage discussion of the psychological and clinical issues when caring for this patient subset in recognition of presentation numbers.
2. Emergency nurses require the following to implement alcohol brief intervention education in the ED:
    a. managerial and educational support for understanding the concepts of alcohol brief interventions as a public health initiative
    b. provision of appropriate staff education coordinated by the clinical nurse educator and delivered by a NNSWLHD Drug and Alcohol Clinical Nurse Consultant (CNC) to ensure staff knowledge and confidence
    c. adequate staff, quarantined time and a quiet, discreet environment to provide patient education.
3. The Northern NSW Local Health District Chief Executive will need to petition the NSW Ministry of Health eHealth Department regarding necessary clinical redesign Systems redesign of the ED electronic medical record First Net to include a distinct icon built into the patient assessment. This would immediately prompt
4. This system redesign would –
    a. ensure that emergency nurses to take an accurate substance use history, guide any required education so patients do not ‘fall through the gaps’.
    b. provide contemporaneous, cost effective and accurate alcohol-related data sets that can support future health initiatives.
5. Research to further develop findings of this study could comprise:
    a. additional studies in different settings to assess the experiences of other emergency nurses, acknowledging the exploratory nature of the study, and given the dynamic nature of the methodology.
    b. cost benefit analysis regarding the costs involved with implementing the recommendations and the overall savings made by the potential decrease in alcohol misuse and subsequent financial imposts on the health system and society.

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PARTICIPANT INFORMATION SHEET
RESEARCH PROJECT

An exploration of experience of Emergency Department registered nurses working with patients presenting with an alcohol related illness or injury at a small rural coastal hospital

Invitation
You are invited to participate in a research study into the experience of Emergency Department registered nurses working with patients presenting with an alcohol related illness or injury at a small rural coastal hospital

The study is being conducted by Elizabeth McCall, Nurse Manager, Byron District Hospital, Byron Bay.
Before you decide whether or not you wish to participate in this study, it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully and discuss it with others if you wish.

1. 'What is the purpose of this study?'
The purpose is to document the essence of what it is like for Emergency Department registered nurses to interact with, and provide care for patients whose alcohol misuse has necessitated presentation to the hospital for treatment.

2. 'Why have I been invited to participate in this study?'
You are eligible to participate in this study because you are a First Line Emergency Care (FLEC) accredited registered nurse who works in the Emergency Department

3. 'What if I don't want to take part in this study, or if I want to withdraw later?'
Participation in this study is voluntary. It is completely up to you whether or not you participate. If you decide not to participate, it will not affect your working conditions now or in the future. Whatever your decision, it will not affect your relationship with your managers or other staff.
If you wish to withdraw from the study once it has started, you can do so at any time without having to give a reason. However, it may not be possible to withdraw your data from the study results if these have already had your identifying details removed.

4. 'What does this study involve?'
If you agree to participate in this study, you will be asked to sign the Participant Consent Form.
This study will be conducted by conducting three focus groups comprising six to eight participants for data collection, as the intent is to explore the opinions and perspectives of the FLEC registered nurses working in the Emergency Department. Following this, in-depth interviews of one novice FLEC registered nurse and one expert FLEC registered nurse will be conducted to acquire a diverse understanding of the nurses' experiences'. The invitation includes participation in both the interviews and the focus groups, although you may not be selected for the interview phase.

5. 'How is this study being paid for?'
The study is being sponsored by the Health Education and Training Institute (HETI) of the New South Wales Ministry of Health and the Northern New South Wales Local Health District (NNSWLHD).

6. 'Are there risks to me in taking part in this study?'
There may be risks associated with this study that are presently unknown or unforeseeable. In spite of all reasonable precautions, you may experience discomfort while participating in this study due to the subject matter. As you are reflecting on your experiences, the reasonably foreseeable risks and discomforts may include:

- loss of reputation with peers related to frank discussion within the focus groups
- loss of confidence in self or peers related to frank discussion within the focus groups

There may also be risks associated with this trial that are presently unknown or unforeseeable, for example, concerns engendered through reflection on personal and/or family/friends alcohol consumption and related possible concerns in the focus groups and interviews.

7. 'What happens if I suffer injury or complications as a result of the study?'
If you suffer any discomfort as a result of this study, you should contact the study researcher as soon as possible, who will assist you in arranging appropriate support through the NNSWLHD Employee assistance Program (EAP).

8. 'Will I benefit from the study?'
This study aims to further nursing knowledge and may improve future management of patients with an alcohol related illness, injury or issue presenting to an Emergency Department by gaining an understanding of how nurses experience interaction with these patients. Information gained may assist future research directions regarding the implementation of staff support, education and systems improvements necessary to support and care for this sub-set of patients. However it may not directly benefit you.

9. 'Will taking part in this study cost me anything, and will I be paid?
Participation in this study will not cost you anything. Both the interviews and focus groups will be conducted while you are on duty as far as possible. Light refreshments will be provided during the study focus groups.

10. 'How will my confidentiality be protected?'
The researcher and one other staff member will be the only people to attend the focus groups and both will assure participants of confidentiality. Additionally each focus group will be asked to assure the confidentiality of the experiences discussed within that group. The sole researcher will be the only person to collect the in-depth interview data. Any identifiable information that is collected about you in connection
with this study will remain confidential and will be de-identified for analysis. Only the researcher named will have access to your details and results that will be held securely at Byron District Hospital.

11. 'What happens with the results?'
It is an integral part of the HETI Rural Research Capacity Building program that findings of the research will be disseminated by presentation at a conference and submission of a peer reviewed journal article for publication consideration. Therefore, if you give me your permission by signing the consent document, I plan to discuss/publish the results by :

- Publishing the research final report on the HETI web site
- Reporting findings to both the management and staff of the hospital and to the NNSWLHD sponsor.
- Submitting paper describing the research study and results for presentation at a conference yet to be determined
- Submitting an article describing the research study and results for publication in a peer-reviewed journal yet to be determined.

Results of the study will be provided to you, if you wish.

12. 'What should I do if I want to discuss this study further before I decide?'
When you have read this information, the researcher Elizabeth McCall will discuss it with you and any queries you may have. If you would like to know more at any stage, please do not hesitate to contact me on 0266396692.

13. 'Who should I contact if I have concerns about the conduct of this study?'
This study has been approved by the North Coast NSW Human Research Ethics Committee. If you at any stage have a complaint about the research project you may contact the North Coast NSW Human Research Ethics Committee, Research Ethics Officer - PO Box 821, Murwillumbah NSW 2484, Phone 02 66720269 or email EthicsNCAHS@ncahs.health.nsw.gov.au

Thank you for taking the time to consider this study. If you choose to be a participant could you please return the consent form by …….. I will then contact you to schedule a time and date for your interview, if you are selected and for a relevant focus group meeting when you are on duty.

If you choose to participate could you please write or type three words on separate pieces of paper to bring to the focus group meeting. An arbitrary focus group member will be invited to draw the words out of a hat one at a time and read them out so that group members do not have to put forward their own point of view in the first instance. This will assist in eliciting anonymous information without group members feeling vulnerable in the first instance and to generate discussion.

I appreciate your consideration of this invitation.

If you wish to take part in it, please sign the attached consent form. This information sheet is for you to keep

Consent Form
Focus Group Meetings

Title of study: An exploration of experience of Emergency Department registered nurses working with patients presenting with an alcohol related illness or injury at a small rural coastal hospital

I, …….(insert name) agree to participate in this research project , and know that participation will involve participation in a focus group meeting regarding what it is like to work with patients who present to the ED with an alcohol related illness, injury or issue. I understand that the focus group meeting will be recorded on a digital recorder that I am able to request recording to cease at any time during the focus group I understand that written notes will also be taken by an observer and that I am able to request written transcription to cease at any time during the focus group meeting.

I understand that I have been requested to write or type three words on separate pieces of paper to bring to the focus group meeting. An arbitrary focus group member will be invited to draw the words out of a hat one at a time and read them out so that group members do not have to put forward their own point of view in the first instance. This will assist in eliciting anonymous information without group members feeling vulnerable in the first instance and to generate discussion.

I have read and understood the Participant Information Sheet. I have been given the opportunity to ask any questions relating to the research and I have received satisfactory answers. I understand that I am free to withdraw my consent and discontinue the use of my information at any time and without prejudice.

I understand that my responses will be treated with the confidentiality and that any information that is obtained in connection with this study will be de-identified. I understand that I have the ability to review, edit or erase any of my information from audio or written transcripts.

I also agree that research data gathered from the study may be published and/or used in future studies and that potentially identifiable information will not be used in any reports at any time.

I understand that I can lodge a complaint about the focus group meeting by contacting the Research Ethics Officer, North Coast NSW Human Research Ethics Committee, PO Box 821, Murwillumbah NSW 2484, Ph: 0266720269, Email: EthicsNCNSW@ncahs.health.nsw.gov.au

…….Signature of Participant

……...(Please PRINT name)

…….Signature of Witness

…….(Please PRINT name)

…….Date

A report will be produced by June 2014
If you would like a copy of the final report from this study, please indicate with your name and address.

Principal Researcher is Elizabeth McCall, Byron District Hospital, Ph : 0266396692

Consent Form
In-depth Interviews

Title of study: An exploration of experience of Emergency Department registered nurses working with patients presenting with an alcohol related illness or injury at a small rural coastal hospital

I, …….(insert name) agree to participate in this research project , and know that participation will involve a face to face interview regarding what it is like to work with patients who present to the ED with an alcohol related illness, injury or issue. I understand that the interview will be recorded on a digital recorder and that I am able to request recording to cease at any time during the interview.

I have read and understood the Participant Information Sheet. I have been given the opportunity to ask any questions relating to the research and I have received satisfactory answers. I understand that I am free to withdraw my consent and discontinue the use of my information at any time and without prejudice.

I understand that my responses will be treated with confidentiality and that any information that is obtained in connection with this study will be de-identified. I understand that I have the ability to review, edit or erase any of my information from audio or written transcripts.

I also agree that research data gathered from the study may be published and/or used in future studies and that potentially identifiable information will not be used in any reports at any time.

I understand that I can lodge a complaint about the interview by contacting the Research Ethics Officer, North Coast NSW Human Research Ethics Committee, PO Box 821, Murwillumbah NSW 2484, Ph: 0266720269, Email: EthicsNCNSW@ncahs.health.nsw.gov.au

…….Signature of Participant

……...(Please PRINT name)

…….Signature of Witness

……..(Please PRINT name)

…….Date

A report will be produced by June 2014
If you would like a copy of the final report from this study, please indicate with your name and address.

Principal Researcher is Elizabeth McCall, Byron District Hospital, Ph : 0266396692

Appendix D

KEY WORDS BROUGHT TO FOCUS GROUP MEETINGS AND INTERVIEWS BY PARTICIPANTS

Words in the major prevalence lists were brought to the focus group meetings by greater than two participants. Words in the minor prevalence lists were brought to the focus group meetings by two or less participants and were either subsumed and discussed under another word or not discussed due to time constraints with group approval.

Interview One – 10th January 2013

Empathy
Values
Powerlessness

Focus Group One – 14th January 2013

Major prevalence	**Minor prevalence**
Frustration	Guilt
Disgust	Optimism
Humour	Pity
Security	Danger
Incomplete	

Interview Two – 18th January 2013
Burden
Appreciation
Tolerance

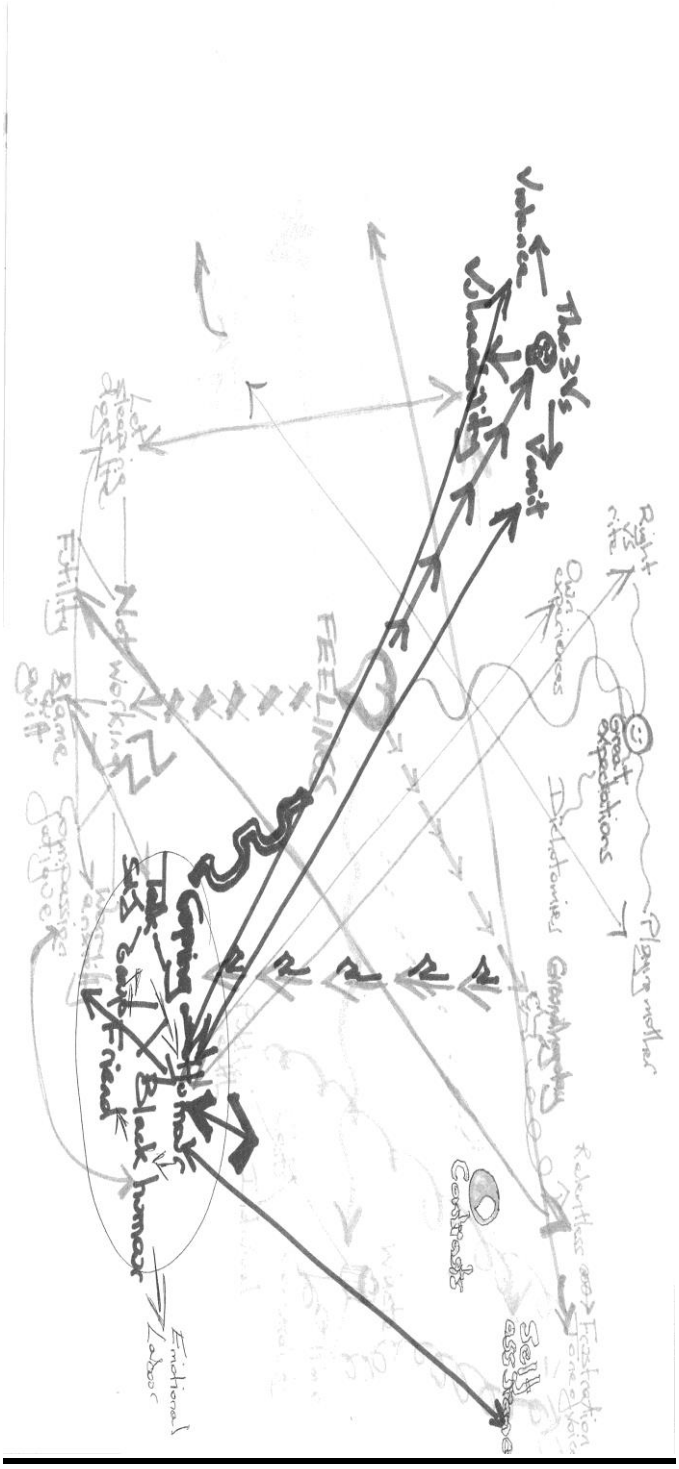
Focus Group Two – 23rd January 2013

Major prevalence	**Minor prevalence**
Frustration	Hopelessness
Messy	Acceptance
Difficult assessment	Unsafe
Inevitable	Manipulative
	Patience

Focus Group Three – 7th February 2013

Major prevalence	**Minor prevalence**
Frustration	Irresponsible
Anticipation / not another one	Irritability
Concern/sadness	Experimentation
Demanding	Foolish
	Despair

MIND MAP



FINAL CODING TREE

Ground hog day

Relentless nature of presentations-

- Constant nature of presentations
  - Feelings of burn out
  - Worn out
  - Frustrated – exemplified by tone of voice
  - Exasperated
- No longer just when there are big events
- Every weekend
  - No improvement
  - Demanding
  - Repetitive
  - Don't learn anything
  - Just patching up
  - Hope that issues may be addressed in an venue

- Use of humour – link to coping mechanism

What a waste –

Time -
Needing to spend time with alcohol affected patients -

- Behaviours
  - Alteration in mood
  - Potential for violence
  - Decreased abilities

- Maintain patient safety
  - Difficulties in obtaining history
  - Vomiting/aspiration
  - Conscious level
  - Increased risk for falls/injury

- Dealing with related injuries

- Worth spending the time initially to manage them more effectively

- Decrease in empathy related to impact on time

Constraints put on resources –
Length of time spent with alcohol affected patients reduces time spent with other patients-

- Staffing resources required for alcohol affected patients
  - At least 1 nurse
  - HSA
  - Possibly police
- Assessment, investigations & treatment required

Cost to society –
Taxpayers' money spent on alcohol misuse presentation-

- Costs to the individual
- Costs to family

- Costs to others

Public health issue –
The societal acceptance of alcohol misuse

- Picking up the pieces
    - Need for preventive initiatives
- Biggest health burden on society
- Political issues
- Business interests
- Advertising
- Societal acceptance of misuse
    - Comparisons to alcohol consumption in Europe
    - Schoolies
    - Sporting & music event
    - Australia Day
- Societal expectations regarding health care
    - Not taking responsibility

It's not working and I don't feel good about it

Futility & helplessness –
Frustrations related to alcohol misuse & nursing interventions not changing patients' behaviours – link to relentless presentations

- Resignation spills over to hopelessness/powerlessness
- Over and over again
- Frequent flyers -
    - Chronic alcoholism – self abuse
    - Modus operandi
- Water off a duck's back

Nurses' anger, blame & guilt – link to coping mechanisms, dissonance and EL
The dissonance of wanting to be compassionate and feeling guilty for negative thoughts and feelings about patients

- Blaming the patient
    - Putting up a hard shell
    - Oscillating between anger and empathy
- Nurses meant to be compassionate
    - Nurses conflicted
- Nurses seen as witches

Compassion fatigue
The exhausting nature of relentless presentations

- Victim mentality of patients
    - Manipulative
    - Demanding
- Worn out
    - No breaks
- Personal experiences/prejudices

Worry & anxiety
Nurses want to be assured that the patient doesn't have any underlying injury or illness

- Critical that you get it right
    - Watching & waiting
- Worried, scared and anxious
    - The snowballing effect of anxiety on practice
- Keep them overnight if worried
- Patient unsafe to be discharged
- Relief when the patient wakes up
    - Feeling isolated
- Difference between alcohol misuse presentations and others e.g. cardiac

    - No protocols to follow unless patient unconscious
    - Uncertainty

Let sleeping dogs lie
While nurses feel they need to wake patients who are alcohol affected to ensure patient safety, they are sometimes fearful of doing that because of the potential abuse and violence that may occur

- Can I put if off a bit longer
    - Possibility of jeopardising care
    - Uncertainty of not knowing if there is any underlying injury or illness
- Anticipation associated with knowledge and history
    - Sweet as pie one minute, tearing the ED apart the next
    - Usually quite nice
    - Not knowing what will trigger violence
- Waking the patient aggravates the behaviour

A nursing wish list

Compassion and empathy
Nurses want to exemplify compassion and empathy for patients – link to dissonance of compassion fatigue. Note tone of voice when speaking of compassion

- Reminding self of patient history and story
    - Empathy generated
    - Acknowledging the humanity of the patient as they start to sober up
- Acceptance
    - This presentation might not heal them
    - No-one wants to be an alcoholic
- Maintain professional equanimity
    - Don't show frustration
    - Don't blame them
- Beneficial interactions during crisis
    - Offering support for the future
    - Making a difference
- Thinking about the family & friends

Competent
Nurses recognise the professional responsibility to maintain patient safety

- Difficult to assess
    - No clear history
    - Other health workers ambivalent/ blasé
- Don't just assume
    - Follow the guidelines
    - Initiate all the necessary observations

Knowledgeable
Nurses want to have the skills and knowledge to educate patients

- Knowledge deficit
    - Joining the dots
- Lacking confidence
    - That's not my job
    - I'm not trained
- Using convincing communication skills
    - Depends on patient receptivity
    - Crisis precipitating change
- Not threatening
    - Just a nurse
    - Tough love
- Recognising public health issues
    - Getting them at a younger age
    - Keep trying

A go to person
Nurses want access to services they can utilise in the ED

- Time poor
  - Not enough time to sit & counsel patients
- It's not my job
  - I'm not trained
  - It's not my role
- A liaison worker
  - Availability
  - Time

Violence, vomit& vulnerability

Violence
The behavioural manifestations of alcohol misuse – note the dissonance with maintain patient safety

- Setting the boundaries
  - Recognition of potential threat
  - Withdrawing care
  - Using police and security
- De-escalating threat
  - Communication

Vomit
How the physical aftermath of alcohol misuse affects nurses

- Disgust
  - Smell
  - Messy
  - Dirty
  - Filthy

Vulnerability
Nurses need to protect self, other staff and patients – note dissonance of maintaining patient safety, withdrawing care and associated worry & anxiety – link to clinical decision making & experience

- Tolerance
  - As long as safety is maintained
- Withdrawing care
  - Maintain safety
  - Worry about patient care
- Vulnerability affects patient care – link with competence/professional responsibilities
  - Stepping around the patient
  - Not acting in best interests of patient
  - Keeping distance
  - On edge
- Clinical confidence
  - Making the judgement call not to treat

Great expectations
Playing mother
Nurses are more forgiving of young people's alcohol misuse – link to own experiences

- Playing mummy
  - Lecturing the kids
  - Are they listening
- It's experimental
  - There's still time to change
  - More inclination to help them
  - They'll grow out of it
- It's the 1st time
  - How do you know
  - Looking for presentation patterns
  - Learning the lessons
- Tolerance

    - It's a party town
    - It's a youthful town
    - It can be fun
    - They are going to take risks
    - Age appropriate
- Apologetic
    - I'm sorry

Right versus rite
Nurses question whether young people see alcohol misuse as a rite of passage or as a right to do as they please

- What does it mean
    - Do they understand
- Expectations
    - Patching them up regardless
    - Putting up with their bad behaviour
- The whole bar has been lowered

Dichotomies
Nurses have differing opinions about tolerance, age and type of alcohol misuse

- The locals
    - History and knowledge
    - Differing opinions on behaviour
- The travellers & visitors
    - 18-30
    - Male
    - Buffed
    - Differing opinions on respect
    - Differing opinions on remorse
- Mixing it up
    - Drugs, caffeine drinks and alcohol
- Fly in, fly out towns
    - Similarities with behaviours
    - No allegiance to town

Own experiences
Nurse were able to recall their own youthful alcohol misuse – link to humour

- Identification
    - Recollection
    - Embarrassment

- Resilience
    - Not dependent on ED care
    - Self reliance
- Lower threshold
    - Huge amounts of alcohol
    - Mixing
    - Going out to get drunk

Contrasting the behaviours and practices of experienced and less experienced nurses
Self –assurance
Experienced registered nurses have the ability to cut to the chase and know when to treat and not to treat – link to relentless presentations, frustrations & costs

- It can wait until tomorrow
    - Just a bandage
- Time management
    - Don't argue – just triage & treat

- Less frustration
    - Higher tolerance
    - Ability to de-escalate
- A more global view

- Putting empathy into practice

The cost of coping

Humour

Using humour to defuse potentially violent situations and having fun – note the dissonance regarding emotional labour and the toll taken on psychological well-being

- The best shifts ever
  - Happy Diggers appreciative
  - Drunks are hilarious
- Funny after the event
  - Debriefing
- De -escalating a tense situation
  - Get them off guard
  - Establish a rapport
  - Personalising the patient
- Works if you're not too tired

Black humour

Nurses finding the humour in incidents that regard human suffering as absurd rather than pitiable, or that considers human existence as ironic and pointless but somehow comic – link to compassion fatigue

- A way of surviving
  - Us against them
- Shock tactics
  - Expressing the inexpressible

Playing the friend

Tactics used to protect self & others

- Reading the situation
  - As soon as they walk in
- Coming down hard
  - More probability of accepting boundary setting

Self & group talk

Nurses shutting down negative feelings at the expense of their own psychological well being

- Questioning own reactions
- Blowing up
- Raising your voice
- Putting up a wall
- Trying to be positive
- Retreating/withdrawing