



uOttawa

L'Université canadienne
Canada's university

FACULTÉ DES ÉTUDES SUPÉRIEURES
ET POSTDOCTORALES



uOttawa

L'Université canadienne
Canada's university

FACULTY OF GRADUATE AND
POSTDOCTORAL STUDIES

Lisa Freeman

AUTEUR DE LA THÈSE / AUTHOR OF THESIS

M.Sc. (Nursing)

GRADE / DEGREE

School of Nursing

FACULTÉ, ÉCOLE, DÉPARTEMENT / FACULTY, SCHOOL, DEPARTMENT

The Lived Experience of Being a Trauma Nurse: "Seeing Through Cloudy Situations"

TITRE DE LA THÈSE / TITLE OF THESIS

Frances Fothergill-Bourbonnais

DIRECTEUR (DIRECTRICE) DE LA THÈSE / THESIS SUPERVISOR

CO-DIRECTEUR (CO-DIRECTRICE) DE LA THÈSE / THESIS CO-SUPERVISOR

EXAMINATEURS (EXAMINATRICES) DE LA THÈSE / THESIS EXAMINERS

Meryn Stuart

Alwyn Moyer

Gary W. Slater

LE DOYEN DE LA FACULTÉ DES ÉTUDES SUPÉRIEURES ET POSTDOCTORALES /
DEAN OF THE FACULTY OF GRADUATE AND POSTDOCTORAL STUDIES

**The Lived Experience of Being a Trauma Nurse:
“Seeing Through Cloudy Situations”**

Lisa Marie Freeman

Thesis submitted to the Faculty of Graduate Studies and Post-Doctoral Studies
In partial fulfillment of the requirements for the degree of Master of Science in Nursing

School of Nursing
Faculty of Health Sciences
University of Ottawa

© Lisa Marie Freeman, Ottawa, Canada, 2005



Library and
Archives Canada

Bibliothèque et
Archives Canada

Published Heritage
Branch

Direction du
Patrimoine de l'édition

395 Wellington Street
Ottawa ON K1A 0N4
Canada

395, rue Wellington
Ottawa ON K1A 0N4
Canada

Your file *Votre référence*

ISBN: 0-494-11272-7

Our file *Notre référence*

ISBN: 0-494-11272-7

NOTICE:

The author has granted a non-exclusive license allowing Library and Archives Canada to reproduce, publish, archive, preserve, conserve, communicate to the public by telecommunication or on the Internet, loan, distribute and sell theses worldwide, for commercial or non-commercial purposes, in microform, paper, electronic and/or any other formats.

The author retains copyright ownership and moral rights in this thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without the author's permission.

AVIS:

L'auteur a accordé une licence non exclusive permettant à la Bibliothèque et Archives Canada de reproduire, publier, archiver, sauvegarder, conserver, transmettre au public par télécommunication ou par l'Internet, prêter, distribuer et vendre des thèses partout dans le monde, à des fins commerciales ou autres, sur support microforme, papier, électronique et/ou autres formats.

L'auteur conserve la propriété du droit d'auteur et des droits moraux qui protègent cette thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation.

In compliance with the Canadian Privacy Act some supporting forms may have been removed from this thesis.

Conformément à la loi canadienne sur la protection de la vie privée, quelques formulaires secondaires ont été enlevés de cette thèse.

While these forms may be included in the document page count, their removal does not represent any loss of content from the thesis.

Bien que ces formulaires aient inclus dans la pagination, il n'y aura aucun contenu manquant.


Canada

Abstract

From the time of admission through rehabilitation, trauma nurses are faced with the challenges of caring for the survivors of traumatic injuries (Neff & Stinson-Kidd, 1993). Trauma unit nurses are responsible for detailed assessments, documentation of all events, management of crisis situations and providing continued emotional support of patients and family members. Research shows that care of the trauma patient places great cognitive, emotional and physical demands on the trauma nurse. However, the literature review indicated that limited work had been done which captured the perspectives of trauma nurses and no studies could be found which explored the meaning of being a trauma nurse. Therefore, a qualitative study using interpretive phenomenology was undertaken to describe the lived experience of being a trauma nurse.

In-depth semi-structured interviews were conducted with a purposive sample of seven registered nurses employed in a trauma unit within a university-teaching hospital. The transcripts were analyzed for recurring themes emerging from the data according to the procedure outlined by Colaizzi (1978).

Four themes were revealed in the data analysis: "*Being on guard all of the time,*" "*Being caught up short,*" "*Facing the challenge,*" and "*Sharing the journey.*" The seven participants agreed that the essence of being a trauma nurse was captured in the metaphorical statement: "*Seeing through cloudy situations.*" Despite the many challenges participants faced on a daily basis, they were able to see through the cloudy situations and find meaning and satisfaction in being trauma nurses. The negative aspects about being a trauma nurse were offset by the positive moments.

Acknowledgements

I would first like to express my sincere thanks to the nurses who took the time out of their busy schedules to share their thoughts and experiences with me. I have learned so much from your experiences. It truly was a privilege for me to listen to your stories.

I would like to acknowledge the financial support I received throughout the MScN program: RNAO Nursing Research Interest Group (NRIG) – Open Research Grant, The Zagerman Family Nursing Research Scholarship, and The Ottawa Hospital Civic Auxiliary Bursary.

I want to express my gratitude to my thesis supervisor, Dr. Frances Fothergill-Bourbonnais, for her guidance and wisdom. I truly admire your commitment to students and research. Also, a sincere thank you to my other thesis committee members, Dr. Meryn Stuart and Judy Rashotte, for sharing their time and expertise.

To one of my best friends, Lisa Bitonti, with whom I have shared laughter and tears. Without you, I would not have been able to make it through the MScN program. I appreciate you for your thoughtfulness, generosity, wisdom and sense of humour.

Finally, I want to thank my family for their love and support. To my parents, Mike and Joan Freeman, I am forever grateful for your endless encouragement. To my husband, Chris, I express my deepest appreciation for your understanding, love, and support.

Table of Contents

ABSTRACT	2
ACKNOWLEDGEMENTS	3
TABLE OF CONTENTS	4
LIST OF TABLES	7
CHAPTER 1 – INTRODUCTION	8
1.1 Background	8
1.2 Purpose of the Study	10
1.3 Research Questions	10
CHAPTER 2 – REVIEW OF THE LITERATURE	11
2.1 The Meaning of Being	11
2.1.1 Situation	13
2.1.2 Engagement	15
2.1.3 Concern	16
2.1.4 Temporality	16
2.1.5 Humans are self-interpreting beings	17
2.2 The Experience of Being a Nurse	17
2.3 Trauma Nursing Practice	20
2.3.1 The evolution of trauma nursing	22
2.3.2 Caring for trauma patients	22
2.4 Summary of the Review of Literature	26
CHAPTER 3 – METHODS	27
3.1 Research Design	27
3.2 Methodological Assumptions	27
3.3 Eligibility Criteria	28
3.4 Participants	28
3.5 Setting	29
3.6 Process of Data Collection	31
3.6.1 Pilot test	31
3.6.2 Main study	31
3.7 The Interview Process	32
3.8 Characteristics of Participants	33
3.9 Data Analysis	34
3.10 Methods to Ensure Rigor	36
3.10.1 Credibility	36
3.10.2 Applicability	38
3.10.3 Consistency	38
3.10.4 Neutrality	38
3.11 Protection of Human Rights	39

CHAPTER 4 – FINDINGS AND DISCUSSION	40
4.1 Introduction	40
4.2 Overview of the Findings	40
4.3 The Cloudy Situations	43
4.3.1 Theme 1: Being on guard all of the time	43
4.3.1.1 Feeling scared	44
4.3.1.2 Feeling the need to watch your back	48
4.3.2 Theme 2: Being caught up short	50
4.3.2.1 Feeling disrespected	51
4.3.2.2 Feeling like you are going to lose it	54
4.3.2.3 Feeling uncertain	58
4.4 Seeing Through Cloudy Situations	62
4.4.1 Theme 3: Facing the challenge	62
4.4.1.1 Looking beyond what the patient had done	62
4.4.1.2 Being a trauma junkie	66
4.4.2 Theme 4: Sharing the journey	70
4.4.2.1 Helping families get through a difficult time	71
4.4.2.2 Being there for each other	75
4.4.2.3 Seeing patients recover	78
4.4.2.4 Having that human touch	81
4.5 Summary of Findings	83
CHAPTER 5 – IMPLICATIONS FOR PRACTICE, EDUCATION AND RESEARCH	85
5.1 Introduction	85
5.2 Implication for Nursing Practice, Education and Research	85
5.2.1 Implications for nursing practice	85
5.2.2 Implications for nursing education	93
5.2.2.1 Clinical staff education	93
5.2.2.2 Formal education	94
5.2.3 Implications for nursing research	95
5.3 Role of the Advanced Practice Nurse (APN)	97
5.3.1 Expert clinician	97
5.3.2 Consultant	98
5.3.3 Educator	98
5.3.4 Researcher	100
5.3.5 Leader	100
5.4 Limitations	101
5.5 Conclusion	102

REFERENCES	103
APPENDIX A: Letter of information for research study	120
APPENDIX B: Consent form	122
APPENDIX C: Demographic data and interview guide	123

List of Tables

Table 1 – Description of Participants	35
---------------------------------------	----

Chapter 1 – Introduction

On a busy evening shift in the trauma unit of an urban hospital, Janice, a 30 year old trauma nurse, admitted three patients from the emergency room to the trauma unit. The first patient is a 50 year old male with a fractured ankle who was involved in a motor vehicle accident. He had been drinking and driving, lost control of his car and swerved into an oncoming vehicle. The second patient, a passenger in the oncoming vehicle, is a 40 year old woman. The vehicle contained a family of five who were on their way home from a summer vacation at their cottage. The mother fractured both legs, had several internal injuries and sustained a closed head injury. Her 13 year old daughter was taken to the Children's Hospital with a fractured arm and pelvis. Her husband and other two children, aged 3 and 13 months, died at the scene of the accident. The third patient is a 25 year old male who was involved in a gang related incident. He has a gunshot wound to the right shoulder. The three patients are located merely a few rooms apart from each other. The image created by this story is one that has and could occur in any trauma unit.

1.1 Background

Trauma is the leading cause of death for people under age 45 years in Canada (Smartrisk, 1998). In 2000/2001, there were 198,040 injury admissions to acute care hospitals in Canada (Canadian Institute for Health Information, 2003). In total, patients with trauma-related injuries spent 1,935,413 days in Canadian hospitals in 2000/2001 (Canadian Institute for Health Information). Indeed, trauma has been identified as one of the top three reasons for individuals to visit an emergency department in Ontario (Chan, Schull & Schultz, 2001). For the purpose of this study, trauma refers to a severe sudden or unexpected physical injury caused by an external force or violence that requires immediate medical attention and intervention. The injuries resulting from trauma could be related to incidents such as gunshots and stabbings, motor vehicle collisions, construction accidents and unintentional falls.

When a serious injury occurs, a person is immediately transferred by ground or air

ambulance to the hospital. Once the patient is stabilized and emergency procedures are completed in the emergency department, patients are admitted to a *trauma unit*.

When patients are transferred to the trauma unit, trauma nurses are involved in assessment of the patient and in planning and implementing different aspects of care.

Trauma unit nurses are responsible for detailed assessments, documentation of all events, management of crisis situations and providing continued emotional support of patients and family members. Many trauma nurses have specialized training in trauma and have taken courses such as the Trauma Nursing Core Course (TNCC). Trauma nurses work in a variety of settings such as emergency departments, intensive care units and trauma units. For the purpose of this study, the term *trauma nurse* refers to nurses who work in a trauma unit.

I have worked in a multitude of nursing settings including trauma. The introductory story is similar to many stressful shifts that I experienced as a trauma nurse. Situations such as this led me to contemplate the amount of stressful and challenging situations that trauma nurses are exposed to on a daily basis. I wanted to know if other trauma nurses shared similar experiences. I chose this topic because of my strong personal interest in the experiences of trauma nurses. The study evolved from having been a trauma patient as well as from professional experience as a trauma nurse. My own clinical experience caring for trauma patients as well as that of being a trauma patient revealed that the care was very complex, challenging and required a great deal of knowledge and skill. For me, being a trauma nurse was emotionally, physically and cognitively demanding.

1.2 Purpose of the Study

The purpose of this study was to describe the lived experience of being a trauma nurse. This study is intended to advance the profession's understanding of what it means to be a trauma nurse.

1.3 Research Questions

1. What is the lived experience of being a trauma nurse in a trauma unit?
2. What are the factors that facilitate or hinder being a trauma nurse?
3. What are memorable and difficult situations that trauma nurses have encountered during their practice?

Chapter 2 – Review of the Literature

In keeping with the principles of qualitative research, a selective review of the literature was completed prior to data collection, in order to guide the development of the research questions. This chapter includes a discussion of Martin Heidegger's (1927/1962) philosophy of Being, which served as the philosophical underpinning for answering the current study's research question "what is the lived experience of being a trauma nurse?" In addition, an overview will be provided on the research, specifically phenomenological studies conducted on the experience of being a nurse. A review of the literature on the nature of trauma nursing practice and caring for trauma patients will be discussed in order to provide a background on existing literature related to the delivery of health care to trauma patients. The chapter will conclude with a summary of the review of literature pertaining to the research questions.

2.1 The Meaning of Being

Martin Heidegger, a German 20th century philosopher, questioned the meaning of Being. To ground his philosophy, Heidegger (1927/1962) first distinguished between Being and being. Being with a capital "B" is the primordial condition or "ground" that allows everything else to come into existence; whereas being with a small "b" is everything else, people and the whole complexity that exists as world (Lemay & Pitts, 1994). Heidegger sought to illuminate Being, and make it the central question of concern to philosophers. Heidegger challenged the foundations of knowledge by shifting from a philosophy concerned with epistemology (knowing) to one primarily concerned with ontology (being). In other words, he turned the focus that sought to ask the question

‘how do we know what we know?’ to an ontological perspective that asks ‘what does it mean to be a person?’ (Leonard, 1989, p. 42).

In his major work *Being and Time* (1927/1962), Heidegger considered the reasons why the question of Being had been overlooked and attributed this to the view that Being was so universal and taken for granted that philosophers did not see any reason or need to discuss it. Heidegger saw Being as the “darkest concept of all” which could only come to light and be revealed through an examination of human ways of being.

Heidegger (1927/1962) contended that phenomenology was the only method by which to do *ontology*, the study of Being. *Dasein*, defined by Heidegger, is an aspect of being human that has the capability for seeking the understanding of being in the world. Heidegger gave the name *Dasein* to the type of being that we call human beings. In Heidegger's terms, for the human being to exist as *dasein* is to exist “authentically” (p. 68). Heidegger called *Dasein*'s activity of existing as *Being-in-the-world*. *Being-in-the-world* is therefore an essential part of the structure of *Dasein*, and inseparable from it. Heidegger refers to the term world as meaning a unified field of concerns and interests, such as the world of the nurse. “Being in” such a world refers to one’s engagement with the meaning-giving concerns and interests that define the field (Heidegger, p. 78-90).

In Heideggerian phenomenology, meaning resides neither solely within the individual, nor the situation, but in a transaction between the two. To be human, Heidegger contended, is to be thrown into a world in which we are already involved, that is, we are already skilled at existence. The everyday practices of *Being-in-the-world* are so familiar and taken for granted that we often lose sight of them. In Heidegger’s view, the hidden meaning of phenomena is revealed through a description of everyday

experience. By examining human ways of being-in-the-world, we are able to bring to light the meaning of Being. In this way, Heidegger sees that there is a “clearing” in which specific forms of human experience are revealed (1927/1962). This clearing allows that which is hidden to become accessible and show up as what it is. This understanding of Heidegger’s notion of Being was used to reveal the meaning of Being for humans in a particular context, which was the focus of the current study. By examining the ways in which participants in the current study experienced being trauma nurses, the meaning attributed to this phenomenon was revealed within their own context.

In examining Heidegger’s (1927/1962) philosophy, it is important to further consider his analytic of Being. Through analyzing Heidegger’s ways of Being, we are able to move closer to understanding the question of what it “means to be”. The person is comprised of many facets, which have an impact on how the person experiences the world and the ontology of Dasein. Although it is not necessary to give an account of all the Heideggerian analytic of Being, there are a number of tenets underpinning Heideggerian phenomenology that were relevant to exploring the research questions. The following Heideggerian tenets of Being were considered to be useful and relevant to this study: situation, engagement, temporality, care and concern, and humans as self-interpreting beings.

2.1.1 Situation

Benner and Wrubel (1989) described situation as the concerns, issues, information, constraints and resources at a given span of time and place as experienced by a particular person. According to Heidegger (1927/1962), entities can only show as

what they are against a background of the situation, and the interpretive practices of a particular period of time, language and historical culture. Thus, the situation shapes how human beings exist in the world, that is, their “being-in-the-world”. Situation helps us understand the kinds of people we are in everyday affairs by virtue of the practical contexts of worldly involvement in which we find ourselves. “Being-in” is not a spatial relation, but rather indicates the way that human beings relate to other entities (both human and nonhuman).

For Heidegger (1927/1962), understanding what it means to ‘be’ involves acknowledging Dasein’s relationship to the past, the future and its situatedness in our current world. Dasein involves itself in all kinds of projects and plans for the future. Dasein not only has history, it is also its own past. It lives in the present and gets caught up with the issues and affairs of the moment. Thus, one is embedded in a world where one has a past, present and future, all of which influence the current situation.

Any theoretical understanding of lived experience must be context specific. Personal interpretation of the situation is bounded by the nature of the situation and the way the individual is in it. People live their experiences in the individual context of their lives. As Leonard (1989) asserted, “persons not only have a world in which things have significance and value but they have qualitatively different concerns based on their culture, language and individual situations” (p. 40). Therefore, people are engaged in living their lives in their worlds, and it is unrealistic to suggest that people’s interpretation of their life is unrelated to their Being-in-the-world. The concept of Being-in-the-world acknowledges that the context of people’s lives is crucial in the interpretation of their life experiences.

The current study which focuses on the meaning nurses attribute to their lived experience of being trauma nurses, embraces this notion of Being-in-the-world. Through Being-in-the-world of a trauma unit and through the experience of being trauma nurses, the study participants derived meaning of their situation from their own unique background and previous life experiences.

2.1.2 Engagement

Heidegger (1927/1962) used the concept of engagement to characterize everyday involvement in the world. Heidegger believed that Being was already part of the world. That is, Being-in-the-world is to be embedded in the world, to dwell there and be involved with other people and things. Heidegger described the different ways people are involved in situations in the world in terms of the different relationships between tools and people. He called these ready-to-hand, unready-to-hand and present-at-hand.

According to Benner and Wrubel (1989), our everyday practices are aspects of ways of coping with the world. When a person is actively involved in a situation, the equipment is ready-to-hand. We may interact with people and things in a transparent (or unaware) way (ready-to-hand). When provoked by something or some person in an unusual way, we react in a less familiar way or in an "unready-to-hand" fashion. In other words, we continue to interact with people and objects in our everyday existence without thinking about what we are doing until we are stimulated by the unusual. For example, the sounds from a heart monitor connected to a patient recede into the background so that only irregularities are noticed by the nurse. At the point when we become aware, at some level, of what we are doing, we change our level of awareness and way of interacting to

fit the context and make it all work. The present-at-hand mode of engagement is characterised by detachment and objectivity. In these situations, people stand outside activities and objectively reflect on them.

2.1.3 Concern

Another essential facet of the person from Heidegger's perspective is concern, which means things and people matter to us. The concept of concern explains why we are in the world and refers to a person's active and engaged involvement in the world. As persons, we do what we do through concern, through involvement with the world and others. Concern is temporal, changing from situation to situation. According to Benner and Wrubel (1989), nurses have their own networks of concerns that arise out of their own personal history, professional history and the situation. As nurses, they have nursing concerns, and the nature and role of these concerns shape their practice (Benner and Wrubel, 1989, p. 91).

2.1.4 Temporality

Temporality is a factor that was central to Heidegger's (1927/1962) ontological analysis of Dasein. Temporality is the way in which people simultaneously live in the present, are influenced by the past and are projected into the future (Benner & Wrubel, 1989). Temporality in this sense does not refer to the linear passage of time, but to the way the person is situated, or embedded in the present that is made meaningful by the past and the possibilities that exist for the future. The person brings to each present moment all of their understandings of his or her past. Heidegger acknowledged that

historicity and temporality are essential for the way in which human beings understand themselves (Benner and Wrubel).

Temporality is an important concept for rendering meaning in the current study. Trauma nurses are temporal beings whose past, present and future will influence the way in which they interpret and render meaning from their experiences as trauma nurses.

2.1.5 Humans are self-interpreting beings

Heidegger (1927/1962) believed that people are self-interpreting and have the ability to reflect upon their existence while engaged in everyday activity. We are able to locate, describe and interpret our Being-within-the-world from our own standpoint. As self-interpreting beings, we take part in a shared background of common meaning that can be made public through dialogue (Benner, 1984).

2.2 The Experience of Being a Nurse

Phenomenology has gained respect in nursing as a valid approach to the study of nursing as a human science, and to the art and science of human caring (Munhall & Oiler, 1986; Parse, 1981; Patterson & Zderad, 1976). It offers a means by which human phenomena or the lived experiences of the life world of nurses and patients can be understood. An exhaustive review of qualitative studies on the experience of being a nurse was conducted using CINAHL, MEDLINE and PsycInfo databases. The lived experience of being a nurse has been researched in various specialties of nursing such as oncology (Haberman, Germino, Maliski, Stafford-Fox and Rice, 1994), emergency (Peterson, 1996) and operating room (Tedin, 1996), but not yet in trauma.

Williams (1996) conducted a study using a naturalistic, interpretive approach to elicit, to hear and to understand both expert and non-expert nurses' perspectives about their life experience of becoming and being a nurse. Ten experts and ten non-expert nurses were interviewed using a semi-structured interview guide. Participants identified that their workplace experiences and type of nursing specialty signified a particular way of being a nurse. One pattern of workplace experience suggested that nursing was structured by tasks and activities; being a nurse meant getting work done safely and expediently according to pre-defined standards. A second pattern of experience emphasized skilled caregiving in terms of patient centered processes and outcomes; being a nurse meant being a member of a certain specialty and exercising professional judgment and skill on behalf of designated patients and families. In speaking about being a nurse, all participants revealed that they learned to interpret nursing practice in a particular way. They indicated that their understanding of nursing was shaped by their work situation and by the type of nursing they practiced. The meaning, or worth of nursing practice, was represented in the way nurses were asked to carry out their activities. This study suggests the environment in which nurse's work contributes to the shaping of who they are as nurses. As well, this study signifies that organizational culture impacts the way in which nurses interpret their work. It was of interest to the author of this study as to how culture influences the meaning of being a trauma nurse.

Haberman et al. (1994) conducted a descriptive phenomenological study of oncology nurses and the meaning of their work. The researchers sought to identify factors that influenced nurses' decisions to enter nursing and specialize in oncology. Interviews were conducted with 38 oncology nurses at six different sites in the United

States. Results of the study revealed that personal experiences such as family experiences with cancer, the challenges of administering sophisticated cancer therapies, and influential role models, influenced the participant's decision to specialize in oncology. Participants derived professional rewards from valuing each patient as a "whole person", providing family-centered care and from the complexity of oncology care that challenged their nursing skills. Nurses found that personal rewards and career survivorship were embedded in several ongoing discoveries: work offers a unique laboratory for learning about life in general, distancing maneuvers are necessary for self-preservation, and the fuzzy boundary between work and personal life must be constantly renegotiated. Oncology nurses found the best in the worst of situations by living fully in the cancer experience by embracing their patients' heartaches and triumphs, by sharing a collective sense of pride in their specialty, and reporting a high level of job satisfaction.

Tedin (1996) conducted a study to investigate the lived experience of the operating room (OR) nurse. Interviews were conducted with six OR nurses in a 600 bed hospital located in southeastern United States. Results of the study revealed that despite time crunches, technological difficulties, personality discord, humiliation, life threatening situations and the lack of support, the nurse's primary focus was the patient. Experience was identified as being paramount to the OR nurse's view of potential outcomes for a patient. Experience influenced the nurse's confidence to identify needs of the patient, surgeon, scrub technician, anesthesiologist, and the family. OR nurses also identified that oppressive behaviors such as violence were present within their environment. Another meaning uncovered was that the OR nurse was driven by the OR schedule, time,

technology, and the needs of the patient. Time and technology affected the patient care provided in the OR nurse's everyday activities.

Peterson (1996) utilized phenomenological methods to examine the lived experience of practicing emergency room (ER) nurses. Face-to-face interviews were conducted with eight nurses in one emergency department in the United States. Themes uncovered in the study included: interaction of person and practice, progression from novice to expert, and job pressures. The theme of interaction of person and practice included identification of areas in which the participants' personal preferences and their professional requirements in the Emergency Department intersect and influence one another. Participants identified that they liked the fast pace, challenge and the adrenaline rush they experienced as they provided emergency care. Participants revealed that their work as emergency nurses impacted their personal lives. The theme of evolution of emergency room expertise and progression from novice to expert discussed the breadth of knowledge and competencies that emergency nurses must acquire in order to become expert nurses. The theme of job pressures described the stress and emotion that participants experienced as a result of working in the emergency department and how the participants coped with the job pressures.

2.3 Trauma Nursing Practice

“Patient and family recovery is heavily dependent on the skills of trauma nurses as caregivers, communicators, collaborators and coordinators throughout the cycle of trauma” (McQuillan, Von Rueden, Hartsock, Flynn & Whalen, 2002, p. 107). Although some authors assert that there are great demands placed on the trauma nurse, there is a

paucity of literature that examines trauma nurses from their perspective. This is evident in a review of the literature that revealed no literature on the experiences of trauma nurses and three pieces of literature on caring for trauma patients, one of which was an article on the emotional impact of caring for trauma victims (Hogan, 1990). The following section will briefly discuss the evolution of trauma nursing and review the current literature on trauma nurses and the practice of caring for trauma patients.

2.3.1 The evolution of trauma nursing

Nurses have long been challenged by the complexity of the health care needs of seriously injured patients and their families. As a result of wars that produced traumatic injuries in epidemic proportions, nurses gained experience in caring for the wounded. The knowledge gained from the experiences of the front-line nurses has provided valuable information in helping to understand trauma in civilian life. Although no clear records exist, researchers posit that Florence Nightingale may have led a group of women in caring for war casualties during the Crimean War in 1854 (McQuillan et al., 2002). Many nurses provided treatment and comfort to battlefield casualties. During this time, nurses provided makeshift hospital facilities, bathed and dressed wounds and sought proper sanitation, hygiene, and control of infection. Since that time, nurses have cared for the wounded, seeking new ways to manage traumatic injuries.

During the 1970s, a few facilities throughout the country began to make tremendous advances in caring for seriously injured patients. As a result of caring for a large number of injured patients, these institutions developed a staff of physicians and nurses proficient in caring for complex injuries. An interdisciplinary team was created to

facilitate the coordination of resuscitation efforts, evaluation, and management plans for trauma patients. This became known as the “trauma team.” As trauma continued to evolve, the requirement for specialized units and nursing care for trauma patients became necessary. Thus, various specialized “trauma units” were developed throughout the 1980s and 1990s. Currently, there are 6 designated trauma units in Canada. Trauma patients are also cared for in other settings such as intensive care units, orthopedic and general surgery units.

2.3.2 Caring for trauma patients

Many authors assert that care of the trauma patient places great cognitive, physical and emotional demands on the trauma nurse (McQuillan et al., 2002; Neff & Stinson-Kidd, 1993; Von Rueden, 1991). For example, trauma nurses have to be knowledgeable about trauma assessment, mechanism of injury and the high risk of complications that threaten the client (Keenan, 1995). As well, Neff and Stinson-Kidd assert that endurance is required, because the trauma nurse reorganizes and constantly resets priorities, since patients’ needs and status may change hourly. In addition to caring for the trauma patient, trauma nurses also assist the family members in coping with the stress and emotional devastation that accompanies a sudden severe injury. According to Solursh (1990), continuous exposure to patient and family crisis situations, day after day, takes an emotional toll on trauma nurses, even though they try to defend and harden themselves against it.

Strenuous physical demands are also placed on trauma nurses caring for trauma patients (Von Rueden, 1991). Due to the multiple injuries that trauma patient’s

experience, many of them cannot participate in self-care activities, requiring the nurse to perform all of the activities of daily living. For example, a patient who has been involved in a motor vehicle accident may have fractured extremities and require several nurses to transfer him/her in the bed. As well, many patients have heavy drainage of bodily secretions and are diaphoretic. Therefore, it is not uncommon for the nurse to give a trauma patient several baths and complete bed linen changes in one of his/her shifts.

The trauma unit nurse closely monitors and assesses the patient for changes in his/her condition. Frequent reassessment and documentation of changes as well as interventions in response to physical instability are ongoing responsibilities. In addition to physical assessment, the nurse evaluates the patient's psychologic adjustment to injury and plans interventions to help them deal with the emotional impact of their traumatic event. As well, the trauma nurse continually provides information to the family concerning the patient's injuries and condition. "Early assessment and appropriate interventions such as providing information, active listening, facilitating flexibility in visiting, and family caregiver conferences are key to effective management of families of trauma victims" (McQuillan et al., 2002, p. 119).

As the patient recovers from his or her physical injuries, the trauma unit nurse focuses on maintaining physiologic stability, preventing complications and facilitating emotional recovery. During this time, the patient takes on a more active role in planning and participating in care. The trauma nurse teaches the patient to take increasing responsibility for his or her care and activities of daily living. Family members are encouraged to actively participate in the process. Once physiologic stability is achieved,

emphasis of care progresses to recovery and adaptation. Patients may be discharged home or transferred to a rehabilitation unit.

Curtis (2001) conducted a study to identify the issues related to nursing care of trauma patients in one hospital in Australia. A series of nursing focus groups were conducted with nurses from the emergency department, high dependency surgical ward and several general surgical wards. The nurses were asked seven questions related to their experience of working with trauma patients. The resulting data identified recurring themes, such as communication, education, documentation, pain management, workload and resources. Each group identified a lack of communication between teams, poor documentation and a general lack of awareness of the trauma patient management plan. As well, all groups identified problems with inexperienced medical and nursing staff. Limitations of the study included lack of identification of the number of nurse participants, and the overly generic themes revealed from the data analysis. Although Curtis' study related to the care of trauma patients, the nurse participants in the study were not all trauma nurses.

An anecdotal account was written by Hogan (1990) on the emotional impact of caring for trauma victims. The article described the range of feelings such as inadequacy, frustration, powerlessness, fear, guilt, insecurity and sadness that nurses may experience in the course of delivering care to trauma victims. Hogan discussed professional and job related stressors that could affect a nurse's response to significant incidents. Strategies such as debriefing sessions and team meetings were discussed as ways in which nurses could survive the impact of trauma nursing. Additionally, she suggested that job responsibilities should be varied when possible and that managers and staff should

evaluate work schedules for flexibility, adequate vacations, adequate breaks and a balance between work and relaxation. Limitations of the article include that it was based on one person's opinion and may not accurately reflect trauma nurses' perceptions of caring for trauma patients. The article was written in 1990, therefore, trauma nurses may now have a different perspective on caring for trauma patients.

Morse and Procter (1998) investigated the comfort work of trauma nurses in the emergency department. In this qualitative study, data were collected using videotapes of patient care in the trauma rooms of two certified Level I trauma centers. The video cameras were mounted on the wall of the treatment room. Videotaping commenced as soon as the patient entered the room and continued until the patient was transferred. Audiorecording was achieved by using microphones attached to the cameras. The care provided to 67 trauma patients was analysed using observational methods and linguistic analysis. They revealed that during painful procedures, when patients exhibited extreme distress, one nurse usually assumed the role of comforter. The nurses used a patterned mode of speech ("comfort talk"), touch, and distinctive posturing behaviors that enabled the patient to endure the agony and maintain control. Morse and Procter suggested that the comfort work of nurses in trauma situations enabled patients to endure and reduced shock and post-traumatic stress following trauma care. A limitation of this study would be that videotaping could have resulted in a behavioral staff change, therefore, the study may not have reflected the nurses' actual behaviors. The study was also limited to trauma nurses who work in the emergency department.

2.4 Summary of the Review of Literature

The literature review on the experience of being a nurse indicated that nurses in a variety of specialties found meaning in their work through professional rewards and through the challenges and complexities of their specialty. The type of nursing specialty as well as the type of work environment shaped nurses' way of being a nurse and impacted the way in which they interpreted the meaning of being a nurse. The current study builds on these rich descriptions of the phenomenon of being a nurse, by expanding nursing understanding and sensitivity to the experience of being a trauma nurse.

The literature indicated that limited work has been done related to trauma nurses and no studies could be found which explored the meaning of being a trauma nurse. Therefore, a qualitative study examining the lived experience of being a trauma nurse would enhance the understanding of what it means to be a trauma nurse from the perspective of trauma nurses themselves and contribute to the further development of nursing knowledge in this area. The findings that emerge from this study may find meaning not only to those nurses directly involved in the research, but to other nurses within the nursing profession. For those nurses who may be contemplating trauma nursing, the themes that emerge from this study may increase their understanding and awareness of what being a trauma nurse encompasses.

Chapter 3 – Methods

3.1 Research Design

This study used an interpretive phenomenological approach to explore trauma nurses' experiences of being a trauma nurse. The interpretive phenomenological, or hermeneutic approach, was chosen for this study because it is the empirical study of the qualitatively similar and different ways in which various phenomena in the world around us are experienced, conceptualized and apprehended (van Manen, 1990). Its primary objective is the direct investigation and description of phenomena as experienced in life, attempting to provide an understanding of the internal meanings of a person's experience in the lived world (van Manen). Within this view, persons are self-interpreting beings and become defined in the course of living a life (Benner and Wrubel, 1989; Heidegger 1927/1962). Heidegger suggested that interpretive phenomenology is the most appropriate method to study human action. No separation exists between subject and object in interpretive phenomenology but rather a belief that human beings are part of the world.

3.2 Methodological Assumptions

Certain assumptions are inherent to the interpretive phenomenological method including the assumption that study participants are knowledgeable about the topic under investigation and expert by virtue of their participation in the phenomena (Morse & Field, 1995). This method also assumes that participants are honest and do not intentionally fail to reveal aspects of their experience. It is assumed that trauma nurses in the current study

will be receptive to sharing their experiences with the researcher and through the process of sharing and reflecting, both participant and researcher are changed.

3.3 Eligibility Criteria

For the purpose of this research, the participants were required to meet the following inclusion criteria:

1. to be a registered nurse currently working in the trauma unit of the target hospital,
2. to be able to converse fluently in the English language,
3. have at least one year of work experience in a trauma unit,
4. work at least 40 hours every two weeks in the trauma unit of the target hospital.

In order to maintain a homogenous sample, the first criterion was established to exclude other trauma unit staff (that is, student nurses, physicians, allied health workers). The second criterion was required as the researcher is not bilingual. The third and fourth criteria were established to ensure that the nurses selected for the study had enough exposure to trauma nursing practice in order to have experiences upon which to reflect.

3.4 Participants

In order to provide a variation of experiences, a purposeful sample of seven trauma nurses was selected for this study. The exact sample size was not determined prior to the commencement of nurse recruitment but rather re-evaluated on an on-going basis during data collection. According to Morse (1991) and Lincoln and Guba

(1985), sampling and data collection cease when the research obtains coherence and does not collect any new information and the richness of the data is meaningful to report. However, because of the length of the data-gathering interview(s) and the detail of the complete description, the sample size is usually small (Omery, 1983), ranging from a single case study to ten participants for a phenomenological study (Polit and Hungler, 1999).

By the seventh interview, thick and rich descriptions with numerous comments and examples indicated the number of participants was considered sufficient (Munhall, 1994).

3.5 Setting

Participants were recruited from a trauma unit within a 1,400-bed academic health sciences centre in a large city with a population over 1 million. The participating hospital was selected as it is a tertiary care centre designated to care for and sustain life in acutely ill trauma patients. In 2002/2003, 909 trauma patients were admitted to this hospital and 69% were defined as major trauma. From January 1, 2001 to December 31, 2001, 61% of all injured patients were involved in motor vehicle collisions (this can include: pedestrians, drivers, passengers, bicyclists, motorcyclists, and recreational motorized vehicles) and more than one in six trauma patients suffered stabbing or gunshot wounds. The following description of the setting is based on information provided by the nurse manager of the trauma unit chosen for the study.

The trauma unit is an in-patient setting where adults are admitted to receive medical and nursing care for injuries caused by a traumatic event. Patients are admitted

to the unit with Trauma as the admitting service. The unit has the capacity to hold 36 trauma beds. There are 7 private rooms, 6 semi-private rooms and 5 ward rooms (4 beds/room). A central nursing station is located in the middle of the unit, and is predominantly a communication centre. Equipment, central supplies, and emergency carts are all located in the immediate periphery.

The unit is staffed with 28 full-time, 5 part-time and 18 casual registered nurses who provide care for all trauma patients on a twenty-four hour basis. The nurses work both 8 and 12 hour shifts. There are 6 male nurses out of the total complement of 51. The nurse to patient ratio is 1:3-4 on days, 1:5-6 on evenings and 1:6 on nights. All staff receive a minimum of five weeks orientation to the unit and preceptors assist with orientation to the clinical area. The medical team consists of staff physicians and medical residents who rotate through the unit on a monthly basis.

The philosophy of care in the participating hospital is patient focused care. Patient focused care on all units is built upon four core-care processes which include: identifying concerns, decision making, caring and service, and evaluating outcomes. Staff listen to what is important to patients and families in order to identify concerns. In decision making, staff explore and clarify options and respect patients' choices based on their personal values and beliefs. Through caring and service, staff act on concerns and provide care requested to meet patients', residents' (long-term care) and families' expectations. By evaluating outcomes, staff review progress with patients, residents, and families and make changes to improve satisfaction.

3.6 Process of Data Collection

3.6.1 Pilot test

According to Sorrell and Redmond (1995), an interview is individualized for different research approaches. Therefore, it is important to 'pilot test' an interview guide. A pilot test was conducted with one trauma nurse before the main project was undertaken in order to gain more experience in qualitative interviewing and to test the semi-structured interview guide. Minor changes were made to the wording of the questions. Data received from this interview were not included in the data analysis.

3.6.2 Main study

During the research proposal phase of the study, a meeting was held with the nurse manager of the trauma unit of the potential target hospital. The purpose of this first meeting was to determine if the trauma unit met the study criteria and if the unit staff were interested in participating in the study. Verbal support was obtained and a copy of the proposal was provided to the nurse manager. Permission was sought to conduct this study from the University of Ottawa Faculty of Health Sciences Human Research Ethics Committee and the appropriate research committees of the target hospital.

Prior to data collection, a second meeting was held with the nurse manager to discuss the recruitment process. The nurse manager was willing to assist the researcher with recruitment and, to this effect, distributed a poster throughout the unit. The poster explained the study and provided a date that the researcher would conduct a presentation to the nursing staff. Two weeks following the distribution of posters, the researcher met with the nursing staff on the trauma unit, using lunch or evening break as a format. At

the meeting, the researcher explained the study and distributed information sheets (Appendix A). Nurses who expressed an interest and met the inclusion criteria were encouraged to leave their name and telephone number so the researcher could contact them to set up an interview.

A total of fifteen trauma nurses met the eligibility criteria and were contacted by the researcher. Of the fifteen potential participants, the researcher was able to make telephone contact with seven nurses and all of them verbally agreed to participate in the study. The purpose of the study and the data collection procedure were reviewed at this time. At the time of the first interview, a formal written consent was obtained (Appendix B). The interviews were scheduled at a mutually convenient time. All of the interviews were held at the target hospital in a private conference room and took from 60-90 minutes. By the seventh interview, richness and depth of content was achieved.

3.7 The Interview Process

The researcher conducted one-on-one semi-structured interviews with seven trauma nurses. Each interview began with the researcher collecting both demographic and clinical data from the participants (Appendix C). Prior to the beginning of each interview, the researcher reiterated the purpose of the study and explained that the interview would be audio-taped. The researcher explained that participants were free to stop the interview at any time or skip over any questions with which they were not comfortable. A flexible, semi-structured interview guide (Appendix C) provided guidance for the interview. The researcher started the interview with a general opening question asking participants to talk about what it is like being a trauma nurse.

Participants were encouraged to provide details about their experiences and anecdotes to illustrate their impressions and ideas. When necessary, the researcher used questions from the interview guide to facilitate articulation of the participant's lived experiences. Participants felt at ease and talked freely throughout the interview. Field notes and a reflexive journal were also used for collecting data throughout the study in order to record personal reflections about the interviews as well as to record all methodological decisions made throughout the study. Both were completed within 24 hours of interview completion.

3.8 Characteristics of Participants

The seven participants of the main study were female ranging in nursing experience from 2 to 41 years. Years of experience as a trauma nurse as well as years in the current trauma unit ranged from 2 to 18 years. Of the 7 participants, 6 obtained a diploma in nursing and 1 obtained a degree in nursing. Table 1 represents a summary of the participant demographics. For reasons of confidentiality, each participant has been given a pseudonym.

Table 1 – Description of Participants

Name	Edna	Anna	Jane	Mary	Betty	Susan	Joan
Age	≥ 31-40	≥ 61-70	≥ 41-50	≥51-60	≥31-40	≥21-30	≥21-30
Gender	Female	Female	Female	Female	Female	Female	Female
Years of experience as a nurse	10	41	18	40	23	5	2
Years of experience as a trauma nurse	3.5	18	14	17	15	3	2
Years of experience in current trauma unit.	3.5	18	14	17	7	3	2
Basic Education	Diploma in Nursing	Diploma in Nursing	Diploma in Nursing	Diploma in Nursing	Diploma in Nursing	Degree in Nursing	Diploma in Nursing
Education in trauma	Emergency Nursing Certificate	Attends trauma conferences and courses provided by the hospital.	Hospital courses in trauma, trauma orientation	Hospital courses in trauma.	Takes trauma courses provided by the hospital.	Trauma Nursing Core Course	Trauma orientation

3.9 Data Analysis

The goal of the interpretative analysis was to understand the meaning of being a trauma nurse. Data analysis was performed by the researcher according to the procedures outlined by Colaizzi (1978) and van Manen (1997). Colaizzi described his procedure for analysis as being developed from Heideggerian existential phenomenology and therefore, it was compatible with the interpretive approach taken with this study.

The initial step in the data analysis required the researcher to become familiar with the participants' descriptions of the experience. As soon as possible following the interview, each tape was transcribed verbatim. The tape was replayed to check the transcription for accuracy and to add notations regarding changes in voice, significant

pauses and inflections (Morse & Field, 1995). Each transcript was read several times in order to acquire a feeling or sense of what was being described.

Every sentence or sentence cluster of the description was read line by line to determine what was revealed about the experience of being a trauma nurse. Key words and phrases pertaining to the phenomenon were highlighted. A manual method of highlighting (colour-coded) was used to sort the data. Codes were placed into broad categories as patterns emerged. Each transcript had a two-inch margin on the right and left side so that the researcher could place comments on the pages.

For each of the significant statements, the researcher reflected on the participant's meaning and used creative insight to arrive at formulated meanings. The above process was repeated for each transcribed interview and the resulting aggregate of formulated meanings was organized into clusters of themes, which were validated by referring back to the original transcripts to ensure no data had been ignored or added. Colaizzi (1978) referred to this procedure as making a "precarious leap" in order to bring meaning to the extracted statements. Through the process of making comparisons and asking questions, connections between categories began to emerge.

The results of the analysis were then integrated into an exhaustive description of the lived experience of being a trauma nurse through the process of interpretive phenomenological writing. The process of phenomenological writing is characterized by careful reflection that allows the meaning of the experience to emerge (van Manen, 1990). Bergum (1991) described that "writing and rewriting, the constant search for deeper meaning, changes not only the understanding of particular parts of the study but

also the totality of the study, which again requires rewriting” (p.66). This constant search for new understanding is what is described as the hermeneutic circle.

A final step to seek truthfulness of the analysis was achieved by returning to the participants and asking them to indicate if they perceived the data that emerged as reflective of their experience.

The analysis process did not proceed in a linear fashion. It involved multiple readings, multiple interpretations, refinement of themes, returning to the text for validation and clarification, and conferring with participants and experts for confirmation of themes. Essentially, the main goal of the process used in phenomenology is to illuminate the meaning of the experience and to convey the meaning in a way that can be understood by the reader (van Manen, 1984).

3.10 Methods to Ensure Rigor

Rigor in qualitative research is important to the practice of good research (Streubert & Rinaldi-Carpenter, 1995). Sandelowski (1986) described four criteria related to rigor in qualitative research. They are: (1) credibility (truth value); (2) applicability (fittingness); (3) consistency (auditability); and (4) neutrality (confirmability). These four components were used in this study to ensure trustworthiness of the data and subsequent analysis.

3.10.1 Credibility (Truth value)

To ensure the credibility and dependability of the findings, the researcher must demonstrate that the findings and interpretations are credible to the participants who shared their experiences. Lincoln and Guba (1985) stated that credibility of a study

requires that the interpretations developed from the data accurately reflect the lived experiences of the participants. This is known as member checking. Once data analysis was completed, follow-up interviews were conducted with six of the seven participants in order to determine if the resulting themes reflected the participants' experiences of being trauma nurses. Each of the participants was provided with a table of the four major themes and categories as well as a summary that included quotes to support the themes. During the review of the themes and quotes, participants were noted to be nodding their heads 'yes' in agreement. Comments from participants related to the four main themes included: "*Yes, that is very accurate*" (Betty); "*That's good, yeah it's really good*" (Jane); "*Your findings reflect exactly how I feel*" (Mary). The participants refuted none of the themes identified.

In addition, some of the transcripts and a copy of the themes were independently reviewed by a researcher familiar with phenomenological methodology to determine whether they could "adopt the same viewpoint as articulated by the researcher, also see what this researcher saw, whether or not they agree with it" (Giorgi, 1970, p. 78). The reviewer agreed with all of the themes that were developed.

Polit and Hungler (1999) stated that the "researcher's training, qualifications, and experience are important in establishing confidence in the data" (p. 429). My personal and clinical experience with trauma served to enhance credibility of the researcher and investigation.

3.10.2 Applicability (Fittingness)

Applicability (fittingness) refers to likelihood that the findings of the study are applicable to others in comparable situations. According to Sandelowski (1986), “a study meets the criterion of fittingness when its findings can ‘fit’ into contexts outside the study situation and when it’s audience views its findings as meaningful and applicable in terms of their own experiences” (p. 32). The findings of this study may be applicable to other trauma nurses working in other trauma units, outside of the study situation. In addition, members of the research committee as well as nursing colleagues of the researcher who had experience in the nursing care of trauma patients identified that they “experienced the fit”.

3.10.3 Consistency (Auditability)

Sandelowski (1986) wrote that a study and its findings are consistent when another researcher can clearly follow the “decision trail” used by the investigator in the study. The researcher has left a decision trail including the discussion of decisions taken about the theoretical, methodological and analytic choices throughout the study. In addition, the researcher has provided rich excerpts from the transcripts for the reader.

3.10.4 Neutrality (Confirmability)

Neutrality (confirmability) refers to the freedom from bias in the research process and product (Sandelowski, 1986). Neutrality is achieved when auditability, truth value, and applicability are established (Sandelowski). Although hermeneutic inquiry does not seek to eliminate bias, it seeks to make it as transparent as possible. Therefore, in order

to bring these assumptions into the clearing, a reflexive journal was kept. The reflexive journal consisted of: (1) a personal diary documenting both the researcher's personal beliefs and assumptions, and insights which occurred during the study, and (2) a log in which methodological decisions and rationales were documented and shared with the reader.

3.11 Protection of Human Rights

This research study received ethical approval from the University of Ottawa Faculty of Health Sciences Human Research Ethics Committee and all appropriate research committees of the target hospital prior to commencement of participant recruitment. To ensure the participant's right to informed consent, all were given an information sheet (Appendix A) which included an explanation of the study. Initial consent was obtained verbally from the participants when they indicated a desire to participate in the study. At the beginning of each interview, the researcher outlined the purpose of the study, the possible risks and benefits to the participants, the voluntary nature of participation, and the time commitments. Questions or concerns were addressed and the participants were informed that they could withdraw from the study at any time and refuse to answer any questions posed by the researcher. Written, informed consent (Appendix B) was obtained by the researcher at the time of the first interview and each participant was given a copy of the consent form.

The audio-taped interviews were numbered and pseudonyms were used for all participants to assure privacy and confidentiality. All patient information, transcripts, and audio-taped interviews were kept in a locked office.

Chapter 4: Findings and Discussion

4.1 Introduction

The findings are revealed from the experiences as described by seven trauma nurses who work in a trauma unit at a large university teaching hospital. This chapter is a presentation and discussion of the findings in relation to the original purpose of the study. Memorable and difficult situations that revealed the lived experience of being a trauma nurse as well as factors that facilitated or hindered being a trauma nurse are threaded throughout the findings. In addition, relevant literature is interwoven throughout the discussion.

4.2 Overview of the Findings

According to Benner and Wrubel (1989), nurses bring to practice, understandings about people and situations that they have gathered from their background and previous work experiences. In other words, when situated in familiar contexts and performing everyday tasks, nurses are actively engaged in the world and move through experiences utilizing pre-existing meanings and taken-for-granted understandings. According to Heidegger (1927/1962), this mode of engagement is referred to as being in the ready-to-hand mode of existence. In this taken-for-granted mode of existence, there is no particular reason to question the meaning of one's life since all is unfolding according to one's plan. For the participants in the current study, the taken-for-granted mode of existence was based on their perceptions and expectations of being a trauma nurse. These perceptions and expectations were derived from previous experiences as nurses, the philosophy and mission of the trauma unit as well as the moral imperatives of nursing

(e.g., caring, respect, integrity, dignity). As noted previously, the participants in this study have been embedded in a hospital and unit culture that is philosophically driven by patient focused care which includes identifying concerns, decision making, caring and service, and evaluating outcomes. The values of the hospital and trauma unit include excellence, collaboration, accountability, respect and empowerment.

According to Heidegger (1927/1962), when a person is troubled by an experience, smooth functioning is interrupted which causes them to pause, reflect and re-intepret the situation. Heidegger refers to this as the unready-to-hand-mode of existence. For participants in the current study, many of the taken-for-granted aspects of being trauma nurses were disrupted by some of the challenges they began to encounter on a daily basis. Many of the challenging situations included elements that were not congruent with their perceptions of being a nurse and therefore were troubling. Participants were not situated in a familiar context and the taken-for-granted aspects of being a trauma nurse could no longer function smoothly resulting in feelings of tension.

The overall essence of being a trauma nurse is captured in the metaphorical statement: "*seeing through cloudy situations.*" This metaphor reflects the journey through which participants discovered meaning and satisfaction in being trauma nurses. For participants in the current study, the journey began with "*being in cloudy situations,*" which represented the challenges participants encountered on a daily basis and the resulting feelings of tension. The cloudy situations are captured in the themes: "*being on guard all of the time*" and "*being caught up short.*" "*Being on guard all of the time*" captures aspects of being a trauma nurse that contributed to the participants feeling as though they had to be on guard for their own safety and that of other patients. These

feelings included: “*feeling scared*” and “*feeling the need to watch your back.*” The second major theme, “*being caught up short,*” reflects the feelings of tension participants experienced as a result of the disparity between what they expected as trauma nurses and what they experienced. These feelings included: “*feeling disrespected,*” “*feeling like you are going to lose it,*” and “*feeling uncertain.*”

The “*cloudy situations*” which participants encountered often caused them to feel desituated, disengaged and disconnected from their normal way of being-in-the-world as trauma nurses. However, it was in this state of anxiety that participants developed insight into the taken-for-granted and the ways in which their past caring practices as nurses were meaningful. Participants in the current study reflected on the challenges they encountered and were able to identify ways in which they faced these challenging situations. Therefore, the third theme, “*facing the challenge,*” reflects ways in which participants began to see through the cloudy situations by not only “*looking beyond what the patient had done*” but also by “*being a trauma junkie.*”

The final theme, “*sharing the journey,*” reflects the aspects of being a trauma nurse that enabled participants to “*see through cloudy situations*” and find meaning and satisfaction in being trauma nurses. When the participants were involved in challenging situations with patients, they experienced tension as well as a loss of connection and engagement with the world around them. They felt disengaged and displaced from their usual way of being-in-the-world as trauma nurses. However, by “*helping families get through a difficult time,*” “*being there for each other,*” “*seeing patients recover,*” and “*having that human touch,*” participants were able to reengage themselves in the world by finding ways to care and make connections with patients, families and co-workers.

The experience of being a trauma nurse will be supported by the participant's own words throughout the presentation of the themes.

4.3 The Cloudy Situations

4.3.1 Theme 1: Being on guard all of the time

As trauma nurses, participants revealed that they felt as though they had to “*be on guard*” for their own safety and that of other patients. From their perspective, many of the patients admitted to the trauma unit were members of gangs. Many of these patients refused nursing care and frightened the participants by being verbally and physically aggressive. As a result of this behavior, participants “*felt scared*” when caring for these patients.

Additionally, participants described the need to “*watch their back*” as they carried out nursing interventions with some of the patients on the trauma unit. Several patients, such as those who suffered a head injury, had the tendency to become very aggressive and violent. Participants never knew what to expect when they were approaching head injured patients. They always had to be aware of their surroundings and have an escape route out of the room. The violent nature of some of the trauma patients caused participants to be concerned about the safety of other patients. Participants were constantly on guard for the safety of their coworkers, other patients, and visitors.

4.3.1.1 Feeling scared

Feeling scared was a powerful emotion that all of the participants experienced in their work as trauma nurses. Some of the participants recalled certain situations in which

they felt scared while others described types of patients that evoked this feeling.

Participants consistently spoke of “feeling scared” when taking care of patients who were admitted to the trauma unit as a result of gang related activities such as gun shot wounds and stabbings. Many of the “gang” patients were described as young males between the ages of 20 and 30 and were described as being a “whole new culture.” Several of these patients refused to follow rules of the hospital or treatments prescribed by physicians or other members of the health care team. For example, Betty commented: *“Generally they are hard to nurse because they have big attitudes and they swear a lot and they don’t want to follow the routine of the hospital.”*

According to Linck and Phillips (2004), violent patients can have detrimental effects on the quality of patient care. Disruptive behaviors such as violence and aggression overshadow the patients' hospitalization and may interfere with the nurse's ability to accurately identify patients' problems in a timely manner. Therefore, ineffective nursing interventions may prevail. For participants in the current study, caring for gang patients caused them to feel stressed and fearful about their own personal safety, which in turn interfered with their ability to adequately care for their patients as reflected by their lack of engagement and connectedness. Gang patients instilled fear in the participants because they were often verbally aggressive and at times physically aggressive towards the nurses. Susan expressed how she didn't *“understand how someone could treat another human being like that...they call us names, yell at us.”* Similarly, Jane expressed that she found these types of patients *“scary”* and felt *“scared taking care of them.”*

Feelings of being scared affected participants' temporality or lived experience of the present and the future. Benner and Wrubel (1989) pointed out that temporality is the way the past influences how the person lives in the present and this, in turn, affects how the person perceives the future. In the current study, many of the participants experienced previous violent encounters with gang patients in which they felt scared and unsafe. For example, Betty described a situation in which a gang patient became angry with a young nurse and attempted to barricade her in the room. Previous violent experiences with gang patients as well as the "threat" of possible violence impacted the way in which participants' encountered any gang patient admitted to the trauma unit. Each time, participants felt fearful and consequently were unable to encounter the patient in an open and relaxed manner. They felt vulnerable in the presence of a gang patient, fearing that the patient may become aggressive if they were not able to do what the patient wanted. Participants felt that they could not be themselves around these patients because they were constantly worried that the patient could become angry. Susan described: *"Some of the nurses have been called all sorts of names and some of the nurses have been physically threatened. That's scary when nurses are physically threatened...it's hard when you don't feel safe at your own job."*

Previous fearful experiences with gang patients caused participants to feel uncertain about their future as they questioned their ability to continue working in an environment where they felt scared and unsafe. Many participants expressed feeling scared going into work every day because they feared they would have to take care of a gang patient. Susan commented that *"you never know what they could do to you...they*

could attack you or follow you home from work and that's scary." Mary shared a story in which one of the nurses felt scared for her own safety:

It is scary, like the one that I was telling you about that treated me OK because he thought I was like his mother. He got very mad at another nurse and she yelled back at him and he yelled at her. And the fact that she yelled at him was not good, I mean that didn't help the situation at all. I can see her point because she was mad but you shouldn't do that because that just gets them going big time. And he came back with a friend and walked around and where this friend came from, I don't know, but you know that is sort of scary because his friend was not a nice looking person. I don't know where he came from but he walked around with the patient and was really nasty to the nurse. It was to the point that we did tell the nurse to take a taxi or not go on the bus unescorted or not go out of the hospital to the parking lot without an escort. Because you never know...this gang stuff is all new, there wasn't the gangs and now it is the majority of patients.

Additionally, the participants felt scared around the visitors who accompanied gang patients. Often the visitors were fellow gang members who would linger in the patient's room and hallways. According to these trauma nurses, the majority of visitors were young men who congregated around the patient's bed and made the nurses feel intimidated. Betty described that you *"have to watch their visitors...we look after them but they do have the swearing and the attitudes...so we just have to be on guard with that too."* As a result, participants found they were constantly asking the visitors to leave and often had to call security to escort them out of the hospital. Jane recalled:

They never come by themselves; there's 50 of them in the room and they don't obey the rules so you are asking them to leave and they don't leave and then you have to call security and that's scary you know. I find them scary, it's not just one culture, it's that whole age group, that 20 year old that had been shot you know, it doesn't matter what race they are or anything, it's very similar in all of them.

Participants then feared that gang fights or retaliation by other gangs could take place on the unit and threaten their safety. Jane recalled: *"Sometimes you wonder if they are going to pull a gun out at you, if you ask them to leave and they balk at leaving."* This finding is congruent with findings revealed in a phenomenological study conducted by Catlette (2001) on workplace violence in an American emergency department. In her study, several of the participants identified gang violence as a risk factor in the emergency department. Catlette revealed that often gang-related incidents involved gang members retaliating against other gang members and that made staff feel fearful.

Overall, the findings clearly demonstrate that the behaviour of gang patients as well as their numerous visitors, had an impact on these trauma nurses and the quality of nursing care they were able to provide. Heidegger (1927/1962) used the concept of engagement to characterize everyday involvement in the world. He described the different ways that people are engaged in the world using the terms "ready-to-hand," "unready-to-hand," and "present-at-hand." Being actively involved and seeing the world through the ready-to-hand, taken for granted lived experience allows us to explore meanings that are often hidden in everyday practices (Heidegger). In contrast, when something becomes unready-to-hand, the situation becomes altered, and the person loses

the maximum grasp that was available in the ready-to-hand mode of engagement. For participants in the current study, being involved with gang patients heralded an abrupt discontinuation of participant's normal way of being-in-the-world. Participants in the current study were individuals in whom gang "life" was not part of their reality. Thus, being involved in violent encounters or experiencing the "threat" of violence brought about feelings among participants that were not congruent with their background. Their normal way of making connections, engaging in relationships and demonstrating caring practices were now being called into question. They felt disengaged from the everyday world, as their usual way of being involved was disrupted. Their world became "clouded (unready-to-hand)" and participants felt disconnected and at times desituated from their normal environment and way of being-in-the-world. The trauma unit that was once considered a place where participants felt comfortable conducting their work became a place where they felt scared, unsafe and uncertain.

4.3.1.2 Feeling the need to watch your back

In addition to feeling scared, participants revealed that they felt the need to always "*watch their back*" and be on guard for unpredictable situations. Many of the patients admitted to the trauma unit suffered severe head injuries and had the potential to become very agitated and aggressive. Participants described that head injured patients had a certain type of violent aggression and as a result they always had to be careful for their own safety in their presence. For example, Betty explained that "aggression" in all of the neuro patients "*is very similar and you have to be on guard all of the time and be careful of yourself and your own safety.*" Head injured patients were described as being very

unpredictable and had the potential to turn violent at any time. One minute the patient would be fine and the next minute they would try and attack one of the nurses. The participants encountered several incidents in which head injured patients attempted to bite, kick or strike out at them. For example, Susan shared one of her experiences with a head injured patient:

There was a young kid who was in a car accident, he was I think 18 and you couldn't reason with him and he would...actually he hit a couple of the nurses and you couldn't tell him what to do, he was on medication for it to calm him down but you know he was fine one minute and then you'd really have to watch his arms because you never knew when he was going to strike at you. He was a tall guy so you always had to be on guard with him.

These findings are congruent with other studies that have reported bizarre and disruptive behavior, such as screaming outbursts, aggression, disinhibition, delusions, hallucinations, or incoherent verbalizations among brain injured patients (Grzankowski, 1997; Guentz, 1987; McQuillan et al., 2002).

Participants experienced feelings of anxiety and vulnerability when caring for head injured patients related to their inability to control aggressive behaviors or predict periods of agitation. Participants felt that they could never turn their back on a head injured patient and were on constant guard for their own safety as well as the safety of other patients and visitors. They always had to be on “*the look out*” and have a plan in mind in case they were attacked. Betty described:

You always have to look out. What I do is always leave the door open and you can't corner yourself in the room away from the door because you can get,

you know, barricaded in the room. I know they don't mean to do it but they get aggressive and you have no way of getting out of the room. So it is always smart to be prepared for that.

In addition, the physical layout of the trauma unit in the current study contributed to participants watching their back as patients were often in a four-bed room located at the end of a hallway. Nurses working in other rooms would not be aware of a colleague experiencing difficulties. Participants described having to work in nursing teams so that if one nurse got into trouble, another would be nearby to provide assistance or call for help. Participants also revealed being concerned about the safety of other patients. Often the head injured patients were in the same room as other patients who suffered a traumatic injury. Therefore, participants feared that these patients could become angry or violent and lash out at other patients, coworkers, or families.

4.3.2 Theme 2: Being caught up short

In their struggle of caring for trauma patients, participants described a disparity between what they expected as trauma nurses and what they experienced. The theme of “*being caught up short*” reflected this disparity. Based on their own personal values as well as the mission of the hospital, participants in the current study expected to work in an environment where they were treated with respect and dignity. But, on the contrary, participants experienced situations in which they “*felt disrespected*” and unappreciated by their patients. This in turn caused feelings of tension and anxiety amongst participants as their expectations of being a trauma nurse had become incongruent with their reality. Participants experienced feelings of anger because of the way they were being treated and

often “*felt like they were going to lose it*” with some of the patients. They believed that they did not deserve to be treated so poorly yet felt they had to live with this experience because they were nurses. They wanted circumstances to change but they “*felt uncertain*” about what to do.

4.3.2.1 Feeling disrespected

Respect is a moral principle that implies valuing another person’s essential dignity and worth. Therefore, when a person is ignored, mistreated, disregarded, or dismissed lightly or thoughtlessly, it is a sign of disrespect (Laschinger, 2004). Several participants in the current study revealed feeling disrespected by patients who were members of gangs or patients who had committed a serious crime. They described these patients as being very demanding and “difficult to get along with.” Jane commented: “*they all demand perfect care but they don’t treat us with any kind of respect at all and that’s hard.*” Susan shared similar views and recalled:

A lot of the patients that come into the trauma unit are members of gangs...a lot of these patients are young males and they just have no respect for the nurses. They don’t listen to anything that you say and they treat us like crap. They complain about everything and act like they are royalty.

As a result of the patients’ disrespectful treatment, participants internalized their feelings and harbored feelings of anger and frustration. This finding is congruent with a Canadian study conducted to assess nurses’ responses to abusive behaviour from patients (Lurkur, 2002, as cited in Kearsley, 2004). Fifty-five percent of the 550 nurses in the study reported experiencing emotional abuse in their last five shifts. Over the previous

year, as many as 3,550 threats of assault were uttered to the nurses. Forty-six percent of the nurses reported feeling angry as a result of the abuse. Feelings of avoidance, a reduction in patient contact, shock, and a reduction in job satisfaction were also predominant responses.

Participants expressed frustration at being unable to provide care as a result of recurring negative attitude from these patients. Jane shared: *It's frustrating because these guys refuse nursing care and then they complain that they are getting awful care.*” In addition to frustration, a few of the participants described feelings of being tired and angry as a result of being treated disrespectfully. They wanted to yell back at the patients and tell them that they did not have a right to treat them so poorly but felt they could not because it would cross professional boundaries. Susan described that being disrespected was one of the most difficult things about being a trauma nurse. Similarly, Betty commented that *“you get tired of being treated this way; you just get tired of having to deal with the mentality of some these people...you just get a little bit tired of the lack of appreciation.”*

For these trauma nurses, the development of a therapeutic and caring relationship with the client was considered a moral imperative of nursing. However, there were times in which they were unable to make a connection with patients and develop therapeutic relationships because the patients either refused care or treated the nurses disrespectfully. Although one of the values of the trauma unit was respect, participants conveyed that it was very difficult to establish relationships and act respectfully while being treated disrespectfully. To illustrate this, Jane commented that *“you really have to make yourself do the job and it's hard with those kind of people.”*

Participants shared that they felt like they were not able to do their job properly and described feeling more like a hotel maid or servant rather than a nurse. Susan summed up this perspective in the following way:

It's hard working with these people from gangs that are constantly rude and obnoxious. It's not enjoyable taking care of them. I just feel like I can't be myself and I can't do my job the way I would like to around them.

Overall, when participants were treated with disrespect, they felt unappreciated, unimportant and they began to question their ability to perform their nursing work. They wanted to provide patient focused care in a respectful and caring manner. However, they questioned how to do this if they were constantly being treated disrespectfully.

According to Kutaka (2002), the nurse-patient relationship is the heart and soul of nursing practice. However, there is a lack of research related to problematic nurse-patient relationships when nurses find themselves unable to cultivate a relationship or caring attitude toward a patient. Podrasky and Sexton (1988) used an exploratory survey design to determine who nurses identify as difficult patients and how nurses might react to them emotionally and behaviorally. Patients to whom nurses reacted negatively were described as being demanding, complaining, manipulative, impolite, unreasonable and uncooperative. Similar to the participants' emotions in the current study, frustration and anger were the two most common emotions that the nurses felt when interacting with difficult patients. Podrasky and Sexton noted that any time there is a threat to the quality or quantity of interactions between patients and nurses, there is a threat to the nursing care that patients receive. Similarly, Nield-Anderson et al. (1999) reported that both nurses and patients may suffer consequences as a result of difficult behaviors. For

example, a patient may receive inadequate care, a nurse may feel alienated and ill-treated in her workplace, and patient outburst can disrupt the delivery of care to other patients.

4.3.2.2 Feeling like you are going to lose it

When patients were aggressive or disrespectful, some of the participants felt so angry that they “*felt like they were going to lose it.*” At times when patients were yelling at them or calling them names, they wanted to yell back at them but knew it was inappropriate and unprofessional. Susan described: “*They make me so angry that I just want to snap back at them but I know it is not professional so I just try and keep quiet which can be very difficult.*”

In addition, several participants described feeling like they were going to lose it with some of the head injured patients. The trauma unit was described as being chaotic all of the time because head injured patients were constantly screaming and yelling, trying to get out of bed, and pulling at lines and tubes. For example, Anna commented:

It’s just difficult with head injured patients because they are confused for long periods of time and you are always getting the same patient assignment for continuity of care. It’s more mentally draining than emotional, sometimes you feel like you are going to lose it with them.

Participants struggled to maintain a therapeutic environment while dealing with the loss of control of some of the patients. To illustrate this, Joan shared one of her experiences with a head injured patient:

There was a guy that fell down the stairs. He was an alcoholic and he fell down the stairs and his wife didn’t find him until the next morning and he like had a

pneumo and had fractures all down his left side. I felt really bad for him because we had to put him in four point restraints; he had pulled out everything. He had pulled his IV, he had pulled out his NG. Everything was out. The only thing he had left was his chest tube and he was in four point leather restraints and he wouldn't keep any of his clothes on and threw all of the blankets off of the bed. It was like this naked man in four point restraints lying in the bed and he looked awful, you know he looked awful. And you know there was nothing I could do because I couldn't control him...but I think it is challenging in the sense that you feel like they are acting like animals and you feel bad because you are kind of treating them that way too.

According to Harris et al. (1999), instances of extreme uncooperative or self-destructive behavior can cause severe distress in hospital nursing staff. Participants in the current study shared that they were unable to complete other tasks or see other patients because they were constantly in the room with the head injured patient attempting to calm them or preventing them from hurting themselves or others. This in turn caused feelings of frustration among the nurses as they felt they were neglecting their other patients. In addition, participants expressed feeling guilty because they had to restrain these patients or give them medications to calm them down.

In addition to spending considerable amounts of time with head injured patients, participants spent additional time with their families. Participants revealed that families would become very concerned because they did not understand why the patient was always so confused and agitated. According to Fowler (1997), aggression and violence among head injured patients can be very distressing for families, especially when the

patient starts to pull at various tubes or attempts to get out of bed. Families were reluctant to spend time with their loved one for fear that they may become violent. As a result, participants spent time explaining the patient's behavior to the families. For example, Susan shared:

Families get angry when their relatives act out and they expect that you as the nurse should be able to do something about it. As a trauma nurse, you spend a lot of time with the family, talking with them and letting them share their emotions. It is such a stressful time for all of these families so sometimes they just need someone to vent to. We are the ones at the bedside 24 hours a day so we usually know them the best.

Participants began to question their ability to care for these patients when their personal safety was in jeopardy or when they felt like they were going to lose it. This finding is congruent with results revealed in an Australian descriptive study conducted by O'Connell, Young, Brooks, Hutchings and Lofthouse (2000) to determine nurses' perceptions of the nature and frequency of aggressive behaviors in general wards and high dependency areas. The findings revealed that nurses reacted emotionally in a variety of ways after experiencing an aggressive verbal incident. The most common emotions reported were frustration and anger.

Additionally, many of the participants in the current study expressed frustration with the fact that they could not reason with head injured patients. Participants expressed feeling angry because the patients would not listen to anything they said and resisted everything the nurses attempted to do. For example, Mary commented:

Sometimes I feel frustration and anger. Frustration with the head injury, the fact that they won't be quiet. You feel like saying "why can't you realize that you can't do it this way." But you can't do that, so frustration is the word for it and anger that they are being abusive to you. You have to take a deep breath and I try and control my anger. I have learned how to do that. I am not as bad as I used to be. It is very hard to understand why they are being like that.

As trauma nurses, their mission was to act on concerns and provide care to meet patients', residents' (long-term care) and families' expectations. However, participants were often unable to provide care in the manner desired to head injured patients. Due to the patient's state of confusion and limited comprehensiveness, the nurses were unable to develop a relationship with head injured patients. Anna expressed how frustrating it was when *"you are trying to do your best to take care of them and they are more times than not doing things against what you are trying to do."* The nurses experienced mental and physical exhaustion because they were constantly "fighting" with the patient. For example, Susan recalled an experience working with a head injured patient:

You need to have a lot of patience in order to nurse head injured patients. We just recently had this young guy who was in a motor vehicle accident. He had a diffuse axonal injury. Anyway, he was constantly yelling out and trying to get out of bed. He was pulling at things, trying to take his clothes off and trying to stand up on the bed. Sometimes it is just so hard to work a 12 hour shift with these patients. They don't understand what they are doing and you are constantly at their bedside trying to put their clothes on or lie them back down in the bed. You can't reason with these patients and sometimes it starts to get to you. You have to

repeat the same things over and over again. I remember I kept having to say to him, "You are in the hospital, you were in an accident, you need to lie back down in bed." It was just so frustrating having to repeat the same thing over and over again. Some of the head injury patients can get really violent, some of them will try hit you, bite you, spit at you. I know that they don't know what they are doing but it is still so frustrating for you as the nurse. It's hard to maintain your patience...they really start to get on your nerves.

This finding is similar to findings revealed in a phenomenological study conducted by Hainsworth (1998). Eight acute care nurses were interviewed on their experiences of caring for neurologically devastated patients. Seven themes were uncovered: fear and vulnerability, trying to connect (with patients), empathy, futility, feeling abused (by families), struggling for support (from colleagues and physicians), and seeking affirmation through physical care. According to Hainsworth, the inability to develop relationships and establish reciprocity in the nurse-client relationship was extremely troubling for the nurses in her study.

4.3.2.3 Feeling uncertain

Although participants voiced feeling scared and disrespected, they were uncertain as to what steps to take to remedy the situation. Participants felt helpless because they didn't know what to do or where to turn for assistance. From the perspective of the participants, trauma nursing had changed over the past few years. Participants felt that they were being emotionally and physically abused by some of the patients and they really did not know what to do about it. Susan shared her feelings about patients that

treated her poorly: “*We never used to have these types of trauma patients, just in the last few years it seems like that is the majority of patients that we get. It’s all new to the nurses and we don’t really know what to do.*” Participants felt as though they had to take this type of treatment because they were nurses. Anna shared:

Some people have certain behaviors that perpetuate themselves because there is no accountability. My question is “why do we do that?” If I go to the bank or go to the store and I abuse the clerk, they are going to get the police to get me out of there, so why should somebody come and abuse me at work because I am a nurse? Is that what being a trauma nurse is about? No, so I have a problem with that. I think that it will come that the administration or the College of Nurses will be forced to take a look at this; it is not going to stop here. It wasn’t like this a few years ago... and it is escalating. I would like to see this addressed before something happens.

Emergency room nurses in the United Kingdom expressed similar views as the participants. In a phenomenological study conducted by Hislop and Melby (2003) on the lived experience of violence in accident and emergency, all twenty-six nurse participants saw themselves as being there in a caring capacity and they could not understand why they should be the target of verbal outbursts and physical abuse. Participants felt that it was unfair that patient’s anger was directed at the nurses who were trying their hardest to help.

As a result of the way they were being treated, many of the participants harbored feelings of helplessness and anger. This finding is congruent with an anecdotal account written by Hogan (1990) on the emotional impact of caring for trauma victims. Hogan

described the range of feelings such as inadequacy, frustration, powerlessness, fear, guilt, insecurity and sadness that nurses may experience in the course of delivering care to trauma victims. Anna, a participant in the current study, experienced both internal as well as external anger. She commented:

Because there is no policy or no answer it makes me feel kind of helpless in a way, it makes me think a lot and question myself...am I being judgmental, should I try and look at the person differently...it really makes me angry. They can act however they want but because of their behavior, it has some effect on us who are trying to work with them. If somebody comes in and they are really very abusive and physical...you know and abuse. We wouldn't tolerate it outside and we have to take it here because we are nurses and I have a problem with that.

Similarly, Edna commented: *"It's very frustrating and makes you very angry because we are being abused, physically abused, emotionally abused, yet we can't do anything about it."* Edna conveyed that she did not report the violent incidents because she did not think anything could be done about it. This finding is congruent with the literature which indicates that underreporting of violent or aggressive incidents is possibly linked to some nurses' perceptions that violence is 'part of the job,' or perhaps an indictment of their caring skills. For example, Sofield and Salmond (2003) used a descriptive correlational design with 461 nurses to describe the experience of verbal abuse in a large multisystem hospital and to determine variations in verbal abuse according to hospital type and the correlation of verbal abuse with intent to leave the organization. Results of the study revealed that nurses continue to accept abuse because they believe that they do not have the power to change it. Over half of the participants believed they did not have the skills

to respond to the abuse and accepted the abuse as “part of the job.” Participants in the study believed that verbally abusive incidents caused an increased turnover in staff and that verbal abuse contributed to an increased shortage of nurses. Of the study participants, 11.9% (n = 54) considered looking for a new job and 33.4% considered resigning as a result of verbal abuse. Participants identified regrouping, supporting colleagues, and understanding other point of views as other coping strategies.

Many of the trauma nurses were becoming very upset and unhappy with the way they were being treated. They wanted something done but were uncertain about how to go about resolving the situation. Participants’ sense of temporality was disrupted as they became uncertain about the future. Their previously smooth flow of life was suddenly arrested and the taken-for-granted future seemed both distant and unclear. They felt if something wasn’t done soon that there would be several nurses leaving the trauma unit. Jane commented: *“Nobody has a right to be treated the way some of these patients treat us. I don’t know what we are going to do but something needs to be done or there will be a lot of nurses leaving the unit.”* This finding is similar to the literature which reveals that abuse is one of the reasons for many nurses leaving their positions, either by transferring to another job within the organization, resignation, or leaving the profession altogether (Braun, Christle, Walker & Tiwanak, 1991; Sofield & Salmond, 2003).

Many of the participants in this study struggled with coming to terms with this kind of treatment and were in the process of sorting through their own emotions. Anna commented:

I have to learn to deal with it, I am really quiet about it now but I am just going through my own process and my own feelings for that and I still hope and I still

try and keep an open mind and try to do what I can but sometimes it is really difficult because it's just more than giving care that is involved. It is developing a relationship with this type of person.

4.4 Seeing Through Cloudy Situations

4.4.1 Theme 3: Facing the challenge

Throughout the interviews, participants discussed several challenges that had a negative impact on their role as trauma nurses. However, participants chose to see through the clouds by facing the challenges they encountered. For example, participants faced the challenge of taking care of patients who had caused harm to others by “*looking beyond what the patient had done.*” As well, “*being trauma junkies,*” provided an explanation for why these nurses continued to remain as trauma nurses.

4.4.1.1 Looking beyond what the patient had done

In addition to the patients admitted to the trauma unit as a result of gang related activities, there were other patients who were not members of a gang but had committed crimes such as drinking and driving or other criminal activities. Participants in the current study found it very difficult to cope with the anger they felt towards some of these patients who had caused death or injury to others. For example, Joan commented:

It's hard sometimes with the patients that you know have killed an innocent person or have inflicted these injuries upon themselves. I just do basic care with some of them. I do what I need to do. I just keep reminding myself over and over again that this is my job. This is my job and I have

to realize that these people are sick individuals and they all deserve nursing care. But it is very difficult when you know what some of the people have done.

However, the nurses could provide care to these patients who had committed crimes as they did not have to deal with the behaviours of the gang patients such as disrespect and the numerous visitors who often were fellow gang members. Participants were able to develop a relationship with these patients who had committed crimes by “looking beyond what the patient had done.” This strategy enabled some participants to nurse in a caring way for these patients. For some participants, spending time talking with the patient enabled them to make a connection and get to know them in a way that brought down their a priori assumptions. To illustrate this, Edna shared:

I try and look past what they have done. I have taken care of patients who have been charged with serious crimes who are under arrest and you look what they have done and you think well how can you do that...but as I start to care for the person and get to know them...my attitude changes and sometimes they can be a really nice guy or a really nice women or, you know, so its you kind of, its almost, not forgive, but you kind of put what they have done out of your mind cause it could have been accident.

For these participants, being treated with respect was an important aspect of being a trauma nurse. When treated with respect, they were able to look beyond what the patient had done and see the patient in a different way and begin to create a connection. For example, Jane commented in her second interview:

A couple of the gunshot patients that we have had have been really good, really, really nice guys. And you know you don't mind so much then. You know they are

probably a jerk but they still are a nice jerk. As long as they treat me nice, then we get along fine.

As trauma nurses, participants attempted to forget what brought the patient into the hospital and treat them the same way they treated everyone else. As Mary reflected, *“You try to provide the same care to everyone no matter what circumstance brought them into the hospital.”* Participants treated these patients in a way that they would want themselves or their loved ones to be treated. Joan described: *“I always think about if that were my husband, or my brother or my mother in the bed, how would I want them to be treated and that is exactly how I treat them.”*

According to Benner, Tanner and Chesla (1996), “confronting extreme deviancy and social disintegration shatters cultural illusions (p. 106).” For example, caring for patients who may have caused harm to others confronts the nurse with issues that are centrally at odds with the goals of nursing care, and nurses must come to terms with this conflict on a personal level and determine how they will respond. Benner, Tanner and Chesla state that nurses must come to terms with the pain and with the differing values of those for whom they care. The participants in the current study tried to be nonjudgmental and to remember that these patients who had committed crimes were still human and they deserved care. Jane found a way to care for these patients, by connecting with them on a different level. She commented:

I go in not even with the attitude of what they have done anymore...you still have to do the work, the work still has to be done so sometime you have to get through all of that. I don't ask very many questions because I don't want to be subpoenaed or anything. So I stay away from what happened, I stay away from their past and

we talk about the weather and we talk about TV shows, we talk about everything else that can't get me into trouble.

The strategy of “looking beyond what the patient had done” was not reflected in the trauma or critical care literature, however, it has been explored in other areas of nursing such as correctional health. In a descriptive phenomenological study, Weiskopf (2000) interviewed nine nurses employed in correctional institutions to illuminate the experience of caring for inmate-patients. Weiskopf found that participants in her study looked beyond the inmate’s past behavior in order to work with them as patients. They felt strongly that it was not a nurse’s place to judge patients for their crimes, because the law had done that already. Rather than being judgmental, they described caring as accepting inmate-patients as human beings and putting aside the inmate’s custody history. They acknowledged the inmates’ good qualities as well as their poor choices. They accepted inmates for the way they were and expressed feeling good as they got to know the patients and had interactions with them. In the current study, although there were many descriptions of disrespectful and violent patients, participants expressed the need to treat patients, as they would want themselves or their families to be treated. This sentiment was also reflected in a hermeneutic study that examined the structure and development of caring practices behind prison walls through the professional and personal experience and engagement of prison nurses (Maeve, 1997). Maeve reported that nurses felt an obligation to care for inmate-patients and found a way to care for them. This was accomplished by a process of identifying with inmates and maintaining a caring attitude by treating the inmate as they would their own family members. Maeve stated

the most important thing learned from the author's time spent in the prison setting was that the primary nursing role is health care, not punishment.

4.4.1.2 Being a trauma junkie

Membership in an elite group provided an explanation for why participants in the current study remained in the field of trauma nursing. Many of the nurses expressed "*feeling special*" because there were not a lot of trauma nurses in existence. Edna illustrated this notion of exclusivity: "*There are not a lot of trauma units around so that is like a true specialty. The fact that it is almost an elite type because there are not a lot of trauma nurses out there.*" The participants felt very proud to be trauma nurses and felt special because they could do this type of work. Jane shared: "*I think I'm proud to be a trauma nurse. It's different. Like the surrounding hospitals are peripheral hospitals who don't have these types of patients. They all come here so that makes it kind of special that you can deal with these patients.*"

Participants felt that it took a certain type of person with a "*certain mindset*" and knowledge level to be a trauma nurse. As trauma nurses, they felt that trauma nursing was more complex and challenging than other types of nursing. Participants in the current study felt their work was important and multifaceted requiring many skills. Participants felt important because they had the knowledge and skills to deal with all aspects of patient management, particularly in recognizing and responding to changes in their patients' physiological condition. This result is similar to findings reported by Chaboyer, Najman and Dunn (2001) who conducted a study to determine the relationship of perceived autonomy and perceived collaboration with medical staff with the value

nurses place on their jobs. Critical care nurses perceived their jobs to be more valued than non critical care nurses. This was related to expertise required to care for unstable patients and close working relationships with other team members such as physicians.

Being a trauma nurse was perceived as more intellectually challenging because it required knowledge to care for patients with multiple injuries and the complications that frequently developed from these injuries. For example, it was not uncommon for patients to be admitted with neurologic, cardiopulmonary and abdominal injuries. The participants felt special because they had knowledge of multiple body systems whereas other types of nursing focused on one particular body system. Jane shared her feelings about working with a complex trauma patient:

It made me feel like a trauma nurse is very special because other nurses couldn't cope with all those injuries that he had. And I see them come from the agency and they're not used to working on the trauma floor and they don't see the whole, like, they can't get the whole picture together. They might be looking just at the chest tube or something, but they don't know that the leg is bleeding. It's a real skill to be, to have the whole person involved, whereas other services, like if you are just on general surgery, that is all they are looking at, whereas here you are dealing with a head injury and the chest and the ortho and often plastics. So it's a real challenge. I'm proud that we do it. It's quite a specialty really.

Being recognized and respected by others as “trauma nurses” instilled feelings of pride and satisfaction amongst participants. When they told people they were trauma nurses, they felt that others considered them special or “better” nurses because they worked with

trauma patients. For example, Edna shared: *“I have to say that when you tell people that you are a trauma nurse, they say ooohhh, you know you get a little more respect, because it is a specialty.”*

Feelings of pride experienced by participants in the current study are similar to those experienced by oncology nurses. Haberman et al (1994) conducted a descriptive phenomenological study of oncology nurses and the meaning of their work. Results of the study revealed that the challenges of administering sophisticated cancer therapies and the complexity of oncology care kept oncology nurses motivated and engaged. Similar to participants in the current study, oncology nurses found the best in the worst of situations by sharing a collective sense of pride in their specialty, and reporting a high level of job satisfaction.

In addition to “feeling special,” participants described being a trauma nurse as being a “trauma junkie.” Trauma nurses became addicted to trauma. They became addicted to the complexities and challenges of trauma. Participants loved the unpredictability of trauma and the anticipation of the unknown. One minute a patient could be fine and the next minute their condition could deteriorate significantly. Anna described:

It is challenging because no two days are the same...no two patients are the same. So you are kind of kept on your toes, you have to think outside the box, you have to be sensitive and have a good sense of humour and you have got to be knowledgeable.

For participants in the current study, humour was used as a coping mechanism to help them deal with the difficult situations they encountered on a daily basis. While

caring for challenging patients, appropriate use of humour was found to be an effective approach that nurses relied on to help them deal with the challenging situation.

Participants described that interacting in a humorous fashion was helpful to both patients and nurses and was a factor that facilitated being a trauma nurse. For example, Joan shared how having a sense of humour helped her through difficult situations:

Humour gets me through a lot of situations, that is my way of dealing with it.

What is the point of getting stressed out, because if I get stressed out, the patient will feel that I am stressed out and the family will be stressed out. If I can make light of it and just be there and help them get through every day, day by day, then that is how it is going to project to everyone else that is around.

It has been repeatedly documented in the nursing literature that nurses benefit from humour. Buckwalter (1991) highlighted the use of humour as a coping strategy by nurses working in geropsychiatric settings. Humour techniques to help oncology nurses cope with their stressful working environment also have been addressed (Simon, 1989).

Participants in the current study craved the adrenaline rush and excitement that they experienced when a high-profile, complex case was admitted to the trauma unit.

Trauma junkie...can't get enough of it. You can almost get...when you get a high profile case...high profile being media, not necessarily a famous person, like an accident that has been highly publicized and you kind of think "oh I'm special because I am taking care of this person" and the fact that being a trauma nurse is something that I am meant to do and it is exciting and that is why I keep coming back for more punishment.

During her second interview, Jane corroborated Edna's comment with the following:

“Being a trauma junkie is exactly right, exactly...because you get different reactions. People ask what floor you work on and you say trauma, and people say, ‘ahhhh.’ You get instant respect. You know you don’t have to do anything and you get respect.”

Similar to participants in this study, accident and emergency nurses in the United Kingdom reported being attracted to the excitement and challenge of working in the emergency department (Payne, Dean & Kalus, 1998). Accident and emergency nurses revealed that they chose to do emergency work because it was exciting, extremely busy, challenging and they had the opportunity to interact with a variety of clients. Raingruber and Ritter (2003) reported similar results in a phenomenological study in which they examined the lived experience of expert emergency room nurses in order to describe their sources of work satisfaction. Experienced nurses described appreciating the challenge of working with complex patients, valuing the unpredictable nature of their work, and enjoying the intensity and fast pace of the emergency room.

4.4.2 Theme 4: Sharing the journey

For the participants, the meaning of being a trauma nurse was not only doing for patients and families but also being present in their moment of crisis and need. Although participants encountered many challenging situations on a daily basis, they were able to find meaning and satisfaction through other aspects of being a trauma nurse. These aspects included: *“helping families get through a difficult time,” “being there for each other,” “seeing patients recover,” and “having that human touch.”*

4.4.2.1 Helping families get through a difficult time

Being present for families and helping them get through a difficult time was highly valued by participants in this study and made their work meaningful. Participants derived meaning from being able to assist families in coping with stress and emotional devastation that accompanied the traumatic event. Participants described that the suddenness of most traumatic events caused family dynamics to become very unstable. They explained that the families of multiply injured patients experienced significant stress due to the traumatic event that affected their loved one. In order to alleviate some of their stress, participants spent time providing support to the families. This support took the form of providing information and education, encouraging appropriate expression of feelings and making environmental interventions. Anna commented:

We give a lot of emotional support. An injury to their loved one can be very emotionally draining. We allow them to spend as much time as possible with their loved one so that they can get through this difficult time. Not only do we take care of the patients, but we take care of the families as well.

Being involved in a helping relationship with families enabled the participants to provide the comfort and supportive component of their nursing practice. The value of this type of relationship for these participants is congruent with other findings in the literature. For example, in an exploratory-descriptive study by Eriksson (1992), she examined the ways in which nurses communicated caring to the patients and families. The goal of the study was to synthesize a definition of caring communion from descriptions of participants. Nurses were asked their opinion of caring communion and how they applied it in their own caring context. Eighty-nine descriptions were submitted

by participants. From both the patients' and nurses' point of view, the experience implied "the ability to cry with those who cried, laugh with those who laughed, grieve with those who grieved and be happy with those who were happy" (p. 93). Demonstrating that they cared for the patients by sharing the patients' and families' experiences was said to have positively affected the healing process for the families and had eventually led to feelings of joy and satisfaction for the nurses. The nurses in her study stated that they felt they had matured as human beings and that their own life values had evolved. Eriksson found that time as a quantity was of no great significance, but the experience of sharing time was important. Similarly, Soderstrom, Benzein and Saveman (2003) conducted a descriptive study with ten Swedish intensive care nurses on their experiences of interactions with family members. The nurses in the study viewed the creation of an open and trustful relationship with family members as one of the most essential parts of nursing care. Participants showed an interest and a wish to know family members as persons and create relationships. Participants verbalized that receiving positive feedback from family members gave them confidence and satisfaction in their work.

In order to help families make sense of the situation, participants described that they spent a considerable amount of time teaching and explaining things to families. They kept the families informed and let them know of any changes in the patients condition on a regular basis. Jane shared her experience with one family:

You just have to keep going over things, over and over again. I spent an hour with one lady a couple of weeks ago, just telling her that things were normal and we ended up talking about a whole bunch of things.

She came up to me about a week later and said “Do you know how much you helped me the other night?” and I said, “No, not really.” So you have to spend time with them because it is traumatic, it’s a shock for the whole family.

The participants identified the value in entering into and attempting to understand the internal dynamics of the family. Participants expressed that they enjoyed taking time out of their busy schedule to sit and speak with families. Often this was how they would get to know more about their patients and find out what they were like prior to their traumatic incident. These findings are similar to an Australian study conducted by Hammond (1995) who utilized a descriptive survey design to describe the attitudes of intensive care nurses and relatives towards the provision of care by relatives to their critically ill loved one. Results of that study identified that involvement with relatives in care may serve to provide opportunities for the nurse to develop a relationship with families and provide support and reassurance. Additionally, results revealed that patient’s relatives may elicit the benefit of deepening the nurses’ understanding of the critically ill patient.

Many of the participants in the current study formed special bonds with the families because they were in the hospital for a long period of time. When the families received bad news, the nurses made it a point to be there to support them and allow them to vent their feelings. Many nurses cried with families when they received devastating news. They shared the good times as well as the bad. Caring for significant others was seen as an integral part of knowing and caring for the patient. This finding is congruent with a study conducted by Williams (2005) to explore the processes and factors

underpinning families' contribution to patient care in the intensive care unit. Nurses identified that it was through contact with the family that they came to know more about the person for whom they were caring. Through interactions with the family, the nurses generated an understanding of the person behind the patient until they could gain information from the patient themselves. Such understanding was seen as a crucial ingredient of 'knowing the patient.'

Participants in the current study highlighted the importance of responding to the relatives' need for information and to share their concerns. This sentiment was reflected in a phenomenological study on critical care nurses' lived experiences of caring (Bush & Barr, 1997). Caring in the critical care setting emerged as a multidimensional complex process involving assessing and addressing patients' and families' unique needs, with the goal of improving the patients' condition. Results of the study revealed that the nurses considered relatives to be very important to the welfare of the patient and that their physical and emotional needs should be cared for. As well, Hickey and Lewandowski (1988) undertook a descriptive study exploring the topic of families of critically ill patients from the nurse's perspective. Seventy-seven percent (N = 226) indicated that it was emotionally exhausting to become involved with families who needed support, yet eighty-six percent indicated that they would still become involved with families regardless of the possible costs to themselves.

Overall, participants in this study found it very meaningful and gratifying to work with the families of trauma patients. When the participants received positive feedback and gratitude from the families, they felt special and appreciated for their work. They valued the relationships that ensued from their interactions with families and derived both

personal and professional growth. Anna shared: *“I offered them something that meant something to them and helped them get through a difficult time.”*

4.4.2.2 Being there for each other

In addition to being there for families, *“being there for each other”* provided the necessary energy to provide care to patients in challenging, demanding and uncertain situations. All participants emphasized the camaraderie and teamwork that they felt amongst each other. Participants reported that their nursing colleagues provided a strong source of comfort in the management of their job stress. By being there for each other and working together as a team, participants were able to find comfort and support that eased their feelings of being unsafe and scared. Providing support to colleagues as well as receiving support helped the participants to meet the challenges of being trauma nurses. This finding is congruent with a study conducted by Rafferty, Ball and Aiken (2001), who found that nurses with higher teamwork scores exhibited higher levels of autonomy and were more involved in decision-making. Participants in the current study felt that the dangers and challenges they faced were eased by knowing that they were a member of a team in whom they knew and had confidence. The intensity of the work was shared and absorbed by the interdependent team. If one of their coworkers was busy, others would pick up the slack in order to make his/her load easier.

The positive support received from fellow coworkers compensated for the lack of appreciation and respect received from some of the patients. Being there for each other enabled and sustained participants to continue to work in a stressful environment. The support of colleagues in addition to cooperative teamwork enabled nurses to provide

emotional and physical care in their work. Caring shown by colleagues was seen as supportive in motivating the nurse to further caring actions. Susan reflected:

The thing that helps me the most to be a trauma nurse is the support from my co-workers. They are almost like family to me...we hang outside of work as well. If you ever have a problem, all of the nurses are right there to lend a helping hand. I have worked on other floors and the nurses were never as helpful.

The value of peer support in reducing occupational stress experienced by nurses has been extensively documented in the literature. No specific literature was found on the value of peer support among nurses working on trauma units, however research studies in other clinical settings have reported the beneficial effects (Cruchet, 1994; Mobily, Mass, Buckwalter, & Kelley, 1992). For example, Lees and Ellis (1990) in their sample of 50 qualified nurses and student nurses identified peer support as an important coping strategy in times of work-related stress for both student nurses and qualified nurses. Ogus (1990) investigated the relationship between work stress, burnout and social support in a sample of 128 medical and surgical nurses. Nurses with high sources of social support and high levels of satisfaction with that support reported less burnout than nurses with few supports and less satisfaction with those supports, regardless of level of work stress. Results of this study suggested that regardless of the level of work stress, nurses who had, and were satisfied with their supports, experienced less stress and burnout than those nurses without supports or who were not satisfied with their supports. Gaynor, Verdin and Bucko (1995) conducted a study that explored group social support as a component of job morale for bedside caregivers. Results of the study revealed that peer social support was found to be highly related to job morale. Vachon (1998), in

reviewing the stressors and manifestations of stress in oncology and palliative care settings, recognized that a lack of supportive and collaborative workplace relationships diminished nurses' self-esteem and reduced professional effectiveness.

In the current study, having worked together for a certain amount of time and having been through many crisis events together, these nurses knew one another, they knew each other's strengths and they had built up trust in one another. According to Brooks, Wilkinson, and Popkess-Vawter (1994), group cohesion has been identified as a situational support mechanism that assists in problem solving and enhances personal and professional integrity. Through fellowship, the trauma nurses in this study created a working relationship of knowing and understanding one another. Participants depended on one another, not just for completing patient care, but also for an emotional connectedness. They felt cohesion amongst each other that some of them had not felt in other areas of nursing. This special feeling gave them a sense of security and confidence to handle any situation. Participants felt a cohesiveness amongst each other that some of them had not felt in other areas of nursing.

In addition to being coworkers, participants considered each other family and socialized with each other outside of work. Participants explained that the amount of time spent with their colleagues was sometimes more than that spent with their true families. They formed special bonds with their colleagues because they understood what the other was going through. If one nurse was having a bad day, the others would create a space for him/her to talk about his/her feelings in a "safe environment." Mary commented:

But just to go into and sit, like if you have a bad moment with a patient or family and just go into the office and tell the others what just happened to you.

Sometimes they can see the humor and sometimes just talking about it helps to make it better.

4.4.2.3 Seeing patients recover

Being able to see patients recover was considered to be a very rewarding and meaningful aspect of being a trauma nurse. Participants felt very gratified when patients who were once very ill were able to walk out of the hospital. When a patient recovered, participants felt like they had made a difference and had played an important role in their recovery. They felt that they had done a “good job” and that they had provided “good care.” Edna shared one of her rewarding experiences as a trauma nurse:

It would be one of several of the comatose patients that have woken up and been able to leave us in much better shape than when they came in. That is very rewarding when they come back to visit and you don't recognize them because they look so good. You know that is very rewarding that we managed to save that life and actually get them back to almost where they were before the accident or whatever brought them in.

Observing and helping trauma patients recover provided participants with a sense of purpose and motivation to continue their work. These findings are congruent with a study conducted by Mills and Blaesing (2000) who explored the relationships that work values have on the satisfaction that nurses experience with a career in nursing. Results revealed that most nurses identified patient care rewards as the reason for why they

entered nursing, why they remain in nursing and why they would choose it again. The greatest likelihood to be satisfied with a nursing career was found with the nurses who felt like they had made a difference in patient's lives.

Participants revealed how rewarding it was when patients would leave the hospital and then come back to visit them at a later time. It provided closure and enabled them to see that many patients returned to their normal lifestyle. For example, Susan described that "*it made her feel complete*" when patients came back to see her after they were discharged from the hospital. Anna shared:

It is rewarding because we see people come in who are really injured, sometimes severely injured and they leave and come back to see us. We had a patient come back and see us and she had been through a horrible car accident, she was with us for months and she had been through so much and she would always say "I'll walk out of here" and she came back walking and people were crying and she was crying. So when you see that sort of stuff...if you had just a touch in that kind of activity, it really moves you.

Participants in the current study felt that their work was worthwhile when they observed a patient go from a comatose state to a state where they were able to walk out of the hospital. This patient progression gave participants a renewed sense of love for their work and an overall feeling that they had made a difference in patients' lives. The significance of seeing patients' recover has been well documented in critical care nursing literature, however no specific literature was found on the significance of seeing patients' recover for nurses working on trauma units. According to Bailey, Steffen and Grout (1980), critical care nurses derive much of their satisfaction from seeing patients recover,

while Burn, Kirilloff and Close (1983) reported that 160 emergency nurses cited patient improvement, progress and recovery as sources of satisfaction. Bush and Barr (1997) concluded that critical care nurses had feelings of personal fulfillment when they were able to see patient's progress to a better level of well-being.

As well, these trauma nurses expressed how much it meant to them when patients said thank-you. Being appreciated for their work was identified as one of most rewarding aspects of their job. Joan shared:

Seeing them smile, when people say thank-you. I don't think patients realize how much it means to you when they turn to you and they say thank-you for everything you have done. They have no idea, I'll tell them it means so much to hear them say that.

Receiving gratitude from patients provided nurses with a sense of pride and personal accomplishment. Gratitude signified to the participants that their actions made a difference. Recognition of their care was viewed as a meaningful and motivating force because the recognition received for caring motivated participants to continue caring for others. Helps (1997) reported similar findings in a study that involved assessing psychological and physiological experiences to occupational stress of all staff groups working in one accident and emergency unit in the United Kingdom. Findings revealed that one of the most frequent sources of satisfaction among accident and emergency nurses was when patients expressed gratitude for the care provided by the nurses.

4.4.2.4 Having that “human” touch

In "Nursing the finest art: An illustrated history", Patricia Donahue (1996) included a photo of a poster created by Melody Chenevert of a Victorian crazy quilt with the caption "Nursing-a career not measured in years but in moments." She wrote:

A Victorian crazy quilt. A nursing career. What is it they have in common? Rich fabric. Fragmented. Held together by heart and hand. Elaborately embellished with unforgettable moments. Fine art. Painstakingly executed. A work in progress, often unfinished. Chaotic yet controlled. And synergy - the whole is greater than the sum of its parts. In the end we will not remember the years we spent in nursing. We will only remember the moments. (p. 473)

Perhaps the most crucial sustaining element of being a trauma nurse lies in the rewards of the practice itself. Overall, participants considered it a privilege to be trauma nurses. They were given entrance into people's lives and minds and they were thankful that they were able to do that. At the end of the day, the participants felt that their work had importance and that they had done something during their day to make someone feel better. Anna summed up this perspective perfectly when saying:

People are in a stage of life where they are really vulnerable and they need somebody, probably just to listen...just to know that somebody cares...it feels good to know that somebody cares and more often than not you have that kind of human touch in your relationship with them before they leave. I think that is the crux of being a trauma nurse.

Morse and Procter (1995) suggested that the comfort work of nurses in trauma situations enables patients to endure and reduces shock and post-traumatic stress

following trauma care. For the participants in the current study, the comfort work of nursing came through sharing special moments with patients, families and coworkers. Participants described periods of intimacy and special moments with patients and their families and in doing so described themselves as privileged. Participants revealed that real nursing occurred as a matter of special moments. Sharing special moments with patients solidified their commitment and love for their work. Special moments consisted of times in which they were able to “nurse”, such as spending time washing a patient recovering from a motor vehicle collision or getting to know a patient or family member. Edna shared one of her special moments with a head injured patient:

But you talk to them, tell them what it is like outside, what day it is. I'll talk to them while I am bathing them. I try to give them a longer bath. I remember another patient, I put on a tape while I was bathing him, his wife brought in music that they played and I don't know whether it was because of the music or because I was washing his foot and giving him a foot rub but he smiled. So whether he was reliving memories related to the music or I was tickling him or he was just enjoying the foot rub...who knows but he was smiling.

Being invited into some of the most vulnerable moments of people's lives, as well as the personal meaning gained from the encounters, enriched their life experiences. Through intimate human connection, the participant's felt satisfied knowing they were helping others. Special moments became the fuel of future caring commitment. Participant's continued involvement was justified to them in those special moments, uplifting their spirits to continue on in their caring efforts knowing they were not in vain.

These findings are congruent with a qualitative study conducted by Perry (2002). Fifteen acute-care bedside nurses were asked to talk about times in their work life when they felt satisfied that they had become nurses. All fifteen felt most fulfilled with their career choices when they experienced intimate interactions with patients or their family members in which they had made a difference. The essential satisfaction for many nurses came when they established a close connection with their patients. When both the patient and the nurse were fully present in the moment, there was a feeling of union with the other.

In the lived world of the participants in this study, special moments brought a sense of professional fulfillment and satisfaction. Taking the time to share special moments with patients enabled trauma nurses to situate themselves in the moment. Perhaps that is why trauma nurses cherish the special moments and why these moments are remembered.

4.5 Summary of Findings

The current study which focuses on the meaning nurses attribute to their lived experience of being trauma nurses embraces the notion of Being-in-the-world. Through Being-in-the-world of a trauma unit and through the experience of being trauma nurses, the study participants derived meaning of their situation from their own unique background and previous life experiences.

The overall essence of being a trauma nurse is captured in the metaphor: “*seeing through cloudy situations.*” This description brings to light and illuminates participants struggle and journey to make sense of their experience. The cloudy situations include the

themes of “*being on guard all of the time*” and “*being caught up short.*” These themes represent the challenges that participants faced on a daily basis in their work as trauma nurses. The themes of “*facing the challenge*” and “*sharing the journey*” capture how participants were able to see through the cloudy situations and find meaning and satisfaction in being trauma nurses. All of the themes were seen as interrelated and connected in such a way that each one is essential to understanding the lived experience of being a trauma nurse.

Chapter 5: Implications for Practice, Education, and Research

5.1 Introduction

This chapter provides implications for nursing practice, education, research and the role of the Advanced Practice Nurse (APN). The chapter concludes with study limitations.

5.2 Implications for Nursing Practice, Education, and Research

Implications of the study findings will be discussed in this section. The focus will be on suggestions for nursing practice, education, and research in trauma nursing. This section will conclude with the role of the Advanced Practice Nurse (APN) in trauma.

5.2.1 Implications for nursing practice

It is clear from the current study that violence and aggression against trauma nurses is an important issue for nursing practice. Trauma nurses' tolerance of violence and aggression constitutes a complex, multifaceted issue with implications far beyond those of physical safety. The current study revealed that violence and aggression has profound implications on the emotional and physical health of trauma nurses as well as the quality of care they are able to provide to trauma patients. For participants in the current study, situations in which they felt scared or felt as though they had to watch their back caused them to focus on their own needs and safety which in turn impacted the quality of care they were able to provide to the patients and their families.

The quality of nurses' professional practice environments has a direct correlation with job satisfaction, work production, recruitment and retention, the quality of care and ultimately client outcomes (Aiken et al., 2001; O'Brien-Pallas & Baumann, 1992).

Similarly, Erickson and Williams-Evans (2000) revealed that the culture of violence that affects the nursing workplace means that nurses may not feel safe in their workplace. Thus, anxiety and stress about personal safety may complicate and exacerbate other work stressors. Clearly, if trauma nurses are to support others and provide quality care they must feel supported and safe themselves. Therefore, a coherent nursing voice needs to be heard at the clinical level, organizational level and the level of the public that violence and aggression will not be tolerated.

The current study findings reinforce the work of others who have demonstrated that nurses are reluctant to report violent incidents because they feel that violence is “part of the job” (Whittington & Wykes, 1989). According to Lurkhur (as cited in Kearsley, 2004), nurses feel ashamed to report violence and feel that if they report it, they will be blamed by management for being incompetent. If trauma nurses continue to accept violence and aggression as part of the job, this may result in a continuation of the present trend in violence which has profound implications for both trauma nurses and the care they provide to their patients. Therefore, trauma nurses need to be empowered to denounce violence as part of professional nursing practice and recognize that when violence occurs, they can take action to stop it and prevent further occurrences.

One way in which trauma nurses can begin to stop violence and aggression is by playing a role in the creation, evaluation and improvement of workplace processes. By participating on or contributing to workplace safety committees, trauma nurses can be proactive in the development, implementation or revision of policies and procedures related to the prevention and management of violence and aggression. As well, trauma nurses should play a role in the development of best practice guidelines on workplace

health and safety. According to Simms (1999), nurses should work with hospital administrators to formulate policies on violence and staff rights, including the process for reporting violent situations and how administrators will intervene.

Trauma nurses can also advocate with their employer to provide mechanisms for reporting and following up on violence and aggression, such as critical incident debriefing, information sharing about violent and aggressive clients and counselling for nurses who have encountered a violent incident. These mechanisms would provide an opportunity for trauma nurses to reflect on stressful incidents and share their feelings in a safe environment. In addition, trauma nurses need to be supportive of colleagues who encounter violence and encourage them to report those incidents.

Trauma nurses require support when confronting challenging clinical situations such as violence and aggression. Therefore, trauma nurse employers and managers are responsible for establishing a safe environment in which trauma nurses are able to perform their work without being susceptible to violence and aggression. This responsibility may be met by collaborating with nurses to develop and implement policies that support violence-free (zero-tolerance) workplaces, prevention and intervention programs, access to support services for victims of violence, and improved awareness among employees, clients and families. According to Jackson, Clare and Mannix (2002), managers and employers should participate in the development of strong policies to protect staff against violence as well as provide guidance about avenues for help and support for victims of workplace violence. In addition, nurse managers should have a known procedure for reporting violence of any kind and emphasize to trauma nurses that they should report all incidents of violence. By doing so, awareness of the incidence of

violence will be raised, thereby assisting employers and employees in the development of effective policies and strategies to predict and resolve issues of violence. As well, nurse managers should supply appropriate resources such as adequate staffing for client needs and appropriate training on violence prevention and management. Evaluation mechanisms should also be implemented to evaluate the impact of staff education and the need for continue support or alternative strategies to assist staff in managing aggression and violence.

Although participants in the current study recognized that head injured patients often had no control over their violent and aggressive behaviour, participants revealed feeling unsafe when working with these patients due to the layout of the physical environment as well as their uncertainty about what to do when the patient became agitated. This finding indicates that nurses should seek out and use resources to assist them in caring for head injured patients who exhibit challenging behaviours. For example, trauma nurses could advocate for educational sessions on managing aggressive behaviour among head injured patients. Trauma nurses can also play a role in advocating for changes to their physical environment and identifying strategies for the prevention and management of violence. For example, trauma nurses can suggest strategies such as:

- ensuring that unused doors are locked;
- an open concept unit so that nurses can view what is happening on the unit;
- rearrangement of furniture and patient care rooms so that nurses can easily exit;
- limiting access to trauma units with locked doors that require access codes;
- the use of personal alarms or panic buttons;
- the provision of secure bathrooms for staff;

- provision of seclusion areas that allow staff to separate violent persons from other patients, and
- the presence of a security guard 24 hours/day.

Jackson, Clare and Mannix (2002) identified that staff protection from violence needs to be incorporated into the design of buildings and should include facilities such as time-out areas and quiet places. Similarly, Erickson and Williams-Evans (2000) discussed the possible benefits of protective measures such as security monitoring and adequate lighting.

The current study has implications not only for trauma nurses' health and safety, but also, in the broader sense, for the profession's ability to attract and retain trauma nurses within the healthcare system. Fear of violent situations and feelings of being unsafe could have an effect on the recruitment and retention of trauma nurses. Nurses may decide that they are tired of being in constant fear and decide to relocate to another unit or they may choose to leave the profession altogether. As well, it may have a significant effect on the number of people willing to consider a career in nursing at all. Therefore, employers need to involve staff nurses in generating ideas for interim and long-term solutions to patient safety. In addition, the current study may have implications for other areas of nursing such as long-term care or community where the literature indicates that violence is also present.

The current study findings revealed the many challenges and rewards associated with being a trauma nurse. It is important to increase awareness of the challenges trauma nurses face on a daily basis in order to improve the quality of work environment. Trauma nurses and managers must work together to identify sources of work-related stress and to

develop strategies to reduce it. Trauma nurses must also recognize their own personal and job-related stresses and take action to deal with them. Focusing efforts on stress reduction has the potential to improve nurses' work life and job satisfaction and may also lead to higher quality of care for trauma patients. Participants in the current study revealed that they used humour to help them get through stressful situations. In efforts to decrease the rate of nurses' burnout and increase morale, nurse managers should promote an atmosphere where laughter and humor are valued. Humour should be incorporated into continuing education so that nurses can view humour as a valuable resource in interactions among themselves.

It is equally important to increase the awareness of the positive aspects and/or rewards of being a trauma nurse. Participants in the current study clearly identified the rewarding aspects of their work which may have a direct impact on promoting trauma nursing and the recruitment and retention of trauma nurses. For example, participants identified that the challenge and excitement of being a trauma nurse kept them engaged and motivated. These aspects of being a trauma nurse could be emphasized when recruiting trauma nurses.

Findings in the current study have implications for nursing practice in relation to the theme of "*looking beyond what the patient had done.*" Although many trauma patients had caused harm to others, some participants in the current study were able to treat these patients with dignity and respect. Fundamental to caring for a patient who had committed a crime or caused harm to others was being able to see beyond what the patient had done and focus on the person inside. Nurses need to be helped to journey to this place when caring for these patients. Despite the fact that the nurse may not agree

with a patient's lifestyle choice, they must continue to care for these patients and treat them as they would any other human being. According to Paavilainen and Asted-Kurki (1997), nurses must continually reflect on their interactions with clients. Nurses could enhance their ability to care for patients who may have caused harm to others by reflecting on how their values and beliefs impact the nurse-client relationship. Through reflection, nurses can understand and learn how their own attributes can affect the relationship. Nurses can also reflect on their interactions with clients to understand why they acted or responded the way they did.

Findings in the current study indicate that spending time with families and understanding their sense of vulnerability, fear and uncertainty can increase nurse satisfaction and assist in planning targeted care approaches that help families in managing the health experience. It is imperative that nurse managers and educators value and encourage this supportive/communications role of the trauma nurse which has benefits for nurses, families and clients. Trauma nurses may require further education and/or clinical supervision to facilitate the development of competence in caring for patients' families. Educational instruction focused on family-centred care should be incorporated effectively into nursing curriculum, and reinforced through orientation sessions for new nurses and through in-service teaching in the trauma unit.

Findings in the current study revealed that peer support and cohesion contributed to a high level of satisfaction among trauma nurses. Several studies were found in the literature that addressed the positive nature of nurses' interactions. For example, Adams and Bond (2000) used the Ward Organizational Features Scales (WOFS) to examine the relationships between aspects of the organization of acute hospital wards, nurses'

personal characteristics and nurses' job satisfaction. Results revealed that cohesion among nurses was positively associated with professional practice and job satisfaction.

It is important for nurse managers and employers to establish a collaborative and rewarding work culture that promotes nurse satisfaction and retention (Kuhar, Miller, Spear, Ulreich & Mion, 2004; Stolzenberger, 2003). Nurses who feel supported and affirmed by others may function more effectively as a team member, which may enhance the overall working environment of a particular unit. One strategy that nurse managers could use to enhance teamwork is to initiate regular staff meetings in which staff could meet and discuss their unit culture. Through these discussions, nurses could identify barriers to cohesive group functioning including ineffective and negative communication, generational differences, peer competence, and accountability (DiMeglio et al., 2005). This in turn could have important implications for increasing both nurse and patient satisfaction. In addition, DiMeglio et al., suggest that "collaborative rounds, where the RN presents the treatment plan for his or her patients, provides an opportunity for improved communication, professionalism, and competency among the caregivers" (p. 119). As well, nurses need to learn how to be effective team members, and students should be taught to function as team members beginning early in their basic education.

Participants in the current study brought forth new insights into the artful practices of their work by sharing "special moments" they experienced with patients. The current study makes visible the artful experiences of nurses and may be helpful for nurses who have been struggling to envision and value artful nursing. Stories shared by participants in the current study may be viewed as expressive vehicles that convey evidence of the power and promise of artful nursing practice.

5.2.2 Implications for nursing education

5.2.2.1 Clinical staff education

Participants in the current study revealed feeling scared and unsure of how to intervene when involved in violent and aggressive encounters. This finding indicates that nurses should have ongoing training in violence prevention and management. Trauma nurses should benefit from regular participation in skill development workshops to promote self-protection from all kinds of violence, from verbal to physical abuse, how to recognize it, and what to do about it. As well, new nurses should receive information and training during their orientation about possible violent situations and how to intervene. According to Levin, Hewitt and Misner (1998), nurses should receive ongoing training in violence prevention including areas such as de-escalation techniques, self defense and aggression management. In addition, continuous education should be provided that reinforces all staff members' roles in providing peer support and trying to prevent or minimize the effects of violence and aggression on all concerned: staff, patients and relatives. Educational sessions should also be provided to trauma nurses regarding gang culture and strategies to establish relationships with gang members.

Findings in the current study revealed that participant's experienced challenges when working with head injured patients. This indicates that trauma nurses could benefit from educational sessions on head injuries and how to manage these patients when they become agitated. Employers and managers should consider the integration of a variety of professional development opportunities to support nurses in effectively developing knowledge and skills to provide care to head injured clients. For example, a nurse educator could provide an educational session to help staff develop strategies for

managing aggressive behavior among head injured patients. In addition, participants in the current study revealed feelings of frustration when working with some of the head injured patients. Information sharing sessions may be useful for trauma nurses to share and reflect upon their experiences and frustrations of working with head injured patients and to share ideas about possible interventions for confusion management. Expert resources specializing in neurological injuries could be used to assess clients to determine whether the factors that trigger a client's violent behaviour can be tracked and avoided in the future.

5.2.2.2 Formal education

Nursing education should take on the challenge of educating nursing students about the potential for violence and aggression in the workplace environment. According to Erickson and Williams-Evans (2000), risk assessment, violence prevention and crisis intervention need to be incorporated into nursing programs. Similarly, Lam, Ross, Cass, Quine and Lazarus (1999) suggest that basic conflict resolution skills and sharing of experiences from senior should be part of the undergraduate nursing curriculum. Nurse educators can help students prepare to deal with the possibility of encountering violent situations in health care settings. This could involve educating students in assessment, planning, and interventions to prevent or intervene with violent or aggressive behaviors from clients, families, visitors, or others. Nurse educators should foster positive nursing images and respect for nurses' rights to dignity and personal safety through role-modelling. The encouragement of critical thinking through the use of scenarios and role-play may provide an opportunity for students to be exposed to

situations that could occur in the workplace as well as the clinical setting. In addition, all entry-level nursing programs should include specialized content about head injured clients such as the involvement of family throughout the process of nursing care, assessment and management of violence and aggression among head injured clients, communication techniques and appropriate nursing interventions.

5.2.3 Implications for nursing research

The current study has identified several specific suggestions for trauma research that are worthy of consideration. The mere fact that there is so little research in the area of trauma nursing, underlines the need for further work. The insights gained through the current study's analysis highlight the need for future efforts in order to come to a better understanding of the unique experiences of trauma nurses. Specific areas for future related research might include:

1. The current study's findings support the growing body of literature that recognizes nurses as profoundly vulnerable to violence and aggression in the context of the workplace. However, the majority of literature exploring the phenomena of workplace violence and aggression has focused primarily upon nurses working on emergency units (Lee, 2001; Mahoney, 1991; Schneiden & Marren-Bell, 1995), psychiatric units (Nolan, Dallendar, Soares, Thomsen & Arnetz, 2001; Spokes et al., 2002), and long-term care settings (Chambers, 1998; Shah & De; 1998). There is a gap in the literature with regards to violence towards nurses working on trauma units. More specifically, there is a lack of research related to violence towards nurses from gang patients. The findings from the current study indicate a need for further exploration of the

prevalence of violence and aggression towards nurses. Research should include nurses working on trauma units as well as in other areas of nursing.

2. Further research is required on the impact of patient violence and aggression on nurses. Key questions could include: What is the impact of violence and aggression on the nurse-client relationship? Is there a correlation between patient violence and nurses' intent to leave nursing? Is there a correlation between violence and aggression among patients and nurses' job satisfaction?
3. In the current study, participants revealed feeling unsafe and uncertain of how to intervene when working with agitated or aggressive head injured patients. There is a paucity of literature related to aggression and agitation among head injured patients and the impact of their behavior on nurses who are attempting to provide care. Therefore, further research is required on agitation and aggression among head injured patients so as to inform the development of appropriate education and interventions to support trauma nursing practice in the future.
4. Participants in the current study emphasized the importance of spending time with families and helping them get through difficult times. Understanding meanings constructed through family-nurse interactions could be investigated in a variety of settings. Further description and exploration could enhance the development of family nursing theory, research and practice.
5. Future research aimed at determining levels of teamwork, either through quantitative or qualitative methods, would provide greater insight into the effects of teamwork on patient and professional outcomes.

5.3 The role of the Advanced Practice Nurse (APN)

The five primary dimensions of the APN role are: i) expert clinician, ii) consultant, iii) researcher, iv) leader, and v) educator (Hamric, Spross & Hanson, 2000). This section will focus mainly on the role of an APN in the context of a trauma unit as it relates to implications from the findings of this study.

5.3.1 Expert clinician

The trauma APN has a role to develop interest, skills and knowledge related to clinical practice in trauma nursing. The expert clinical practice of the trauma APN could consist of both direct and indirect patient care. The direct care role of the trauma APN could include management and/or coordination of complex patient situations. For example, the APN could provide direct care to a complex trauma patient such as a young adult who has recently become a quadriplegic due to a gun shot wound to the neck. The trauma APN could play a role in diffusing situations with angry patients, working with anxious family members and initiating interdisciplinary care conferences for challenging patients (e.g., head injured patients). As a point of illustration, an APN could initiate a conference involving the interdisciplinary team and family to discuss and decide upon strategies to control unacceptable behaviour exhibited by a client. The trauma APN could also provide indirect clinical care by supporting and mentoring staff nurses caring for complex trauma patients. In addition, the trauma APN could also be involved in coordinating discharge for trauma patients with complex follow-up care such as head injured patients who require extensive rehabilitation.

5.3.2 Consultant

The APN is a content expert and so assists in suggesting a wide range of alternative approaches or solutions to clinical or system problems (Hamric, Spross & Hanson, 2000). The trauma APN can play a role in providing consultation to clinical nurses, managers, educators, physicians and health care professionals regarding clinical and professional practice issues. Consultation may be formal or informal. For example, a formal consult may be generated by a trauma staff nurse who requires guidance in managing a disruptive head injured patient. Similarly, an informal consultation may be a quick clinical question generated by a trauma staff nurse. The trauma APN may also be consulted by administrators in an institution to recommend changes in policy and procedure of trauma care or trauma systems.

5.3.3 Educator

The trauma APN can play an important role in identifying patterns of patient care and staff development needs. As an educator, the APN can plan, develop, and implement health teaching resources and tools for staff, patients, and families. Staff education could include formal in-services, self-directed learning modules, or poster presentations. For example, the trauma APN could provide an education session to help staff develop strategies for managing violent and aggressive behavior. As well, the APN could provide training to staff on violence prevention strategies such as conflict management, crisis intervention and proper restraint procedures. In addition, the APN could provide a forum for communication of problems and structured ventilation of stress. The APN could

initiate critical incident debriefing for staff nurses who have been involved in violent and aggressive situations.

The trauma APN should find ways to model the art of nursing and share stories of artful nursing encounters. For example, the APN could organize sessions in which nurses could reflect upon and share their experiences of artful nursing encounters. The reflection on artful experiences by nurses may encourage other nurses to practice self-reflection to achieve awareness of their own practice and understand the dynamics of client interactions. In addition, an APN could facilitate sessions in which trauma nurses could reflect and share their experiences of how they were able to “look beyond what the patient had done”. Nurses may find that examples cited by other trauma nurses can help them to connect with their patients which in turn could strengthen the quality of care provided to these patients.

The trauma APN could also play an important role in providing or influencing patient and family education. For example, the trauma APN could foster the development of family education programs to bridge the transition from hospital to home. The trauma APN could be involved in teaching high risk or complex trauma patients, such as an elderly trauma patient with multiple fractures. In addition, the trauma APN could participate in the education of undergraduate, graduate nursing students and other health care providers. For example, the APN could teach in formal educational institutions as guest lecturers or they could act as mentors of students within their institutions. The trauma APN may also conduct informal teaching and role modeling for staff nurses.

5.3.4 Researcher

The APN contributes to the understanding and development of evidence-based nursing knowledge through involvement in research and the evaluation and utilization of relevant research findings (Canadian Nurses Association, 2002). The trauma APN could promote and encourage staff involvement in trauma nursing research by facilitating activities such as a journal club or in-services to discuss trauma related research and its relevance to current practice. In addition, the trauma APN could utilize research findings when developing policies, procedures or nursing protocols. As well, the trauma APN could play an important role in identifying relevant clinical questions for study and participate in collaborative trauma related research with multidisciplinary team members. The trauma APN could also present or publish trauma research findings.

5.3.5 Leader

The APN could provide leadership in the ongoing development, implementation, and evaluation of the trauma system. Leadership activities by the trauma APN could be conducted locally, such as in organizational committees or professional groups. For example, the trauma APN can act as an advocate and change agent by bringing their views and perspectives regarding trauma issues to decision-making forums, policy forums and professional organizations. The trauma APN could participate and provide leadership on intra- and inter-disciplinary committees related to the development of policies and procedures related to violence and aggression among patients and visitors. The trauma APN can foster mentoring opportunities that can enhance the transition of colleagues in new positions in both practice and leadership roles.

5.4 Limitations

This study elicited and created meaning of the lived experience of being a trauma nurse. The thematic constructions derived by the researcher may not be applicable or descriptive of the lived experience of every trauma nurse or even all nurses working in the unit chosen for this study. However, the aim of qualitative research is not to reach generalizable findings but to enable deeper understanding of people's lived experiences. As well, the current study was conducted at a trauma centre located in a large metropolitan city in Ontario. Therefore, the findings from the current study may not reflect the experiences of trauma nurses working in other trauma centres located in other cities or communities.

Another limitation of the current study was that all participants were female. Although the interviews generated meaningful data, the findings may not represent the lived experience of male nurses. For example, male nurses may have different experiences and perspective in regards to violence and aggressive encounters with patients.

According to van Manen (1990), we must “remain aware that lived life is always more complex than any explication of meaning can reveal” (p. 18). Thus, a possible limitation of the current study is that the researcher can only rely on the participant’s ability to recall and describe their experiences but can never truly know that the experience of being a trauma nurse has been fully captured. In addition, the findings of the current study are temporal in nature due to the timeframe of the study being 8 months.

5.5 Conclusion

The current study's findings have contributed new knowledge to the understanding of the experience of being a trauma nurse. Findings from the study were integrated into an exhaustive description that the seven participants agreed captured the essence of being a trauma nurse. The overall essence of being a trauma nurse has been captured in the metaphorical statement: "*seeing beyond cloudy situations.*" The four themes of *being on guard all of the time, being caught up short, facing the challenge and sharing the journey*, comprised the fundamental structure of the experience of being a trauma nurse.

Although past research as well as the current study's findings indicate that care of the trauma patient places great cognitive, physical and emotional demands on the trauma nurse, this study has demonstrated that trauma nurses are resilient and perseverant. Resilience is reflected in the participant's strategies for survival, the ways in which they make a connection and find meaning in their work. Despite the many challenges participants faced on a daily basis, they were able to "see beyond cloudy situations" and find meaning and satisfaction in being trauma nurses.

References

- Adams, A., & Bond, S. (2000). Hospital nurses' job satisfaction, individual and organizational characteristics. *Journal of Advanced Nursing*, 32(3), 536-543.
- Aiken, L.H., Clarke, S.P., Sloane, D.M., Sochalski, J.A., Busse, R., Clarke, H., et al. (2001). Nurses' reports on hospital care in five countries. *Health Affairs*, 20(3), 43-53.
- Bailey, J., Steffen, S., & Grout, J. (1980). The stress audit: Identifying the stressors of intensive care nursing. *Journal of Nursing Education*, 19, 15-25.
- Benner, P. (1984). *From novice to expert*. Menlo Park, CA: Addison-Wesley.
- Benner, P., Tanner, C.A., & Chesla, C.A. (1996). *Expertise in nursing practice: Caring, clinical judgment and ethics*. New York: Springer Publishing Company.
- Benner, P., & Wrubel, J. (1989). *The primacy of caring: Stress and coping in health and illness*. Menlo Park, CA: Addison-Wesley Publishing Company.
- Bergum, V. (1991). Being a phenomenological researcher. In J. Morse (ed.), *Qualitative nursing research*. (pp. 55-71). Newbury Park, CA: Sage.

- Bishop, A., & Scudder, J. (1991). *Nursing: The practice of caring*. New York: National League for Nursing.
- Braun, K., Christle, D., Walker, D., & Tiwanak, G. (1991). Verbal abuse of nurses and non-nurses. *Nursing Management*, 22(3), 72-76.
- Brooks, E., Wilkinson, J.M., & Popkess-Vawter, S. (1994). Promoting situational support for nurses in practice. *IMAGE: Journal of Nursing Scholarship*, 26, 305-307.
- Buckwalter, K. (1991). What is the impact of the use of humor as a coping strategy by nurses working in geropsychiatric settings. *Journal of Psychosocial Nursing and Mental Health Services*, 29, 41-43.
- Burns, H.K., Kirilloff, L.H., & Close J.M. (1983). Sources of stress and satisfaction in emergency nursing. *JEN: Journal of Emergency Nursing*, 9(6), 329-336.
- Bush, H.A., & Barr, W.J. (1997). Critical care nurses' lived experiences of caring. *Heart & Lung: The Journal of Acute and Critical Care*, 26(5), 387-398.
- Canadian Institute for Health Information (CIHI). (2003). *National Trauma Registry 2002 Report: Major Injury in Canada*. Ottawa: Author.

- Canadian Nurses Association (CNA). (2001). *Quality professional practice environments for registered nurses*. Ottawa: Author.
- Canadian Nurses Association (CNA). (2002). *Advanced nursing practice: A national framework*. Ottawa: Author.
- Cardona, V.D., Hurn, P.D., Bastagel-Mason, P.J., Scanlon, A.M., & Veise-Berry, S.W. (1994). *Trauma nursing: From resuscitation through rehabilitation*. Philadelphia, PA: Saunders.
- Catlette, M. (2001). Workplace violence experienced by registered nurses in hospital emergency care settings. Unpublished doctoral thesis, The University of Alabama at Birmingham.
- Chaboyer, W., Najman, J., & Dunn, S. (2001). Cohesion among nurses: a comparison of bedside vs. charge nurses' perceptions in Australian hospitals. *Journal of Advanced Nursing*, 35(4), 526-532.
- Chambers, N. (1998). 'We have to put up with it -- don't we?' The experience of being the registered nurse on duty, managing a violent incident involving an elderly patient: A phenomenological study. *Journal of Advanced Nursing*, 27(2), 429-436.

- Chan, B.T.B., Schull, M.J., & Schultz, S.E. (2001). *Atlas report: ED services in Ontario 1993-2000*. Ontario: Institute for Clinical Evaluative Sciences.
- Colaizzi, P. (1978). Psychological research as the phenomenologist views it. In R. Valle & M. King (Eds.), *Existential phenomenological alternative for psychology* (pp. 48-71). New York: Oxford University Press.
- Cruchet, D. (1994). Peer support helps oncology nurses deal with dying patients. *Canadian Oncology Nursing Journal*, 4(4), 164-167.
- Curtis, K. (2001). Nurses' experiences of working with trauma patients. *Nursing Standard*, 16(9), 33-38.
- Dewe, P.J. (1987). Identifying strategies nurses use to cope with work stress. *Journal of Advanced Nursing*, 12(4), 489-497.
- DiMeglio, K., Padula, C., Piatek, C., Korber, S., Barrett, A., Ducharme, M., Lucas S., Piermont, N., Joyal, E., DeNicola, V., & Corry, K. (2005). Group cohesion and nurse satisfaction: examination of a team-building approach. *Journal of Nursing Administration*, 35(3), 110-120.

Donahue, M. P. (1996). *Nursing the finest art: An illustrated history* (2nd ed.).

St. Louis, MO: Mosby.

Ericksson, K. (1992). Different forms of caring communion. *Nursing Science Quarterly*, 5(2), 93.

Erickson, L., & Williams-Evans, S.A. (2000). Attitudes of emergency nurses regarding patient assaults. *Journal of Emergency Nursing*, 26(3), 210-15, 282-288.

Fowler, S.B. (1997). Neurotrauma family interventions. *Journal of Trauma Nursing*, 4(3), 68-75.

Gaynor, S.E., Verdin, J.A., & Bucko, J.P. (1995). Peer social support: a key to care giver morale and satisfaction. *Journal of Nursing Administration*, 25(11), 23-28.

Giorgi, A. (1970). *Psychology as a human science: A phenomenologically based approach*. New York: Harper & Row.

Grzankowski, J.A. (1997). Altered thought processes related to traumatic brain injury and their nursing implications. *Rehabilitation Nursing*, 22(1), 24-28, 29-31.

Guentz, S.J. (1987). Cognitive rehabilitation of the head-injured patient. *Critical Care Nursing Quarterly*, 10(3), 51-60.

- Haberman, M.R., Germino, B.B., Maliski, S., Stafford-Fox, V. & Rice, K. (1994). What makes oncology nursing special? Walking the road together. *Oncology Nursing Forum*, 21(8), 41-47.
- Hainsworth, D.S. (1998). Reflections on loss without death: The lived experience of acute care nurses caring for neurologically devastated patients. *Holistic Nursing Practice*, 13(1), 41-50.
- Hammond, F. (1995). Involving families in care within the intensive care environment: A descriptive survey. *Intensive and Critical Care Nursing*, 1, 256-264.
- Hamric, A.B., Spross, J.A., & Hanson, C.M. (2000). *Advanced nursing practice: An integrative approach* (2nd ed.). Philadelphia: W.S. Saunders.
- Harris, P.S., Duermeyer, M., Ehly, C., Toth-Hartig, S., Hayes, S., Holsapple, L., & Peters, D. (1999). The “impossible patient”: Organizational response to a clinical problem. *The Journal of Clinical Ethics*, 10(3), 242-246.
- Heidegger, M. (1962). *Being and time* (J. Macquarrie & E. Robinson, Trans.). New York: Harper and Row. (Original work published 1927).

- Helps, S. (1997). Experiences of stress in Accident and Emergency nurses. *Accident and Emergency Nursing*, 5(1), 48-53.
- Hickey, M., & Lewandowski, L. (1988). Critical care nurses' role with families: a descriptive study. *Heart & Lung: Journal of Critical Care*, 17(6), 670-676.
- Hislop, E., & Melby, V. (2003). The lived experience of violence in accident and emergency. *Accident and Emergency Nursing*, 11(1), 5-11.
- Hogan, B. (1990). Caring for the trauma victims: The emotional impact. *AACN Clinical Issues in Critical Care Nursing*, 1(3), 495-504,
- Holden, R.J. (1985). Aggression against nurses. *The Australian Nurses Journal*, 15(3), 44-48.
- Jackson, D., Clare, J., & Mannix, J. (2002). Who would want to be a nurse? Violence in the workplace – a factor in recruitment and retention. *Journal of Nursing Management*, 10(1), 13-20.
- Kearsey, K. (2004). Nursing's history of hazards. *Registered Nurse Journal*, 12-16.

- Keenan, K. (1995). The role of nursing assessment of traumatic events in sudden injury, illness, and death. *Critical Care Nursing Clinics of North America*, 7(3), 483-488.
- Kuhar, P., Miller, D., Spear, B., Ulreich, S., & Mion, L. (2004). The meaningful retention strategy inventory. *Journal of Nursing Administration*, 34(1), 10–18.
- Kutaka, G.S. (2002). The essential structure of the lived experience of the connection between nurse and patient. Unpublished doctoral thesis. University of Hawaii.
- Lam, L.T., Ross, F.I., Cass, D.T., Quine, S., & Lazarus, R. (1999). The impact of work related trauma on the psychological health of nursing staff: a cross sectional study. *Australian Journal of Advanced Nursing*, 16(3): 14-20.
- Laschinger, H.K.S. (2004). Hospital nurses' perceptions of respect and organizational justice. *Journal of Nursing Administration*, 34(7/8), 354-64.
- Lee, F. (2001). Violence in the accident and emergency: The role of training and self-efficacy. *Nursing Standard*, 15, 33-38.
- Lees, S. & Ellis, N. (1990). The design of a stress-management programme for nursing personnel. *Journal of Advanced Nursing*, 15(8), 946-961.

- Lemay, E., & Pitts, J.A. (1994). *Heidegger for beginners*. New York: Writers and Readers Publishing.
- Leonard, V. (1989). A Heideggerian phenomenological perspective on the concept of the person. *Advances in Nursing Science*, 11(4), 40-55.
- Levin, P.F., Hewitt, J.B., & Misner, S.T. (1998). Insights of nurses about assault in hospital-based emergency departments. *Image: Journal of Nursing Scholarship*, 30(3), 249-254.
- Linck, C., & Phillips, S. (2004). Managing disruptive behaviors in an acute medical/surgical service: a strategy for success. *Holistic Nursing Practice*, 18(5), 223-229.
- Lincoln, Y., & Guba. E. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage Publications.
- Mahoney, B.S. (1991). The extent, nature, and response to victimization of emergency nurses in Pennsylvania. *Journal of Emergency Nursing*, 17(5), 282-294.
- Maeve, M.K. (1997). Nursing practice with incarcerated women: caring within mandated (sic) alienation. *Issues in Mental Health Nursing*, 18(5), 495-510.

McQuillan, K.A., Von Rueden, K., Hartsock, R.L., Flynn, M.B., & Whalen, E. (2002).

Trauma nursing: From resuscitation through rehabilitation. (3rd ed.).

Philadelphia: W.B. Saunders Company.

Mills, A.C., & Blaesing, S.L. (2000). A lesson from the last nursing shortage: the influence of work values on career satisfaction with nursing. *Journal of Nursing Administration, 30*(6), 309-315.

Mobily, P.R., Mass, M.L., Buckwalter, K.C., & Kelley, L.S. (1992). Geriatric mental health: staff stress on an Alzheimer's unit. *Journal of Psychosocial Nursing and Mental Health Services, 30*(9), 25-31, 38-39.

Morse, J.M. (1991). *Qualitative nursing research: A contemporary dialogue.* Thousand Oaks, CA: Sage Publications.

Morse, J.M., & Field, P. A. (1995). *Qualitative research methods for health professionals* (2nd ed.). CA: Sage Publications.

Morse, J.M., & Procter, A. (1998). Maintaining patient endurance: The comfort work of trauma nurses. *Clinical Nursing Research, 7*(3), 250-274.

Munhall, P.L., & Oiler, C.J. (1986). *Nursing research: A qualitative perspective.* Norwalk, Connecticut: Appleton-Century-Crofts.

Munhall, P. (1994). *Revisioning phenomenology: Nursing and health science research*.

New York: National League for Nursing Press.

Neff, J.A., & Stinson-Kidd, P. (1993). *Trauma nursing: The art and science*.

St. Louis, MI: Mosby –Yearbook.

Newman, M., Sime, A.M., & Corcoran-Perry, S. (1991). The focus of the discipline of nursing. *Advances in Nursing Science*, 14(1), 1-6.

Nield-Anderson, L., Minarik, P.A., Dilworth, J.M., Jones, J., Nash, P.K., O'Donnell, K.L., & Steinmiller, E.A. (1999). Responding to 'difficult' patients: manipulation, sexual provocation, aggression -- how can you manage such behaviors? *American Journal of Nursing*, 99(12), 26-35.

Nolan, P., Dallendar, J., Soares, J., Thomsen, S., & Arnetz, B. (1999). Violence in mental health care: The experiences of mental health nurses and psychiatrists. *Journal of Advanced Nursing*, 30, 934-941.

O'Brien-Pallas, L., & Baumann, A. (1992). Quality of nursing worklife issues: A unifying framework. *Canadian Journal of Nursing Administration*, 5(2), 12-16.

- O'Connell, B., Young, J., Brooks, J., Hutchings, J., & Lofthouse, J. (2000). Nurses' perceptions of the nature and frequency of aggression in general ward settings and high dependency areas. *Journal of Clinical Nursing, 9*, 602-610.
- Ogus, E.D. (1990). Burnout and social support systems among ward nurses. *Issues in Mental Health Nursing, 11*(3), 267-281.
- Omery, A. (1983). Phenomenology: A method for nursing research. *Advances in Nursing Science, 5*(2), 9-63.
- Paavilainen, E., & Astedt-Kurki, P. (1997). The client-nurse relationship as experienced by public health nurses: Toward better collaboration. *Public Health Nursing, 14*(3), 137-142.
- Parse, R.R. (1981). *Man-living-health: A theory of nursing*. New York: Wiley.
- Patterson, J.G., & Zderad, L. (1976). *Humanistic nursing*. New York: Wiley.
- Payne, S.A., Dean, S.J., & Kalus, C. (1998). A comparative study of death anxiety in hospice and emergency nurses. *Journal of Advanced Nursing, 28*(4), 700-706.
- Perry, B. (2002). Growth and satisfaction. *Canadian Nurse, 98*(10), 19-22.

- Peterson, L.M. (1996). The lived experience of practicing emergency department nurses. Unpublished master's thesis, University of Alaska, Anchorage.
- Podrasky, D.L., & Sexton, D.L. (1988). Nurses' reactions to difficult patients. *Image: Journal of Nursing Scholarship*, 20(1), 16-21.
- Polit, D.F., & Hungler, B.P. (1999). *Nursing research: Principles and methods* (6th ed.). Philadelphia: J.B. Lippincott.
- Pollock-Latham, C. (1991). Clarification of the unique role of caring in nurse-patient relationships. In P. Chinn (Ed.), *Anthology on caring* (pp. 183-210). New York: National League for Nursing.
- Rafferty, A.M., Ball, J., & Aiken, L.H. (2001). Are teamwork and professional autonomy compatible, and do they result in improved hospital care? *Qualitative Healthcare*, 10(Suppl II), ii32–ii37.
- Raingruber, B., & Ritter, V. (2003). Intensity and challenge as an aspect of work satisfaction in an urban emergency room. *Nursing Leadership Forum*, 8(2), 58-63.
- Reverby, S. (1987). *Ordered to care*. Cambridge: Cambridge University Press.

- Sandelowski, M. (1986). The problem of rigor in qualitative research. *Advances in Nursing Science*, 8(3), 27-37.
- Schnieden, V., & Marren-Bell, U. (1995). Violence in the accident and emergency department. *Accident and Emergency Nursing*, 3(2), 74-78.
- Shah, A., & De, T. (1998). The effect of an educational intervention package about aggressive behaviour directed at the nursing staff on a continuing care psychogeriatric ward. *International Journal of Geriatric Psychiatry*, 13, 35-40.
- Simms, C. (1999). Don't become a casualty in the war of the words. *Nursing*, 29(12), 48-50.
- Simon, J. (1989). Humor techniques for oncology nurses. *Oncology Nursing Forum*, 16, 667-670.
- Smartrisk. (1998). *The Economic Burden of Unintentional Injury in Canada*. Toronto: Author.
- Society of Trauma Nurses. (2004). *Society of Trauma Nurses*. Retrieved April 26, 2005 from www.traumanursesoc.org.

- Soderstrom, I., Benzein, E., & Saveman, B. (2003). Nurses' experiences of interactions with family members in intensive care units. *Scandinavian Journal of Caring Sciences, 17*(2), 185-192.
- Sofield, L., & Salmond, S.W. (2003). Workplace violence: a focus on verbal abuse and intent to leave the organization. *Orthopaedic Nursing, 22*(4), 274-283.
- Solursh, D.S. (1990). The family of the trauma victim. *Nursing Clinics of North America, 25*(1), 155-162.
- Sorrell, J.M., & Redmond, G.M. (1995). Interviews in qualitative nursing research: Differing approaches for ethnographic and phenomenological studies. *Journal of Advanced Nursing, 21*, 1117-1122.
- Spokes, K., Bond, K., Lowe, T., Jones J., Illingworth, P., Brimblecombe, N., & Wellman, N. (2002). HOVIS -- the Hertfordshire/Oxfordshire Violent Incident Study. *Journal of Psychiatric and Mental Health Nursing, 9*(2), 199-209.
- Stolzenberger, K. (2003) Beyond the Magnet award. The ANCC Magnet Program as the framework for culture change. *Journal of Nursing Administration, 33*(1), 522–531.

- Streubert, H.J., & Rinaldi-Carpenter, D. (1995). *Qualitative research in nursing: Advancing the humanistic imperative* (2nd ed.). Philadelphia: Lippincott Williams and Wilkins.
- Sunnybrook and Women's College Health Sciences Centre. (2005). *Trauma*, Retrieved April 27, 2005 from www.sw.ca/programs/trauma.
- Tedin, P.D. (1996). The lived experience of the operating room nurse. Unpublished master's thesis, University of Alabama, Huntsville, Alabama.
- van Manen, M. (1984). Practicing Phenomenological Writing. *Phenomenology and Pedagogy*, 2(1), 36-69.
- van Manen, M. (1990). *Researching Lived Experience*. New York: State University of New York Press.
- Van Manen, M. (1997). Researching lived experience: Human science for an action sensitive pedagogy. London, Ontario: Althouse Press.
- Vachon, M.L.S. (1998). Caring for the caregiver in oncology and palliative care. *Seminars in Oncology Nursing*, 14(2), 152-157.

- Von Rueden, K.T. (1991). The physical, personal, and cognitive demands of trauma nursing. *Critical Care Nurse, 11*(6), 9.
- Weiskopf, C.S. (2000). The lived experience of nurses' caring for inmate-patients. Unpublished doctoral thesis. The University of Connecticut.
- West, E., Barron, D.N., & Reeves, R. (2005). Overcoming the barriers to patient-centred care: Time, tools and training. [Journal Article, Research, Tables/Charts] *Journal of Clinical Nursing, 14*(4), 435-43.
- Whittington, R., & Wykes, T. (1989). Invisible injury... assaults on staff. *Nursing Times, 85*(42), 30-32.
- Williams, C.M.A. (2005). The identification of family members' contribution to patients' care in the intensive care unit: a naturalistic inquiry. *Nursing in Critical Care, 10*(1), 6-14.
- Williams, S.C. (1996). Expert and non-expert nurses' perspectives of life experiences related to becoming and being a nurse. Unpublished doctoral thesis, University of South Carolina.

Appendix C
Demographic Data

Age:

Gender:

Years of experience as a nurse:

Years of experience as a trauma nurse:

Years of experience in current trauma unit:

Education:

Interview Guide

Thank you for agreeing to participate in this study. I am interested in your experience as a trauma nurse. I would like you to take some time to reflect upon your experience and tell me what it is like in your own words to be a trauma nurse. Feel free to share experiences, talk about whatever comes to your mind.

- 1) Tell me what it is like to be nurse working in a trauma unit.
- 2) Do you see yourself as a trauma nurse?
- 3) Tell me why you are a trauma nurse? (What “drew” you to trauma nursing?)
- 4) Tell me about what kinds of things help you as a trauma nurse.
- 5) Tell me about what kinds of things are not helpful to you as a trauma nurse.
- 6) Describe a memorable or rewarding experience that you have encountered as a trauma nurse.
- 7) Describe a difficult experience that you have encountered in your practice as a trauma nurse.
- 8) Is there anything else you would like to mention about your experience as a trauma nurse?

- Von Rueden, K.T. (1991). The physical, personal, and cognitive demands of trauma nursing. *Critical Care Nurse, 11*(6), 9.
- Weiskopf, C.S. (2000). The lived experience of nurses' caring for inmate-patients. Unpublished doctoral thesis. The University of Connecticut.
- West, E., Barron, D.N., & Reeves, R. (2005). Overcoming the barriers to patient-centred care: Time, tools and training. [Journal Article, Research, Tables/Charts] *Journal of Clinical Nursing, 14*(4), 435-43.
- Whittington, R., & Wykes, T. (1989). Invisible injury... assaults on staff. *Nursing Times, 85*(42), 30-32.
- Williams, C.M.A. (2005). The identification of family members' contribution to patients' care in the intensive care unit: a naturalistic inquiry. *Nursing in Critical Care, 10*(1), 6-14.
- Williams, S.C. (1996). Expert and non-expert nurses' perspectives of life experiences related to becoming and being a nurse. Unpublished doctoral thesis, University of South Carolina.

Appendix C
Demographic Data

Age:

Gender:

Years of experience as a nurse:

Years of experience as a trauma nurse:

Years of experience in current trauma unit:

Education:

Interview Guide

Thank you for agreeing to participate in this study. I am interested in your experience as a trauma nurse. I would like you to take some time to reflect upon your experience and tell me what it is like in your own words to be a trauma nurse. Feel free to share experiences, talk about whatever comes to your mind.

- 1) Tell me what it is like to be nurse working in a trauma unit.
- 2) Do you see yourself as a trauma nurse?
- 3) Tell me why you are a trauma nurse? (What “drew” you to trauma nursing?)
- 4) Tell me about what kinds of things help you as a trauma nurse.
- 5) Tell me about what kinds of things are not helpful to you as a trauma nurse.
- 6) Describe a memorable or rewarding experience that you have encountered as a trauma nurse.
- 7) Describe a difficult experience that you have encountered in your practice as a trauma nurse.
- 8) Is there anything else you would like to mention about your experience as a trauma nurse?