REGISTERED NURSES' EXPERIENCES WORKING IN THE EMERGENCY FAST TRACK AREA

KENNEDY BROWN
Bachelor of Nursing, **University of Lethbridge**

A thesis submitted
in partial fulfilment of the requirements for the degree of

MASTER OF NURSING

Faculty of Health Sciences
University of Lethbridge
LETHBRIDGE, ALBERTA, CANADA

REGISTERED NURSES' EXPERIENCES WORKING IN THE EMERGENCY FAST TRACK AREA

KENNEDY BROWN

Date of Defence: December 15, 2022

Dr. M. Zieber Thesis Supervisor	Assistant Professor	Ph.D.
Dr. M. Sedgwick Thesis Examination Committee Member	Associate Professor	Ph.D.
Dr. T. Oosterbroek Thesis Examination Committee Member	Assistant Dean and Assistant Professor	Ph.D.
Dr. J. Brassolotto Chair, Thesis Examination Committee	Associate Professor	Ph.D.

DEDICATION

Thank you to my family, friends, colleagues, and teachers, without whom my thesis wouldn't have been possible. A special thank you to my son Owen, husband Dave and my parents who were there to support me through the challenges. Thank you to Dr. Mark Zieber for his quick responses, and support, particularly during the weekends and his time off.

ABSTRACT

Emergency fast track area nurses have a unique job where they must balance quality care with efficiency in a fast paced, high patient volume environment. This study was conducted to gain a better understanding of registered nurses' experiences working in the emergency fast track area with a focus on quality of care. Methods: A qualitative descriptive study of eight registered nurses working in an urban hospital was completed. Data were analyzed using Braun and Clarke's (2006) thematic analysis. Results: Moral distress was described by participants when they felt unable to provide quality care. Sub themes of moral distress include: stretched to a breaking point, the balancing act, and resiliency. Participants felt stretched to a breaking point by their numerous roles and responsibilities within the fast track area. Participants strived to balance quality care and efficiency. Participants described resiliency through collaboration with other team members, supportive administration, and resetting.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER 1: INTRODUCTION

Introduction

The emergency department is a fast paced, and highly stressful work environment for registered nurses (Chen et al., 2018). Emergency nurses describe occupational stressors such as heavy workloads perpetuated by nursing shortages and overcrowding (Chen et al., 2018; Yuwanich et al., 2015). Overcrowding in emergency departments that results in adverse patient events is rising (Di Somma et al., 2015; Yarmohammadian et al., 2017). Overcrowding is defined in the joint position statement from the Canadian Association of Emergency Physicians and National Emergency Nurses Association (2013) as “a situation in which the demand for emergency services exceeds the ability of a department to provide quality care within acceptable time frames” (p.2). In current research on fast track areas quality care is often measured using length of stay or time to provider. Quality care is defined by patients as receiving time care from compassionate healthcare providers (Al-Zaru et al., 2013). Overcrowding can result in nurses experiencing feelings of inadequacy in the care they provide to patients (Chen et al., 2018).

Fast track areas are suggested as one sustainable solution to overcrowding (Yarmohammadian et al., 2017). Fast track areas were created as a space in the emergency department where lower acuity patients are treated separately from higher acuity patients; they were initially integrated into emergency departments in North America in the 1980s (Blondell et al., 2006). In the emergency department, output described as moving patients out of the emergency department is increased by separating low acuity patients that require a lower level of care from higher acuity patients (Troxell, 2014). Staffing resources are maximized through a higher patient to nurse ratio, which corresponds to the decreased monitoring requirements and workload of lower acuity patients (Elamir, 2018; Lee et al., 2015).

Current research uses length of stay to measure efficiency in the fast track area (Ray & Reinoso, 2019). Nurses working in the emergency department appreciate the decreased length of stay for acuity patients, but they find their workload is ultimately increased by a greater number of lower acuity patients seeking care (Chen et al., 2018). While there is currently some research on nurses' general experiences in the emergency department, there is very little investigation of registered nurses' experiences working in the fast track area. Nurses are an integral part of the care team in the emergency department, and it is important to understand their experience working in the emergency department and stressors they face (Chen et al., 2018). Moral distress can occur during times of overcrowding when nurses feel unable to provide quality care (Lin et al., 2019; Wolf et al., 2016). Thus, it is important to understand their experiences with workload and quality care in the fast track area. The current study is a qualitative descriptive study on registered nurses' experiences of working in the emergency department fast track area.

Problem Statement

Current evidence supports fast track areas as an efficient solution to overcrowding when they are utilized, as intended, for lower acuity patients (Kim et al., 2015). However, because emergency departments are dynamic environments, frequently higher acuity patients are admitted to the fast track area (Kim et al., 2015). Higher acuity patients admitted to the fast track area can result in negative experiences for nurses; this is due to the backlog of patients and increased workload (Chen et al., 2018; Yarmohammadian et al., 2017). The aforementioned issue can be perpetuated by nursing staff shortages where nurses have to cover multiple areas in the emergency department (De Freitas, 2020).

To date researchers have concluded that the fast track area process is safe, efficient, and leads to a decreased length of stay (Gasperini et al., 2020). However, when emergency departments become overcrowded and there is a lack of staff resources, the quality of care is negatively impacted through missed basic patient care needs (Eriksson et al., 2018). Registered nurses describe high workloads, unit organization, and quality of patient care as occupational stressors (Basu et al., 2020; Chen et al., 2018; Santana et al., 2015). A component of the problem with fast track area overuse is the inevitable decrease in quality of care that registered nurses are able to provide patients in the emergency department (Chen et al., 2018). It is important to understand the effects high workloads and quality of patient care in the fast track area on registered nurses because when nurses feel unable to provide safe, quality care moral distress can occur (Wolf et al., 2016).

While current research shows that quality of care, in terms of length of stay, has improved with the implementation of fast track areas, it would be worth understanding from the perspective of nurses if other aspects of patient care have been impacted (Chen et al., 2018). Understanding how high workloads affect the experiences of nurses working in the emergency fast track area is important because the inability to meet the standards suggested by the Canadian triage and acuity scale (CTAS) (Canadian Association of Emergency Physicians & National Emergency Nurses Association, 2013) can result in a decreased level of work satisfaction, and overall quality of care.

Qualitative descriptive research is often used for quality improvement; this research is aimed at a specific problem, or to describe an experience as opposed to trying to increase conceptual knowledge of a topic (Chafe, 2017). Using a qualitative descriptive approach allowed me to develop a better understanding of participants' experiences working in the fast track area. An understanding was gained of how registered nurses adapt patient care to meet the demands within the fast track area.

Background

Registered nurses working in a small urban hospital were recruited for interviews on their experiences of working in the emergency fast track area. The fast track area from where participants were recruited was a separate area for lower acuity patients with individual patient rooms, and a dedicated waiting area with chairs (Alberta Health Services (AHS), n.d.). In the emergency department measures to improve patient flow were implemented, such as the addition of a float nurse who moved from the acute care side to the fast track area as needed, standardization of patient care through protocols, and patients being moved to a chair in the fast track waiting area, where appropriate once their assessments were completed (Alberta Health Services, n.d.). Considering this hospital and the patient's length of stay, which is used in the research to measure efficiency, the discharge time remained consistent at 2.4 hours over two years after the implementation of the fast track area (Alberta Health Services, 2017).

During the literature review, which is described later in detail, there was limited data on how the experiences of registered nurses working in the fast track area were affected by the changes. However, Chen et al. (2018) found emergency nurses felt powerless in meeting the needs of patients where demand outweighed staff and physical resources. In the emergency department, nurses felt lower acuity patients coming to the emergency department increased their workload (Chen et al., 2018). Emergency nurses also felt treating lower acuity patients took away from their specialized skills and gave the public a perception that the emergency department was for all patient needs, not just emergent ones (Chen et al., 2018). Understanding the nurses' experiences may assist management to support nurses work during periods of overcrowding or when higher acuity patients end up in the fast track area. The findings of this study may help to understand what parts of the fast track area design work well from registered nurses' experience and where there may be some room for improvement.

Purpose of the Study

The purpose of the study was to gain a better understanding of registered nurses' experiences working in the emergency fast track area with a focus on quality of care and design.

Research Questions

The following questions guided the study:

1. What are the experiences of registered nurses working in the emergency fast track area?
2. How do fast track area nurses describe quality care?
3. How fast track area nurses describe their workload in the fast track area?
4. What factors affect the experience of registered nurses working in the fast track area?

Significance of the Study

Existing research on fast track areas focuses on how to improve efficiency by increasing the throughput of patients and decreasing length of stay. A few aspects of the emergency department were found to have influence nurses' experiences. For instance, Laker et al. (2014) found partitioning spaces in the emergency department into a fast track area and an area for higher acuity patients could lead to an imbalance between demand and capacity. Nurses experienced powerlessness when demand outweighed staffing resources, resulting in the inability to meet the demands of patients (Chen et al., 2018). Meeting patients' demands in a timely matter is part of providing quality care to patients (Al-Zaru et al., 2013). Currently there is a lack of research surrounding how nurses meet the demands of patients when higher acuity patients end up in the fast track area.

Fast track areas were developed for lower acuity patients (Ferrand et al., 2018); however, the frequent reality of overcrowding negates some of the benefits (Chen et al., 2018). The aim of this study is to help create a starting place for leadership within hospitals to understand nurses' experiences working in the fast track area with the intent that these findings will be used when creating new policies and making changes. Findings from the current study will be disseminated to inform organizational decision makers on problems experienced by participants, current coping strategies, and what they speculated could be solutions.

Ontological Stance

Qualitative research is used to highlight the voice of participants in research, and to help researchers and readers understand their experiences with a phenomenon (Denny & Weckesser, 2019). My ontological approach can be identified as relativist. A relativist's ontological stance is that there are several social conceptualizations of reality (Creswell, 2014; Guba, 1992). Often different peoples' experiences of a given event or process can result in a variety of perspectives on what or how an event occurred (Creswell, 2014). Understanding different perspectives and how they are formed is a key to interpreting experience versus reality. A relativist believes our truths or perspectives of the world are influenced by our background and the context in which they occur (Creswell, 2014).

When conducting research, it is crucial to understand what shapes our perspectives and actions, as well as the perspectives and actions of the participants (Bracken, 2010). From a relativist perspective one individual may see a given situation as a crisis, while another sees the situation as an opportunity. Braun and Clarke (2021) recognize the effects of the researcher's worldview on the results of the study. Because of the broad range of interpretations of quality care, my own definition of quality care likely influenced interpretation of the findings. As such I will include my own interpretation of the definition of quality care, and how my definition may have influenced the results of the current study. I view quality care as the highest achievable standard of care possible. Quality care extends beyond providing a safe minimal standard of level of care, to taking the time to provide extras such as: warm blankets, a listening ear, and addressing additional patients' concerns, not just the basics. As a relativist and having reviewed the literature I understand that the definition of quality care can have a different meaning for others. As such, my interpretation of quality care may have caused me to identify situations as poor quality care, where others may have thought the care provided was of high quality. I tried to reduce my biases by using the words? of participants to support findings throughout the research process and having a balance of different participants' perspectives.

In the current study I explored participants' different experiences of working in the fast track area. Qualitative descriptive methodology was used with influence from my relativist worldview to understand nurses' experiences of working in the fast track area. Qualitative descriptive methodology was used to understand what participants shared in their experiences, but also note variations in experience (Straughair, 2019).

Summary

In this chapter the topic of fast track areas is introduced. Fast track areas were originally created with the goal of addressing overcrowding in emergency departments (Di Somma et al., 2015). Throughout the literature review current research on emergency fast track areas will be described including gaps in current research. One of the primary gaps of focus will is the lack of studies on the registered nurses' experience working in the fast track area and the importance of their experience. The remainder of the thesis will focus on the importance of understanding fast track area nurses' experiences utilizing a qualitative descriptive methodology.

CHAPTER 2: LITERATURE REVIEW

Current State of Knowledge

Emergency department fast track areas were initially developed and designed to address overcrowding in the emergency department, by triaging patients experiencing lower acuity conditions separately from patients with conditions requiring immediate attention, thereby increasing efficiency (Ferrand et al., 2018). In the literature review the history of fast track areas, current evidence on the fast track area, and how this organizational approach to patient care influences the experience of registered nurses working in the fast track area is described. Problems hindering the ideal of the fast track area will also be explored. The literature is used to support the thesis that more evidence is needed to understand registered nurses' experiences working in the fast track area.

Search Methods

A literature search was completed using the terms "nurses" OR "nursing" OR "nurse" OR "nurses'" OR "nurse's" AND "fast track" OR "streaming" AND "emergency department" OR "emergency room". Using CINAHL search engine, 37 articles were found. Duplicate studies, those not referring to registered nurses (i.e. nurse practitioners) in fast track areas and or the emergency department (i.e. surgical fast track area), and that did not reflect registered nurses' experiences or perceptions, were not included in the aforementioned review. As a result, two articles from CINAHL were included. Proquest returned 39 articles, although most did not relate directly to emergency fast track areas. Of the 39 articles one related to flow in the emergency department and was included as De Freitas' et al. (2020) asked for nurses' opinions on flow.

Since there were very few articles on nurses' experiences in the fast track area, a secondary search was completed on nurses' experience with overcrowding in the emergency department on CINAHL. The terms “nurse” OR “nurses'” OR “nurse's” AND “experience” OR “perspective” OR “view” OR “perception” OR “attitude” AND “overcrowding in emergency department” were used. The search included peer reviewed articles from the last five years and yielded 15 articles. Given the rapidly evolving format of fast track areas, five years was utilized to ensure a relevant reflection of current fast track areas. Studies that did not include the experience or perspective of nurses, or that did not pertain to the emergency department were not included. Of the 15 studies, three were included.

A literature review was completed on the current state of research on fast track areas regarding both their organization and outcomes as there were very few articles found in relation to registered nurses’ experiences working in the emergency department fast track area. The terms “fast track” OR “streaming” AND “emergency department” OR “emergency room” were used in the search. The above terms are the only terms used in current literature to describe a fast track area or a similar area within the emergency department, as such all terms were searched to ensure no studies were missed. The literature review included studies from the last five years that were peer reviewed. As evidence is consistently changing and fast track areas are molding, I only collected data from the last five years to ensure that the articles are relevant and up to date with the latest trends. CINAHL returned 53 articles and Proquest returned 26 articles using the terms quoted above. The abstract of each study was carefully read to ensure no other studies of significance were missed. Of those only 15 were included in this literature review. Duplicate studies, and those not referring to fast track areas in the emergency department (i.e., surgical fast track area) were not included in the review.

In total, 19 articles were reviewed to identify commonalities and differences within the findings and to identify gaps in knowledge. Articles were also assessed for their theoretical framework, results, methodological approaches, site, number of participants, knowledge translation, and gaps (see Appendix A). Knowledge translation strategies were assessed to determine how research findings were integrated into practice on fast track areas, what successes they have had and what the limitations were in current literature. The outcomes of the literature review were organized into themes. Themes that emerged from the literature review were overcrowding, lean theory, differences in fast track area design, efficiency, increase in number of patients, and patient satisfaction. Relevant grey literature such as relevant policies and organizational statements were included.

Themes in the Literature

History of Fast Track Areas

Overcrowding.

Historically, fast track areas in the emergency department were meant to help address the problem of overcrowding by increasing throughput (Yarmohammadian et al., 2017). Increasing throughput means increasing the speed at which patients move through the emergency department (Yarmohammadian et al., 2017). Registered nurses working in the emergency department describe overcrowding as a “traffic jam” because old patients are not moving through the department, and new patients keep showing up (Chen et al., 2018). Troxell (2014) found that a number of the patients waiting to be seen in the emergency department were low acuity patients, which is believed to be a factor adding to overcrowding.

One of the leading issues within the emergency department is adverse events that occur as a result of overcrowding (Hurwitz et al., 2014). Overcrowding affects registered nurses’ experiences by creating feelings of powerlessness related to having no control over the situation and feeling as though the demands of patients exceed the supply of nurses and other resources

(Chen et al., 2018). Strada et al. (2019) compared healthcare providers perceptions of overcrowding to the National Emergency Department Overcrowding Scale (NEDOC) scores; they found that using the NEDOC scale would offer a more accurate measurement of overcrowding (Strada et al., 2019). Findings from Strada et al. (2019) suggest the experience of healthcare providers varies from measurements of overcrowding.

Fast track areas have shown promise with addressing overcrowding, inefficiencies, and maximizing resources (Ferrand et al., 2018). Fast track areas were developed as an area where lower acuity patient needs could be met in a timely fashion without affecting the care of higher acuity patients (Hwang et al., 2014). The idea of the fast track area relies on the assumption that patients in the fast track area are lower acuity; therefore, they would require less monitoring, less staff, and would be seen faster and result in an increase in throughput (Elamir, 2018). Current study findings explore the realities of fast track areas through the experiences of registered nurses.

Registered nurses shared concerns that fast track areas can lead to the sociocultural belief that emergency departments can be used for lower acuity care, leading to an increase in the overcrowding problem (Chen et al., 2018). Registered nurses perceive emergency departments as a place where specialized care is administered to higher acuity patients (Chen et al., 2018). Instead of non-urgent cases being treated in an emergency fast track area, nurses felt patients should be redirected to a more appropriate treatment site, such as a family doctor (Chen et al., 2018). Anxiety and job dissatisfaction occur when emergency nurses feel overwhelmed and unable to provide quality care. The effects of overcrowding on the experiences of nurses working in the fast track area have not yet been explored. Given the unique fast pace and volume of patients, it is important to understand the effects of overcrowding on the experiences of nurses working specifically in the fast track area.

Efficiency.

Efficiency is the main focus of research on fast track areas. Efficiency is a quality indicator measured through length of stay, time to provider, and number of patients who left on their own accord without being seen; fast track area implementations improved efficiency (Chrusciel et al., 2019; Copeland & Gray, 2015; Hajjarsaraei et al., 2018; Kaushal et al., 2015; Lee et al., 2015; Pierce & Gormley, 2016; Sayah et al., 2016; Yarmohammadian et al., 2017). Throughout current research there is a focus on understanding how fast track areas can be organized to maximize throughput and decrease time to physician (Copeland & Gray, 2015; Gardner et al., 2018; Gill et al., 2018; Hajjarsaraei et al., 2018 Khalifa, 2016; Kim et al., 2017; Patey et al., 2019; Smith et al., 2018 Steward et al., 2017; Yarmohammadian et al., 2017). Smith et al. (2018) found that using care teams, which consist of a registered nurse and advanced care provider within the fast track area, results in a decreased length of stay from 216 minutes to 162 minutes. Morrish (2013) found an important aspect for success of fast track areas is assessing the acuity level of patients with longer wait times. Understanding the effects of the fast track area on wait times for different levels of acuity helps to ensure lower acuity patients are not being seen quicker at the expense of higher acuity patients. One theme in the research is while fast track areas are operationalized differently, they have repeatedly been found to increase throughput defined by decreased time to provider and length of stay. Current literature supports the efficiency of fast track areas, yet little research has occurred to see how this level of efficiency is achieved in practice. It is important to understand how the aforementioned level of efficiency is achieved in practice and the effects on other quality indicators such as safety. The current study aims to explore what efficiency means to registered nurses working in the fast track area and if they feel they are able to provide both efficient and quality care.

Fast Track Area Design

Fast track areas are created based on the needs and resources at the site of implementation. Care being provided can be hindered or helped by the design of the area (Hajjarsaraei et al., 2018). Although fast track areas are unique in how they are designed, the primary focus of the fast track areas is the same – to increase efficiency through optimal physical space given the resources available (Kim et al., 2017). To understand the impacts of different designs some researchers have used simulation modelling, using different models on computers to simulate different scenarios (Hajjarsaraei et al., 2018; Kim et al., 2017; Steward et al. 2017). The goal of the simulation research is to understand which design can result in both a decreased wait time and length of stay.

Kim et al. (2017) adjusted the order in which patients were seen based on a wait time threshold, where once a patient with a lower acuity level has waited a given time, they were granted a higher level of priority. Using a wait time threshold, decreases wait time and length of stay for lower acuity patients without affecting the wait time of higher acuity patients (Kim et al., 2017). Steward et al. (2017) used simulation models combined with staff feedback to design their fast track area prior to implementation. The simulations focused on efficiency variables such as wait time and length of stay (Hajjarsaraei et al., 2018; Kim et al., 2017; Steward et al. 2017). Researchers claimed simulation modelling could be used to share the site's operational goals with staff and inform them of how they plan to implement the fast track area (Steward et al., 2017). Stein (2002) reports that efficiency should be regarded as a means to meet the demands, not an end goal. What is meant by Stein (2002) is that efficiency cannot become your only goal, other aspects of quality are important too such as safety. The current study aims to understand how registered nurses working in the fast track area perceive quality of care and if they feel able to meet a standard of care despite the level of efficiency in the fast track area.

Flexibility is another component of staff and physical design studied in literature. Operational flexibility is a complex concept that can be summarized as the staff's ability to adapt and meet fluctuating demands (Ward et al., 2014). Laker et al. (2014) studied the idea of using flexible beds, which are beds used for any level of patient acuity, depending on the needs of the emergency department. Laker et al., (2014) argues that strict allocation of resources between the fast track area and higher acuity side can result in longer wait times given the dynamic qualities of the emergency department. The current study aims to understand the unique insights of registered nurses into the benefits and challenges of working with a flexible staffing model in the fast track area.

Secondary to unpredictability, Ward et al. (2014) found that flexibility in humans, physical space, and volume was important in the emergency department. In theory, the fast track area creates a partitioning of the resources between low and high-acuity patients, but simulation-based research shows that when flexibility and adaptability are integrated into fast track areas the result is higher-performing emergency departments (Ferrand et al., 2018; Hajjarsaraei et al., 2018). In a qualitative study done on flow in the emergency department nurses and doctors shared roles to improve patient flow (De Freitas et al., 2020). De Freitas et al. (2020) observes that when there is a nursing staff shortage, nurses are moved from a dedicated area in the emergency department to help out where needed, which helps to facilitate flow. Further research should be done to understand how staffing assignments, effect the quality of care registered nurses are able to provide to patients. Hearing the experience of registered nurses working in the fast track area could help us to understand where they are able to find flexibility and what they feel is the correct staff mix for the fast track area.

Lastly, Morrish (2013) found it is important to staff fast track areas with the right staff. Morrish (2013) found ideally staff working in the fast track area are experienced, able to multitask, and must be able to keep track of a larger number of patients. Nurse Practitioners are perceived as a cheaper alternative to emergency physicians in the fast track area (Doetzel et al., 2016). Doetzel et al. (2016), Gardner et al. (2018), and Smith et al. (2018) found the incorporation of Nurse Practitioners in the fast track area works well, as they cost less than emergency physicians, length of stay is decreased, time to provider is decreased, and overall patients are satisfied with care. From the aforementioned research it can be deduced Nurse Practitioners offer a cost-effective alternative to physicians in the emergency fast track area.

Increase in the Number of Patients

Chrusiel et al. (2019) and Sayah et al. (2016) found there is an increase in the number of patients coming to the emergency department after the implementation of the fast track area. The increase in patients attending the emergency department could be an expected one, as the Canadian Association of Emergency Physicians (2013) speaks to overcrowding issues increasing in frequency. Patients who use the emergency department often, and those under 25 years of age, account for a large portion of non-urgent visits to the emergency department and come for ease of access and faster results (Burns, 2017; Unwin, 2016). Who is using the emergency department, and the increase in number of patients coming to emergency, will influence registered nurses' experiences because their perspective of their role is based in part on how society perceives their role (Chen et al., 2018). Given that a number of lower acuity patients seek care in the emergency department, registered nurses have begun to feel undervalued for their specialized skills (Chen et al., 2018). Feeling undervalued has a negative impact of job satisfaction (Chen et al., 2018). Further research needs to be done to understand if job dissatisfaction results from feeling unable to meet patients' needs or the lower acuity of the patients attending the emergency department.

Higher Acuity Patients in the Fast Track Area

Fast track areas are designed for non-urgent patients, defined as CTAS levels 4 and 5 (Ferrand et al., 2018; Smith et al., 2018). CTAS level 4 and 5 patients are generally stable patients who do not need to be seen within the first hour of their arrival. However, when emergency departments are overcrowded, higher acuity patients can become streamed into the fast track area (Kim et al., 2015). There is a lack of research on higher acuity patients ending up in the fast track area. The current study examines how registered nurses manage higher acuity patients in the fast track area. Only one study was retrieved where researchers examined the effects of higher acuity patients when they were streamed to the fast track area (Kim et al, 2015). Kim et al. (2015) found there are no effects on readmission rate and length of stay in the hospital when patients are improperly placed. No research was found examining nurses' experiences work with higher acuity patients. It is important to understand the effects of higher acuity patients ending up in the fast track area on registered nurses' experiences because they require more time and a higher level of care than the lower acuity patients fast track areas were developed for.

Staff felt higher acuity patients remain in their rooms for an extended period of time, making it difficult to assess other patients, as such it was important to recognize these patients and relocate them to an appropriate care area quickly (Morrish, 2013). The current study will be used to examine if registered nurses feel adequately equipped to care for higher acuity patients in the fast track area. Understanding nurses' experiences with higher acuity patients is important, because distress and job dissatisfaction result when nurses are overwhelmed and feel unable to provide safe, quality care (Chen et al., 2018).

Patient Safety.

Patient safety is a key aspect of quality care. Physicians and Registered Nurses have identified primary risks to patient safety in the emergency department: high workload, lack of control, and organizational failures (Källberg et al., 2017). High workload such as increased patient-to-nurse ratios and organizational failures, such as insufficient staffing for the level of acuity and patient load, (Källberg et al., 2017) can occur when higher acuity patients are admitted to the fast track area. In their joint position statement, the Canadian Association of Emergency Physicians and National Emergency Nurses Association (2013) declare that at minimum "emergency departments must be capable of providing access to appropriate assessment and treatment within time frames specified by the CTAS" (p.1). During times of overcrowding when their workload was high nurses felt powerless, except to accept current working conditions (Chen et al., 2018). Nursing staff felt they were unable to provide safe quality care, which resulted in feelings of anxiety (Chen et al., 2018). More research needs to be done to understand how and if nurses in other fast track areas feel they are able to provide safe quality care, given the higher patient-to-nurse ratio (Robinson et al., 2005). The current study explores what nurses have learned form their experience and how they adapt their care to manage the workload.

Patient Satisfaction.

Three of the articles in the current literature review focused on patient satisfaction with care provided in fast track areas (Hwang et al., 2015; Jackson, 2016). Hwang et al. (2015) found patient satisfaction improves with the implementation of a fast track area in the emergency department. Hwang et al. (2015) evaluated patient satisfaction before and after fast track area implementation. Hwang et al. (2015) state there was a clear correlation between the implementation of a fast track area and increased patient satisfaction scores. Jackson (2016) chose to assess if there were any differences in satisfaction between lower acuity patients from generation X born between 1965-1981 and generation Y born between born between 1982-2003. No differences were found between the expectations of the two generations for wait time, but younger patients were less satisfied with a higher wait time (Jackson, 2016). While patients are satisfied with care, some nurses felt that they were not able to meet the demands of their patients as demand outweighed supply (Chen et al., 2018). Interviewing registered nurses could help us to understand how they experienced patient care demands. Part of their experience is understanding facilitators and barriers to meeting patients' needs. The current study examines the capacity of nurses working in the fast track area to understand how they manage to treat higher acuity patients in a face paced environment created for lower acuity patients.

Emergency Nurses in the Fast Track Area

During the literature review, limited research was found exploring registered nurses' experiences or perceptions of the fast track area. Chen et al. (2018) have found that job dissatisfaction can occur when nurses feel unable to provide quality care to patients. Similarly Wolf et al. (2016) found moral distress occurs in emergency nurses when they feel unable to provide quality care to patients. The concept of quality care in conjunction with the experience of registered nurses will be explored further in the current study will add to the literature more information about the experiences of registered nurses working in the fast track area. Staff found fast track areas work best when nursing staff were able to control the flow of patients and who would be seen first, as opposed to a first come first serve basis (Morrish, 2013).

Registered nurses who work in fast track areas report they engage in a variety of duties including assessment and diagnosis (with 22% of their time being spent on this activity), medication administration, investigations and procedures, patient communication and comfort, and organization of care (Wise et al., 2020). Registered nurses practice a wider scope of skills wherein they order laboratory investigations and certain medications. Ordering laboratory investigations and medications without a doctor's order is not always within the scope of practice for registered nurses. To meet the workload demands physicians, nurse practitioners, and registered nurses share different tasks and help each other when one had a higher workload (Wise et al., 2020). Researchers concluded when registered nurses, physicians, and nurse practitioners share roles there is better responsiveness to patient care needs (Wise et al., 2020). In a qualitative observational study completed at an emergency department where there were nursing staff shortages, staff felt that expanding the nursing role would not facilitate flow as they did not have enough time to complete the basic nursing role as is (De Freitas, 2020).

Increased scope of practice means more responsibility and tasks for nurses working in the emergency department fast track area, and so when some of the other team members were not willing to share responsibilities, they found that shared roles did not work well (Wise et al., 2020). Part of understanding registered nurses' experience of working in the emergency department is understanding how their role differs from that of registered nurses in other areas. How roles are shared between different disciplines influences the workload of registered nurses (Wise et al., 2020). For example, ordering diagnostic would increase the workload for the nurse in addition to their current duties (Wise et al., 2020).

Scope of practice influences how nurses perceive their role within the team and how they identify themselves (Chen et al., 2018; Wise et al., 2020). Part of understanding the experience of registered nurses is gaining an understanding of how they perceive their role in the emergency department and if they are able to meet the perceived expectations of that role (Chen et al., 2018). The current study examined registered nurses' experiences working in the fast track area and what they perceive as their role.

Gaps in Current Fast Track Area Research

Lack of Qualitative Research

Within the context of this literature review many authors used a quantitative approach, which tends to focus on more of a cause-and-effect relationship (see Appendix A) (Clark, 1998; Creswell & Poth, 2018). Using a quantitative approach, researchers tended to focus on length of stay, number of patients that left without being seen, and wait time (Copeland & Gray, 2015; Gardner et al., 2018; Gill et al., 2018; Hajjarsaraei et al., 2018; Khalifa, 2016; Kim et al., 2015; Patey et al., 2019; Smith et al., 2018).

While quantitative data can be used by researchers to examine important information about cause-and-effect relationships, qualitative data, when conducted properly, allows researchers to gain a rich understanding of participants' experiences with a given phenomenon (Collingridge & Gantt, 2019). From my perspective, the quantitative research completed to date does not allow us to examine other factors at play in the emergency fast track area and how nurses are affected by these changes. For example, Strada et al. (2019) found current measures of overcrowding do not align with the perceptions of staff working in the emergency department. Ratnapalan and Lang (2020) describe how parts of the healthcare system such as fast track areas were once viewed like machines where one aspect of the system could be manipulated, and a predictable outcome would occur. However, factors like resource availability, the complexity and the unpredictability of the emergency department are not accounted for (Ratnapalan & Lang, 2020). More qualitative studies would help increase our understanding of the complexities and changes that have occurred within fast track areas over the last 40 years. The current study examined factors experienced by nurses outside of length of stay such as feeling stretched to a breaking point, and the immense pressure to maintain flow. Understanding registered nurses' experiences offers important insights into what is sacrificed to achieve shorter length of stay in the fast track area.

Summary

Historically, fast track areas are developed to improve throughput and help address overcrowding in the emergency department (Yarmohammadian et al., 2017). Nurses are concerned that while throughput has increased, so have the number of patients seeking non-urgent care in emergency departments (Chen et al., 2018). Fast track areas have been found as a successful intervention for decreasing wait time and length of stay for patients in the emergency department where they are utilized as designed – for only lower acuity patients (Yarmohammadian et al., 2017). Safety becomes a concern when emergency nurses feel improperly equipped to handle patient demands and needs (Eriksson et al., 2018). Operational flexibility within the fast track area has been shown to result in higher performing emergency departments (Ferrand et al., 2018; Hajjarsaraei et al., 2018). Another area of flexibility that may help improve the experience of nurses working in the fast track area is role flexibility where there is more of a shared role between different disciplines (Wise et al., 2020). While the idea of fast track areas seems promising, the current qualitative research represents a lack of understanding of the registered nurses' experiences working in the fast track area. Registered nurses are an integral part of the emergency department team and understanding their experiences with quality of care helps expand the research beyond indicators. Numbers tell an important part of the story, but qualitative research offers a rich description of what is occurring.

CHAPTER 3: METHODOLOGY

Research Method

Insights gained from the literature review reveal more research is needed to understand registered nurses' experiences of working in the fast track area. Chen et al. (2018) found registered nurses' perceive no solution to overcrowding and are unable to meet the mismatch between supply and demand. Feeling unable to meet the ideal standards of care led to job dissatisfaction for registered nurses and low willingness to work in the emergency department (Chen et al., 2018). It is important to gain a better understanding of registered nurses' experiences of quality care and workload in the emergency fast track area. The emergency fast track area is designed with unique challenges like higher patient-to-nurse ratios and the continuous flow of new patients. Using a qualitative descriptive approach, the goal of the current study is to begin addressing the gap in literature pertaining to registered nurses' experiences working in the fast track area. Findings can be used by policy makers and managers from the study site to help inform them of challenges faced by registered nurses in the fast track area.

Registered nurses working in the emergency fast track area that make up the sample were the experts interviewed. Participants' insights led to a greater understanding of what challenges they face, particularly when treating higher acuity patients in the fast track area, and what they perceived as solutions to addressing some of the workload problems.

Theoretical Underpinnings of the Method

Relativism underpins qualitative descriptive studies, meaning truth is believed to be shaped through historical and communal agreement on what truth is and can vary from person to person (Lincoln & Guba, 2005). According to a relativist stance, no purely objective universal truth exists (Bradshaw et al., 2017). Using a qualitative descriptive method, I developed a better understanding of varying perspectives amongst registered nurses working in the fast track area. Relativists believe individuals can conceptualize and experience the world differently (Creswell, 2014). A qualitative descriptive approach uses a naturalistic approach; this means that the assumption is made the researcher can co-create the data and the phenomenon is best explored in its natural setting either through interviewing those that experience the phenomenon or through observation (Bradshaw et al, 2017; Lincoln & Guba, 2005). In this case, registered nurses were interviewed with the intent of understanding their experience working in the emergency fast track area. Using qualitative description, the goal is to describe the phenomenon from the perspective of the participants, and so verbatim quotes were used to support emerging themes (Neergaard et al., 2009). Participant data was analyzed with the goal of collating findings into a description (Neergaard et al., 2009) of the commonly shared experiences of registered nurses working in the fast track area. An interview guide was developed with a focus on quality of care and design.

My experience working in an emergency fast track area gave me insight, but also created biases. For example, I became interested in researching the fast track area because I discovered on busy days I was unable to monitor patients, complete physician orders, and discharge patients. From my perspective, I was unable to complete my perceived responsibilities to an adequate standard. fI chose to conduct this study because I wanted to understand how to better balance the demands of this unique area, while ensuring quality care was provided. As a result, I have a bias towards thinking emergency nurses may not be able to safely monitor their patients during busy times. To ensure credibility I will acknowledge my biases and use direct quotations from participants to support the tentative themes that emerge from the data (Bradshaw et al., 2017).

Epistemology.

Qualitative descriptive research can be used to develop an understanding of healthcare professionals' experiences with a phenomenon (Neergaard et al., 2009), and, therefore, can be used to gather information about the unique experience of registered nurses working the fast track area. In descriptive qualitative research, the researcher will influence what is portrayed in the findings (Sandelowski, 2000). Different researchers should still agree on the analysis, as the researchers are meant to remain closer to the words of participants than in other types of studies (Sandelowski, 2000). Qualitative research is seen as subjective (Bradshaw et al., 2017). Using a qualitative descriptive method, the researcher's goal is to create a description using the words of participants, as opposed to a more theoretical interpretation used in other types of qualitative research (Bradshaw et al., 2017). The researcher influences the research results by choosing what to present, but the researcher's goal is to bring together the accounts of participants into a meaningful description of the experience that researchers and participants agree to be true (Bradshaw et al., 2017; Sandelowski, 2000). Different descriptions of nurses' experiences working in the fast track area were brought together into a meaningful recounting of their experiences.

Sample

Registered nurses were recruited from an urban hospital with an emergency department that contained an acute care side and fast track area. The fast track area was described as a separate area with *"8 beds… with its own separate little waiting room with like 8 or 10 chairs. And then we have like 2 specific rooms, one for like ophthalmology, one for gynecology. So you technically have about 10 beds" (Green).* Participants were recruited from a fast track area staffed with registered nurses and physicians only. Their staffing model did not include licenced practical nurses, nurse practitioners, or physician assistants.

Three aspects of sampling to consider are the number of participants, attributes and demographics of participants, and which recruitment strategies will be used (Creswell & Poth, 2018). Participant demographics were collected including experience working in the emergency department, age, and when their last shift occurred in the fast track area in relation to the interview (see Appendix M). The aim for the current study was a sample size of eight to ten individuals. In the end, eight participants were recruited and interviewed. The number of participants was reasonable for the purposes of this study as the goal was not to produce generalizable findings, but instead a description of registered nurses' experience working in the given fast track area which is fitting with the methodology (Bradshaw et al., 2017).

Inclusion/Exclusion Sampling Criteria

For the current study registered nurses with firsthand experience working in an emergency fast track area were recruited. Purposive, convenience snowball sampling techniques were used. Convenience sampling is appropriate as the results are meant to be utilized locally (Robinson, 2014).

Convenience and purposeful sampling were used to recruit participants. Convenience sampling was used to recruit participants that were readily accessible (Bradshaw et al., 2017), which was appropriate due to the limited scope of the study (Farrokhi & Mahmoudi-Hamidabad, 2012). Registered nurses were all recruited from the same urban hospital emergency department. Purposeful sampling was appropriate because the goal was to gain an understanding of the experience of fast track area nurses working at a single site (Creswell and Poth, 2018). Snowball sampling was used to recruit additional participants given the small number of participants recruited using Facebook, posters, and e-mail. Snowball sampling occurred by asking participants to share the researcher's e-mail and phone number with anyone who might be interested in being a part of the study.

Inclusion criteria for participation consist of; registered nurses from a single site with a minimum of 6 months of experience. I determined six months experience would ensure participants had some experience working in the fast track area. The number of shifts worked in the 6 month period may vary; however, with that length of period the participants that were recruited have all worked several shifts in the emergency fast track area. Recruited participants worked a number of shifts in the emergency department fast track area, and had at least one year of experience working in the emergency department. Recruited participants' experience ranged from one year to more than ten years in the emergency department. Participants had experience working in the fast track area and main emergency department. Both part-time and full-time registered nurses were recruited. Female and male registered nurses were included in the study with ages ranging from less than 30 to more than 40 years old. Our sample group contained participants with varying levels of experience and perspectives, adding to the richness of the data. During the interviews, perspectives ranged on a spectrum from liking working in the fast track area, to neutral, to those whom disliked working in the fast track area. Varying levels of experience and perspectives

Recruitment

Recruitment for qualitative research can be time-consuming and may require multiple strategies (Marks et al., 2017). Strategies used were e-mail (see Appendix C) and Facebook (see Appendix D).

Once operational approval was obtained through Alberta Health Services, an e-mail was sent to management (see Appendix B) by myself, asking for their permission to recruit participants through staff e-mail. Potential participants were able to respond by e-mail to an account used only for this study (fasttrackthesis@gmail.com) or by phone. A Facebook post was made to my personal Facebook page, and permission was granted by the owner of the Emergency Nurses Facebook page to post a recruitment note (see Appendix D). Facebook limits who can see the post, but as all qualified candidates were sent an e-mail this is an appropriate additional method for convenience sampling where the goal is not to create generalizable research (Kamp et al., 2019).

When a potential participant contacted myself, the study information was shared via Consent Form (see Appendix F). The goal was to recruit eight-to-ten participants. Eight participants were recruited, after which there was no further interest. The definition of data saturation varies dependent on the type of study and what the author defines as saturation (Braun & Clarke, 2021). Braun and Clarke (2021), describe data saturation as a useful concept when utilizing a structured approach with a set coding book. The current study used a reflexive approach to data analysis, in which codes, categories, and themes evolve throughout the research process as the researcher engages with the data (Braun & Clarke, 2021). Given the ongoing interpretations of data within qualitative research Braun and Clarke (2021) argue there will never be an end point where true data saturation is achieved, and no new ideas emerge. However, an in depth description of the registered nurse participants' experiences was achieved in this study (Braun & Clarke, 2021). Throughout analysis and reanalysis of the data distinct themes emerged that describe the experience of registered nurses working in the emergency department.

Participants from the current study repetitively described feelings of moral distress when they felt unable to provide quality care to patients. Moral distress can be described as the overarching theme underlying the experience of fast track area nurses. For instance *"it's moral distress…because you want to do a good job…, but I feel there just isn't physically time to do it" (Green).* Participants consistently described feelings of moral distress that occurred when they felt overwhelmed and unable to provide quality care. Sub-themes including feeling stretched to a breaking point, balancing act, and resiliency were described throughout the interviews by participants. Stretched to a breaking point can be described as participants feeling overwhelmed by their numerous roles and responsibilities within the fast track area. Balancing act describes nurses striving to balance efficiency and quality care, and moral distress that can result from feeling unable to provide quality care. Finally, resiliency is described by participants through collaboration with other team members, administrative support, and resetting. While only eight participants were recruited for the study, a rich description of common experiences were developed into consistent themes seen amongst the participants' interviews (Braun & Clarke, 2021).

Data Collection and Analysis

Semi-structured interviews were conducted using an interview guide (see Appendix I). Utilizing semi-structured interviews enhanced congruence of data collected from participants, while providing the researcher with the opportunity to explore important concepts further (Doody & Noonan, 2013). With semi-structured interviews there is flexibility, the researcher can ask questions outside of the guide, reorder the questions, and follow up on important concepts (Doody & Noonan, 2013). I developed the interview guide, and then the supervisory committee reviewed it during the research proposal stage. Prior to interviewing participants, a practice interview was completed with a family member to assess if questions were open ended and to help strengthen interviewing skills. I recorded personal reflections after each interview (see Appendix L), and modifications and improvements were made for the proceeding interviews. For instance, in reflecting about my first interview I found I needed to do a better job of letting pauses occur and asking probing questions. In reading my next interview I found that some of my questions were leading as oppose to probing. For instance, are you able to provide quality care? Throughout the different interviews I worked on different interview skills with the goal of asking open ended questions, while also identifying and understanding the concepts that were important to participants.

Interviews were conducted using Zoom and lasted approximately one hour long. Interviews were conducted on a one-to-one basis and were recorded using Zoom features, encrypted, and saved into Sync. The recordings are important for qualitative descriptive research as the goal is to give an accurate description (Bradshaw et al., 2017) of registered nurses' experiences working in the fast track area. During the interview, I was in a private office to ensure confidentiality and a quiet space with minimal distractions (McGrath et al., 2019).

The option of an in-person interview was provided, but all participants opted for a Zoom interview. Some participants shared they preferred Zoom due to accessibility. Zoom was used despite the personal cost for a licence, as it is a program that the researcher was familiar with and does not require participants to have an account to join the meeting. To ensure participant comfort with the virtual platform, participants were able to choose if they would have their computer camera turned on or off with just their microphone on. Consistent with the findings from Gray et al. (2020), some of the participants communicated that they enjoyed the convenience of participating in virtual interviews. A disadvantage of Zoom interviews is background noise and distractions, because the interviews are conducted from the participant's and the researcher's home (Oliffe et al., 2021). Seven of the eight participants opted for a quiet room in their home, while the other participant began the interview in a main area of the home but moved to a quieter room due to distractions. Additionally, a couple of the participants opted to not use their video, making it difficult to read non-verbal cues (Oliffe et al., 2021). Non-verbal cues can be important for seeing emotional reactions (Olifee et al., 2021).Participants whom chose not to use a camera described feeling more comfortable sharing without the camera on. Zoom was tested for technological problems such as sound, video, transcribing, and recording, with the goal of limiting technological problems. No technological problems were experienced during the interviews using Zoom. If technical difficulties did arise, participants would have had the option of switching to a telephone interview or rescheduling. The recorded files are stored on the Sync cloud storage service in a private folder accessible by the research team only. Sync is a Canadian owned and operated cloud storage with two-way encryption of files. The service follows privacy acts set out federally and provincially for Alberta and Canada (Jason, 2016), and meets the privacy requirements outlined in TCP S2 (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council, 2018). Only the research team had access to these recordings and the files were encrypted and saved under the participant's pseudonym. Consistent with qualitative research, and the meaning a name can hold, participants were able to choose their own pseudonym (Allen &Wiles, 2016). Congruent with institutional policy, recordings will be kept for 5 years after the research study is completed, at which point they will be destroyed. Files were transcribed using Zoom transcription with verification by the researcher, password protected and saved using the participant's pseudonym, any identifying data was removed. Zoom transcription was completed by the researcher listening to the recording and fixing the transcript line by line.

Data Analysis

Braun and Clarke's (2006) six step thematic analysis process was used to analyze the data (see Appendix I). The six steps include: familiarizing yourself with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report (Braun & Clarke, 2006). Braun and Clarke's (2006) data analysis steps were used in the context of the primary researcher's previous experience with the method. Steps were used from Braun and Clarke's 2006 thematic analysis model, with the influence of Braun and Clarke's (2021) newer, more defined reflexive thematic analysis methodology. In Braun and Clarke's (2021) reflective thematic analysis the researcher is identified as a primary interpreter of the data. Braun and Clarke's reflective methodology recognizes that the researcher influences the data through the decisions that are made throughout the research process. Braun and Clarke's (2021) deny a need for data saturation where no new ideas arise and focuses instead on the development of themes that tell a coherent story. The process of data analysis is not linear, themes are not pre-conceived, but instead the interpretation of the data, data analysis, and continuously evolving codes, categories, and themes until rich coherent themes are achieved.

To begin data analysis, data was transcribed word for word into a format compatible with NVivo software (Braun & Clarke, 2006). Interviews were then read and listened to multiple times with the goal of familiarizing myself with the data. Data analysis is described in detail below, including initial coding with the goal of finding words that describe registered nurses' experiences of working in the fast track area, categorization of data and recategorization of data as needed, and searching for themes (Braun & Clarke, 2006). Thematic analysis is used to identify patterns in the interviews (Braun & Clarke, 2006). Thematic analysis was used to help identify recurrent tentative themes in the experiences registered nurses have working in the fast track area. Notes were written on a separate document as part of an audit trail (see Appendix L) to help reflect on how the tentative themes were developed.

Initial Coding

In-vivo coding was utilized where participants' words are coded verbatim (Braun & Clarke, 2006). Data was coded in short phrases used by the participants. For instance, *"the quality of care isn't as good as it should be – like compared to the main site when your patient ratio is a lot smaller" (Keta)* was coded because it described the participants' experience with quality care. Sentences describing how participants felt were also included, such as, *"I love the pace, I love that it is busy" (Julia).* Interview transcripts were read, open coding was conducted using the NVIVO program released in 2020, and then data were analyzed for similar codes that could be sorted into categories (Williams, & Moser, 2019).

Categorization and Recategorization of Data

Once the initial codes were identified? , they were organized into tentative categories in the NVIVO program (Braun & Clarke, 2006). Throughout categorization, transcripts were reread to ensure important codes were not missed and to help make decisions about how different codes combine together into categories (Braun and Clarke, 2006). Throughout the process categories were reviewed with the supervisor, and later on the supervisory committee. The final categories that included: inadequate staffing, overwhelmed by high acuity, overwhelming patient to nurse ratio, catch all bin. Additional categories included balancing quality care and efficiency, strategies used to balance quality care and efficiency, managing flow, team members, and resetting.

Searching for Themes.

Similar categories were then grouped into tentative themes (Braun and Clarke, 2006). Themes are described as more abstract and containing elements that move beyond the words of participants (Braun & Clarke, 2006). After creating the initial tentative themes, categories were collapsed and expanded into tentative themes (Braun & Clarke, 2006). Initial data was revisited throughout the process as the themes became more well defined. Meetings were held between the researcher and supervisor to discuss why categories fits under certain themes and how the developed theme could be more refined. Final tentative themes from the data analysis process were then defined in more detail and renamed multiple times (Braun & Clarke, 2006) using the Nvivo program. At this point in the process there were approximately ten themes. Initially research was stopped at the first three steps as we felt there were not enough participants to achieve data saturation. However, upon review of the definition of data saturation as a coherent well-developed description of the participants' experiences (Braun & Clarke, 2021) we proceeded through steps four to six of Braun and Clarke (2006).

Reviewing Themes

Tentative themes were reviewed for clarity and to decide if there was enough data for the theme to be a stand alone theme or if the theme fit in with another theme (Braun & Clarke, 2006). During this stage the researcher worked between reviewing the data and codes, redefining categories and themes and condensing the tentative themes into rich themes with support. Throughout this part of the process discussions were held between the researcher and their supervisor.

Defining and Naming Themes

Defining and naming themes involves defining the essence of the themes (Braun & Clarke, 2006). There was discussion on which themes may be representing similar ideas and which themes presented separate ideas. After reviewing with committee members, thought was put into what the story is within the theme and how the themes correlate with the experience of participants (Braun & Clarke, 2006). The result included the overarching theme of moral distress, described by three sub-themes including: stretched to a breaking point, balancing act, and resiliency.

Producing the Report

Producing the report involves the step of writing the themes into a coherent story of the data (Braun & Clarke, 2006). The completed thesis was then developed and reviewed a number of times.

Rigor and Trustworthiness

Credibility

Credibility focuses on how credible the data was based on the methods that were used, prolonged engagement with participants, and review of the data (Connelly, 2016). Probing questions were utilized to enhance engagement and gain a deeper understanding of participants' experiences. For instance, can you expand on what you mean when you say quality care? In qualitative descriptive research the researcher is simply describing the experience of the participants and while different researchers may identify different components of the experience, they should be able to agree on the general description that emerges from the data (Bradshaw et al., 2017; Sandelowski, 2000). The primary researcher and supervisor met at regular intervals to group similar categories together into abstract themes underlying the experience of participants.

Themes and categories were amended a number of times with the goal of creating more concrete categories that are well developed and supported. Once the categories were thoroughly developed, research committee members looked for links and deeper meaning to develop tentative themes. Once the primary researcher and supervisor had agreed on the tentative theme, they were then shared with participants. The two participants that responded agreed with the tentative themes and a final draft of the thesis was shared with the remainder of the supervisory committee. Some degree of thick description was achieved wherein the supervisory committee and myself explored the deeper meaning for participants through thematic analysis. However, given the nature of qualitative descriptive research, the current study results remain close to the participant data. Based on feedback from other supervisory committee members, the themes were renamed and developed further. For instance, the theme fast track area nurses experience an overwhelming workload was renamed as stretched to a breaking point.

Confirmability

Confirmability refers to objectivity within the study, audit trails are utilized in qualitative descriptive research to minimize the extent to which the researcher influences the data (Bradshaw et al., 2017; Connelly, 2016). Throughout each stage of the research process, notes were made on researcher biases, and how those biases could be affecting the data analysis (see Appendix L). For instance, my perspective on quality of care was not always the same as participants; that knowledge was utilized to explore the differences, as opposed to confirmation bias wherein I would only look for data that confirmed my own feelings. Biases were acknowledged in the audit trail (see Appendix L) along with detailed notes on why different decisions were made throughout the research process (Bradshaw et al., 2017).

Member checking was done by e-mailing the tentative themes to participants and asking for their feedback. Utilizing this method all participants were given the opportunity to provide feedback. Of the eight participants, two replied and said the tentative theme coincided with their experience working in the fast track area. Given that information, I feel some of the integral parts of the experiences of registered nurses working in the fast track area were captured in the present study.

Dependability

Dependability of data is achieved by stability of the research over time with the understanding experience can change (Connelly, 2016). In-depth analysis occurred throughout each step of the research process and was documented in the audit trail (Bonello & Meehan, 2019).

An audit trail is used to describe how and why the researcher made different decisions about the findings and throughout the research process (Carcary, 2020). The audit trail was used to document what occurred throughout the study, different analysis steps and how data evolved over time. The audit trail was used as a place to acknowledge different biases that could influence the results of the study (Carcary, 2020). Multiple meetings were held between the researcher and supervisor where feedback was provided on the analysis.

Transferability

Transferability of data is left up to the reader and is achieved through a rich description of the findings and description of the context and participants (Bradshaw et al., 2017; Graneheim & Lundman, 2004). Trustworthiness can become a concern when using convenience sampling because often participants are recruited from the same group and share similar traits (Emerson, 2015). While the participants were from a single site, their age and experience working in the emergency department ranged. However, purposeful sampling using convenience sampling is appropriate for qualitative descriptive research because the researcher is often not making generalizations, but focussing on the experience of a certain group of individuals with the phenomenon (Doyle et al., 2020). Purposive sampling enhanced transferability because readers are given a description of the traits and context of those being included in the study (Bradshaw et al., 2017; Graneheim & Lundman, 2004).

Ethical Considerations and Processes

Throughout the research process guidelines set out by the Tri-Council Policy Statement for the ethical conduct of research involving human beings (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council, 2018) were followed. Ethical approval was received from the Health Research Ethics Board at the University of Alberta and given the identification number PRO00115098, prior to recruitment. Operational approval was received from the urban hospital site prior to conducting the research. A consent form was created to ensure all participants are fully informed prior to entering the study (see Appendix E). As interviews were conducted through Zoom, verbal consent was obtained. Verbal consent was obtained by the interviewer reading through the consent form and receiving verbal consent from the participant. Any time the participant used identifying information, names were replaced with pseudonyms on the transcript. Participants were given the option to contact us through the fasttrackthesis@gmail.com e-mail if they would like a copy of the final research report.

Confidentiality and Privacy

Privacy and confidentiality of participants throughout the research process is of the utmost importance. A pseudonym provided by participants was used throughout the research process to help protect their identity. Only those on the research team had access to the original identities of participants. All other members of the supervisory committee only had access to the data analysis and results of the study. The form with participants' names, e-mails, and pseudonyms were encrypted and saved on a personal password protected laptop in a folder. The only documents containing the legal name of the participant were the consent form and a master identity form with contact information for the purposes of contacting them for follow-up interviews if needed.

To maintain confidentiality, research was conducted outside of working hours. To help protect the identity of participants and the hospital anytime it is referenced in the research I referred to it as a small urban hospital. When a participant mentioned the hospital name or location in the interview, then it was transcribed using the generic terms of "hospital". Any colleague names or other identifying information was also changed.

To protect participant from scrutiny they may face if their place of work found out they participated, Zoom interviews were held at a location chosen by the participant. The interviewer was in a private room for all interviews to support participants' privacy.

Power Imbalance

The relationship between the researcher and participant in qualitative studies presents a potential power imbalance (Creswell & Poth, 2018). These participants were recruited from the emergency department where I work as a registered nurse. I am not in a supervisory position, but participants may have felt compelled to participate because they knew me. Given the small 8 participant pool it is unlikely that nurses felt compelled to participate. Precautionary steps were utilized to ensure participants did not feel pressured or coerced into participating by not asking them in person to participate as per the steps outlined under the recruitment section. After explaining the study to the emergency manager, the manager requested that a unit clerk send out the invitation to participate via departmental email. This process helped to minimize any coercion or pressure to participate that could occur if the e-mail came from myself or management.

E-mails and Facebook posts were used to advertise the study, but not to directly contact participants. Participants were not asked the source of their recruitment, as their source of recruitment did not add to their experience working in the emergency department. Throughout the research process, the researcher stressed there were no negative consequences for not participating or withdrawing participation once the research began. If a participant decided to withdraw, they were given the option of having any of their information collected to date within the study destroyed from all sources up until the point when the data was synthesized together. This was included in the consent form and verbally stated in the interviews. No participants chose to end their participation or withdraw their data from the study.

An abuse of power can occur if the researcher asks leading questions unrelated to the research purpose (Creswell & Poth, 2018). Efforts were made to avoid leading questions during the interviews to minimize bias. The interview guide was reviewed by the research team and ethical review board prior to the commencement of the study. During the interview, efforts were made to ensure follow-up questions remained open-ended by ensuring leading words or questions were not used. For instance, by asking “do you want to expand on that topic more”? Personal reflection by the researcher was completed after interviews and included in the audit trail of how future interviews could be improved.

Welfare

There were no anticipated risks beyond those a person would face in their daily lives. However, research participants' mental health is of the utmost importance and the information for the Mental Health Line was available if needed for research participants. None of the participants became distraught or indicated they felt the need to talk to someone about their experience. However, if they had, the Mental Health Line support would have been provided. Participants were able to end the interview at any point in time without providing a reason and without any consequences.

The collected data was utilized with the goal of providing information to administration to help support registered nurses working in the fast track area. This research will help stakeholders like managers in emergency departments to better understand the barriers that nurses face when they engage in patient care in the fast track area. The hope is the results can be utilized to better understand challenges faced by fast track area nurses and how to support them. Participants were able to identify two areas they viewed as problematic and hopefully the information can be utilized to brainstorm and address the problems going forward.

Limitations of the Study

One limitation of using a qualitative descriptive design is the data that emerged from the study will have limited transferability and will reflect the experiences of the participants at the site of study (Bradshaw et al., 2017). Qualitative descriptive research is beneficial in creating a starting point for future research studies. The results from this study will inform future researchers what registered nurses perceive as challenges and solutions. Given that a qualitative descriptive method was used, some of the challenges and problems identified by participants may be limited to the site where they work.

As mentioned in the literature review, each emergency fast track location has a unique design. One limitation of this study is the unique design of the fast track area at the urban hospital where sampling occurred. Fast track area design varies throughout the research and not all design components of the specific site will be transferable to other sites. One example is registered nurses working in the fast track area for current study took on housekeeper, unit clerk, and porter tasks, whereas at other sites nurses are not assigned those duties.

Recruiting only nurses with at least 6 months of experience is a limitation. Having a minimum for experience was appropriate as participants are required to have experience and knowledge of the phenomena being studied (Bradshaw et al., 2017). Given the low number of participants for recruitment at the site of study, we chose six months as a minimum to ensure the participants had some experience, while reducing limitations on our inclusion and exclusion criteria. Given the study was done at a single site with the aforementioned restrictions, we had a small participation pool to recruit from and were only able to recruit eight participants. Trustworthiness was enhanced through triangulation of the data, member checking, and maintaining an audit trail (see Appendix L). The participants gave robust and descriptive interviews, but given the low number of participants it would be difficult to say that data saturation had occurred.

Dissemination

Charmaz (2014) states that reports can be written for a number of disciplines, but the author may need to write differently depending on the audience and journal. The goal is to submit articles to the Journal of Emergency Nursing, and the Leadership of Health Services Journal. The intention is emergency nurses will benefit from understanding challenges and problems faced by other registered nurses in the emergency fast track area. Health care leaders reading these journals can benefit from understanding challenges and problems at other sites to identify and understand some challenges nurses at their own sites may face. Leaders can use this information to support their staff in figuring out which aspects of care to cut and how to support staff in finding a balance between quality of care and efficiency. Data from this study will be disseminated and used to create a basis for larger research studies into challenges and problems faced by nurses working in the emergency fast track area.

I will seek opportunities to present the findings to the leadership team at the small urban hospital which was the location for this study. I hope that the presentation will help to influence future policies and help administration understand challenges faced by registered nurses working in the fast track area. By understanding the challenges, administration can work with emergency nurses to address problems – particularly when higher acuity patients end up in the fast track area.

Summary

The purpose of this qualitative descriptive study was to understand how registered nurses' experience working in the fast track area. This study is important because, to date, there is limited data on how registered nurses' experience working in the fast track area. The theoretical underpinning used is relativism – where reality is relative and created through the perceptions of participants (Bradshaw et al, 2017; Lincoln & Guba, 2005); this means the resulting data is based on the participants' perceptions of their experience. A qualitative descriptive design fits the purpose of this study because using that design allows the researcher to understand and to provide a description of how a certain group experiences a phenomenon (Bradshaw et al, 2017; Lincoln & Guba, 2005), in this case, the experience of registered nurses working in a small urban hospital emergency fast track area. Semi-structured interviews were be conducted with registered nurses working in a small urban hospital emergency fast track area. Interviews were recorded and transcribed, then analyzed using the steps one to three described by Braun and Clarke (2006). Different steps were taken throughout the research process to maintain trustworthiness.

CHAPTER 4: RESULTS

Demographic Data

Eight registered nurses working in a single hospital fast track area were interviewed. Participants varied in age from less than 30 years old to more then 50 years of age (see Appendix M). Experience ranged from one to more than 15 years of experience working in the emergency department. Three of the participants had one to five years of experience, three of the participants had five to ten years of experience, and two of the participants had more than ten years of experience working in the emergency department. Seven of the participants worked the fast track area within seven days of the interview taking place, while one participant had worked the fast track area in the last one to four weeks.

Overarching Theme: Moral Distress

Moral distress emerged as the overarching theme in participants' experiences working in the emergency fast track area?. Participants described moral distress occurred when they were unable to provide quality care to patients. For instance*, "you don't have time… and it's morally distressing because you want to do those things for your patients and you want to help people, that's why we went into this profession" (Green).*. Participants described some examples of when they felt they did not provide quality care. *"You want to take time to do good patient teaching, but like I feel like there's just not physically time to do that" (Green). "You miss a patient who needed an assessment and they end up doing more poorly in the fast track area" (Gemma).*

Participants held themselves to a high standard of care and felt moral distress occurred because emergency nurses strive for perfection, which is not achievable given the limited resources.

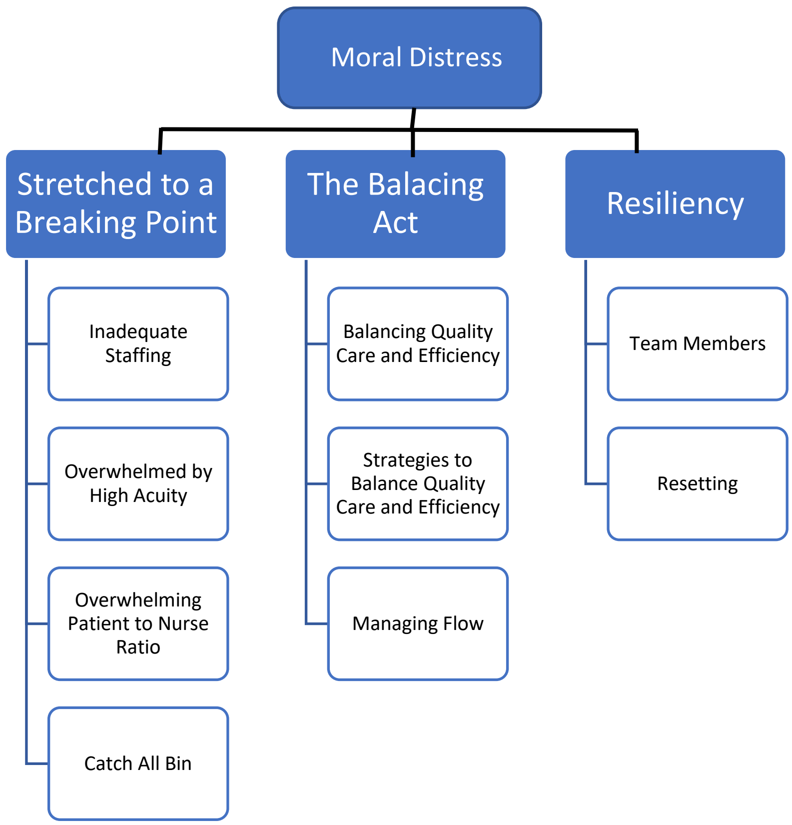
> *Nurses that tend gravitate towards the ER are perfectionists, we like things done a certain way, and we like it done in a certain time frame, because that's just the way our*

> *brains are set, and I find that a lot of us are similar that way... so I find it's a hit to morale (Gemma).*

Moral distress is described through three sub-themes including stretched to a breaking point, balancing act, and resiliency. Stretched to a breaking point describes the moral distress that occurred when the participants were being stretched in multiple directions; working to fulfill a variety of roles in conjunction with inadequate staffing. Keta felt at times, *"defeated… because you're just floating along, trying to put out fires."* Feeling stretched beyond their capacity and unable to provide quality care to patients resulted in job dissatisfaction. Participants shared a deep desire to provide quality care to their patients but were overwhelmed. Stretched to a breaking point includes inadequate staffing, numerous roles, overwhelmed by high acuity, overwhelming patient to nurse ratio, and catch all bin. Balancing Act encompasses the internal struggle participants faced striving to balance quality care and efficiency. Categories supporting balancing act include: balancing quality care and efficiency, strategies used to balance quality care and efficiency, and managing flow. Resiliency describes attributes within the department that participant described as supportive. Supporting categories of resiliency include: team members, resetting, and appropriate patients flow well.

Table 1

Themes and Categories



Sub-Theme One: Stretched to a Breaking Point

Participants described feeling stretched in multiple directions to the point of breaking. *"The amount of work that you encounter in the fast track area is unlike any other portion of the department. There's really no rest, and you're expected to do a lot" (Gemma).* Participants felt inadequate staffing, playing numerous roles, high acuity patients, the overwhelming patient to nurse ratio, and being the catch all bin as leading to an overwhelming workload, and in effect moral distress. Green shared, *"were getting sicker patients that require higher acuity, more attention, reassessment, interventions, treatments, and we're still expected to treat the same volume of patients…, even though they're more complex and they're more sick."* Striving to fulfill numerous roles left nurses feeling overwhelmed. Feeling unable to provide high quality care; led to feelings of inadequacy and moral distress. For instance, *"you're constantly running off your feet, and you can never really catch up when you're in the fast track. Area. This effects the morale, and overall the enjoyment of the job" (Gemma).*

Inadequate Staffing.

Six of the participants felt they were stretched to a breaking point because staffing was inadequate for them to provide quality care. One of the primary concerns shared by five of the participants was the number of times they were left alone throughout the shift. Keta gave the example of *"your unit clerk goes away on break, … and your partner goes on break, which is a common thing so it's just one nurse handling the fast track area."* Six of the eight participants acknowledged instances when their partners were pulled to help on the acute side, leaving them alone. *"If there is something going on, on the acute side, you might literally only have one or so in the fast track area, because they're helping out on the acute side, because that's where they're needed" (Green)*. Having to manage a high volume of patients with inadequate staffing led to moral distress.

> *It's one nurse for 12 to 15 patients and three doctors writing orders on them. So stressful, poor, low, very low quality care is given in fast track in my opinion, and you are not physically capable to comply with AHS guidelines. (Alix)*

Gemma described working in the fast track area as *"constantly running off your feet, and you can never really catch up."* Stressful times were described as when you *"miss a patient who needed an assessment and they end up doing more poorly in the fast track area" (Gemma).*

When questioned about how she copes with those patients Gemma indicated *"you take a certain amount of guilt home with you."*

In participants' experiences higher acuity patients did need to be prioritized. For instance:

> *If you're in the fast track area those patients have to get push back as secondary because if they're in traumas or codes in the other side you have to go take over the acute side in order to keep things running over there. (Gemma)*

The problem was nurses *"essentially abandon the fast track area because they're the least priority, they're the least sick right" (Gemma).* Additional help on the acute care side left the fast track area with a further lack of resources despite the increasing number of patients. For instance, Melissa said "*we're left with an even worse nurse to patient ratio to prioritize other needs and the rest of the department."* Resulting in nurses feeling *"defeated because... you're just floating along, trying to put out fires" (Keta).* Nurses felt hopeless, but to stretch themselves to a breaking point to provide care to both higher and lower acuity patients to the best of their abilities.

Alix, Keta, Lynn, Melissa, and Green felt to be supported in providing safe quality care at least two nurses are needed in the fast track area at all times. *"No less than two nurses in ED2 at all times, and during peak times probably three" (Alix).* Green and Alix felt newer nurses were at a greater risk of becoming overwhelmed than experienced nurses. For instance, if *"new staff are in ED2, and…they're by themselves, it's not safe" (Alix).* Green and Alix postulated that, at the very least, a newer nurse should not be left alone to manage the fast track area.

In some instances Jimmy, Gemma and Alix described moral distress. There were incidences where patients felt the care provided was inadequate, and patients publicly shamed the healthcare system or specific workers. For instance, Alix experienced an incident where a patient attacked her publicly, leading to anxiety around social media. *"A patient posted a long* *post, roasting us about how terrible their care was… it gives me so much anxiety" (Alix)*. Julia speculated that some of the negative social media posts could lead to mistrust in the healthcare system because the public does not typically get to hear to healthcare worker's side of the story. Julia felt *"anytime somebody feels that they've been mistreated by the healthcare system only one side of the story is ever heard, and so it always leaves the healthcare system looking very bad."* In Julia's opinion the public did not always understand the pressure put onto the nursing staff and that at times they were being stretched to the limit. Jimmy and Gemma talked about feelings of inadequacy and guilt that emerge when things were missed. Gemma said *"a part of you takes it home like, should I have caught this?"* When quality care was not provided, ruminating thoughts could stick with the nursing staff; this can lead to job dissatisfaction in a situation where they feel stretched beyond their breaking point. Participants clearly felt distress from both the pressure they put on themselves to provide quality care for patients, and the public view of the quality of care provided.

Numerous Roles.

Seven of the participants felt overwhelmed by the multiple roles they were expected to manage. In addition to their heavy nursing workload, they were cleaning rooms, portering patients, and entering orders. Jimmy, Melissa and Lynn speculated that approximately 20-50% of their shift was spent on non nursing tasks. For instance, Melissa shared *"a lot of my shift, I'm entering orders in a unit clerk role, or cleaning beds in a housekeeping role which I don't mind doing, but it takes away from patient care."* Four of the participants shared feelings of being overwhelmed and unable to provide quality nursing care. For instance, Lynn said:

> *Cleaning beds, cleaning chairs. If you had somebody there all the time,…whose job is to support the maintenance and the turnover of the rooms. Then that is a huge help to free up nurse time because that's a lot of work.*

Nurses were left feeling unsupported and overwhelmed by the workload they were expected to carry out. Given the substantial amount of time spent on non-nursing tasks, Lynn and Melissa felt the addition of support staff could help ease the strain on nurses. For instance, *"not other nursing resources, but other unit clerks and housekeepers and things like that would help with the staffing" (Melissa).*

Overwhelmed by High Acuity.

Participants identified the design and staffing model within the fast track area as having inadequate capacity to treat higher acuity patients. Julia shared the *"fast track area is not equipped or staffed for high quality monitoring of patients that are on that cusp between being fast track and being acute."* Nurses quickly became overwhelmed by the realities of the time required to appropriately treat higher acuity patients. For instance, *"as soon as you get some more complex patients the nurse to patient ratio becomes really overwhelming and it makes it like very tricky to do your job properly" (Melissa).*

Five of the participants felt required to provide care to higher-acuity patients, because there were no other options. Some examples of patients they perceived as inappropriate, but treated were *"acute flank pains in the pain crisis, active fractures that do need reduction, a DKA [diabetic ketoacidosis] patient" (Gemma).* Lynn treated a patient with *"really bad upper respiratory croup where he was tripoding, and every muscle he could use he was using to try and breathe."* Participants felt limited by their options; "y*ou have the responsibility to bring patients back [to the treatment area] wherever you need to bring them back" (Lynn).*

Jimmy, Alix, Keta, and Green did not feel they had the time required to provide quality care to higher acuity patients. *"There's an expectation that higher acuity patients need more care and with that expectation comes almost an expectation of a time commitment as well"*

(Jimmy). "The fast track area is significantly heavier, and can be overwhelming… when you have patients who need IVs and more complex monitoring, or unstable patients, that's when it becomes unsafe" (Gemma). Despite their concerns, they felt a requirement to provide quality care to higher acuity patients. When stretched to their breaking point, providing quality care to higher acuity patients was prioritized. For instance, "*if you don't make the time then you're putting your patient at a huge risk I feel" (Jimmy).* Participants clearly felt it was their responsibility to support their co-workers and higher acuity patients when needed, despite safety concerns, leading to moral distress.

Safety was a concern, because participants felt stretched to a point where they felt overwhelmed, and unable to manage the patient load. For instance, "s*ometimes you feel it's unsafe… especially when you're getting patients that are more acute in your care" (Keta).* Four of the participants experienced shifts where patients did not do well when something was missed, resulting in moral distress. An extreme example Alix shared was:

> *In the last month or two we had a patient who coded in D3 or D2, who was waiting to see a physician in the room. Nobody had gone in to check on him, and by the time the doctor went into the room he was just laying dead on the stretcher.*

Despite concerns raised by other participants, Julia felt adequate care could be provided to higher-acuity patients when needed. She gave an example of a time where she had to treat a trauma patient. "*The trauma patient for example, it was myself and a doctor, it was less personnel managing the trauma, still did all of the things that trauma required" (Julia).*

Seven of the participants described job satisfaction from providing quality care when they were only responsible for treating lower acuity patients. Gemma, Green, Julia, and Lynn felt it was easier to manage the flow of patients and provide quality care to lower acuity patients. Julia described appropriate fast track area patients as *"a prescription refill request or sore ear. You* *know, something, something simple. You know, maybe they just need a little bit of stitches on their thumb and they're not on blood thinners."* For instance, Gemma shared *"sometimes at least, the patients are fast track appropriate so… we can get them in and out of there rather quickly."* They were able to provide the care in a timely manner and move patients through the fast track area. Gemma, Julia, Lynn, and Jimmy were able to manage the flow of a large volume of fast track area appropriate patients because their care was straightforward. *"For your really simple presentations I think it's (quality of care) great" (Jimmy).* Gemma observed that the fast track area *"works a lot more smoothly and it's doable and manageable…because these patients don't need necessarily as much assessment and reassessment as regularly."*

Overwhelming Patient to Nurse Ratio.

Participants perceived the higher patient-to-nurse ratio as overwhelming, and a barrier to safe care. Melissa, Lynn, Keta, Green, and Gemma described the substantially larger volume of patients they would see during a shift in the fast track area. In comparison to the acute care side, Gemma felt *"the volume is significantly larger."* At times Gemma said she had as many as "*50, 60 patients"* to herself while her partner was on break. In general participants described their patient load as 8-15 patients per nurse. Julia found it "*difficult to have a focus on that patient and monitor their overall health picture… because I'm distracted by all of these other patients."*

Seven of the participants experienced instances where they felt overwhelmed. During one of Melissa's shifts she felt *"it was impossible to keep up with reassessing pain, reassessing vital signs after doing IV narcotics with a one nurse to ten patient ratio."* Because of the higher patient to nurse ratio Gemma experienced times where *"patients were put in a room and left there for hours unattended because we're busy doing something else."* Five of the participants felt stretched beyond their means, and unable to provide quality care given the high patient-to-nurse ratio. For instance, Alix felt *"having seven or eight patients per nurse in ED2 is not a safe staff patient ratio, no matter what their acuity is."* Safety became a concern when nurses felt stretched beyond their capacity. Melissa shared similar concerns about patients' safety, as she felt unable to provide quality care to her patients. *"There are some shifts that I've worked that it's been unsafe for lack of better word, to manage with the nurse to patient ratio" (Melissa).* Participants felt unable to *"reassess patients and getting vitals done" (Keta).* Keta felt *"the quality of care isn't as good as it should be compared to the main side when your patient ratio is a lot smaller."* Nurses described feeling like they were put in impossible situations where they felt unable to provide safe, quality care, leading to moral distress.

Four of the participants described the fast track area as chaotic given the limitless number of patients and fast pace. For instance, Gemma shared *"there's no limit to the number of patients we can have in the fast track area between our personalized waiting room, the 10 rooms and the hallway, we get slammed with patients."* With limited resources including staffing, participants struggled to manage the workload. Despite feeling stretched beyond a reasonable capacity, Lynn felt that *"if everybody's doing what they're supposed to be doing to prioritize who needs to be seen first with triage, and then us once they come to the back, then we should be caring for them appropriately."*

According to three of the eight participants, the patient-to-nurse ratio was manageable when working with patients that were described as fast track area appropriate. When treating appropriate patients, nurses were able to move patients through quickly in the way the fast track area is meant to work. "*Sometimes at least, the patients are fast track appropriate so it's just x-rays straight up lab work quick meds, and we can get in and out of there rather quickly" (Gemma).* Job satisfaction occurred when participants were able to move patients through in an efficient manner. When the fast track area was working well, Lynn, Green, and Julia really liked the pace; they enjoyed the feeling of being able to help a large number of people in their shift. For instance, Julia shared: *"I enjoy working in the fast track area. It's almost always busy, we're able to help a lot of people really quickly, and I enjoy that aspect of our department."* Julia and Green liked what they described as the typical fast track area patient. *"Overall like I like the fast track area, because your patients are usually only minor injuries… but the problem is like the flow. Congestion like the department getting overwhelmed really fast" (Green).* Nurse felt a sense of satisfaction when the demand did not exceed either the staffing capacity or resources available in the fast track area. In those instances, they felt able to provide quality care to patients.

Catch All Bin.

Participants described lower acuity patients coming to the emergency department due to the lack of community health services as adding to their patient volume. The fast track area is the "catch all bin" for the community, where patients come whenever there was a lack of a health services such as family doctors in the community. For instance, *"so many of our family doctors have left, and there is a giant shortage. So we're seeing all these family doctor issues in emergency now, which adds to that volume" (Green).* While participants felt they were *"a great resource for the community" (Green)*, they became overwhelmed serving the large volume of lower acuity patients seeking care in the emergency department. Lynn felt *"we would still be able to manage the volume of patients… if we figured out what's needed in the community and addressed those needs."*

Over the last year Alix, Green, Julia, Keta, and Lynn felt like they have been seeing a higher volume of patients due to a number of physicians leaving the community. In Keta's experience *“a lot of people that come into emerg, because they don’t have access to a physician to get care.”* The emergency department becomes the bin that catches all of the patients with nowhere else to go. People are coming to the fast track area seeking basic primary care because they have nowhere else to go for prescription refills and driver’s medicals.

Keta, Alix and Gemma felt the emergency department is being stretched to a breaking point and they can no longer fulfill the role by themselves of family doctor for the overwhelming number of patients seeking lower acuity care. Keta shared *“we need more family doctors; we need walk in clinics we need an urgent care center to help take the load away that comes into the emergency department.*

Green, Lynn, Keta, and Gemma found they were also catching patients whom lack knowledge about how to treat common illnesses, or when to seek care in the emergency department. For instance, Green felt like *‘there’s not a lot of education and not a lot of resources for patients, or even citizens people in general.”* Fast track area nurses were frustrated by the overwhelming workload that came with filling a vast community need. Lynn provided the example of *“a kid has a fever, oh what have you done? You know just management of how you deal with some of those things. I don’t think there’s been a good job of that.”* From their experience, participants felt better education in the community could result in less lower acuity visits to the emergency department.

Gemma and Alix understood why patients with lower acuity problems seek care in the emergency department, whether it be because the patient has nowhere else to go or they lack education about how the healthcare system works. For instance, Alix said *“I understand you’re worried about your kid, I understand you’re worried about that weird lump on your breast that you’ve had for 2 months.”* Participants did not feel patients were the problem, but instead focussed on the lack of community resources. Green, Gemma, Keta, and Lynn felt they could be better supported by public health services through more education being offered in the community.

People in the community have access to Health Link, a phone number people can call for health advice. However, in Lynn and Green's experience, the phone line was not generally a helpful resource. In their experience Lynn and Green found the people on the phone line sent a large volume of patients to the emergency department. For instance, *"95% of the patients say they phoned the health line and the health line told them to either call an ambulance or be seen by a doctor within the next hour" (Green).* Green did not feel the expectation that Health Link set out was reasonable, but acknowledged she did not hear the phone call between the health line and the patient.

Sub-Theme Two: The Balancing Act

The balancing act describes how participants strive to find a balance between quality care and efficiency in the fast track area, strategies used to balance quality care and efficiency, and managing flow.

Balancing Quality Care and Efficiency.

Study participants frequently expressed feelings of an internal struggle to balance quality care and efficiency in the fast track area. Every participant described the fast pace of the fast track area as challenging. For instance, "*sometimes the fast track area can be a challenge in terms of providing proper patient care and following guidelines and whatnot, because it's fast paced, and we see so many people" (Melissa).* Keta described the fast track area as *"a never ending pace, especially during the day and evenings";* there is constant movement, new patients, and orders. Lynn, Jimmy, and Julia found it difficult to provide both quality and timely care to a number of patients at the same time. For instance, Lynn said *"you're working with all ages and all problems, and trying to be respectful of privacy but also trying to ensure that there's good flow."*

Because of the large volume of patients and endless orders, seven of the participants expressed a requirement for efficiency. *"I don't know that efficiency is necessarily what it's meant to be, but I think it's evolved into that because you're getting a bunch of orders very rapidly." (Jimmy).* Lynn said *"we need to be efficient because it's a large volume of people."* Participants questioned how to provide efficiency without sacrificing quality. For instance, Lynn tried to *"not be too efficient at the expense of quality."* Jimmy was constantly assessing what he was willing to sacrifice to maintain flow. For instance *"the quality of care has the potential to suffer… sometimes it's even discharge, instead of doing really good discharge teaching sometimes you'll have patients bouncing back."*

Participants speculated that the pressure to maintain a fast pace came from the large volume of patients in the waiting room, the triage nurse, and physicians. Jimmy shared *"whether that driving force is the nurses, or you know, the waiting room being full, or the physician standing there waiting for patients… it seems to boil down to efficiency, on that fast track side."* The experience was more of an internal pressure because they wanted to help their patients and colleagues. For instance, Alix felt *"pressure from triage makes it stressful, you want patients to get seen faster, you know wait times are long, you're worried about patients."* The pressure could lead to moral distress when they felt had to choose between providing quality care and efficiency. For instance,

> *When your partner is on break there's 50, 60 patients and just you, so they definitely get lower quality of care because they can be put in a room and left there for hours unattended because we're busy doing something else. (Gemma)*

Jimmy felt the fast track area resulted in job dissatisfaction for some nurses because *"they are not giving the nursing care that they wish they could give because it is so fast pace."* As described by Jimmy, some nurses struggled to find a balance between quality and efficiency that they were comfortable with. When there were no physicians in the fast track area, Alix and Lynn felt that work could come to a stand still. Alix shared *"you could be sitting in ED2 for like an hour plus, just sitting there with nothing to do, waiting for doctors."*

Lynn and Julia felt privacy was an important aspect of quality care. Alix, Keta and Lynn liked that the design of the department was conducive to privacy for patients, if needed. They had individual patient rooms with doors. However, Alix, Lynn, and Julia felt that efficiency was maintained at the cost of privacy. For example, Alix felt putting patients in the hallway was problematic because *"when the physician comes to talk to them about the results to discharge them, then they have to give them their results out in public."* Alix felt it *"wasn't ideal"* for patients to receive their results in the hallway and struggled with the lack of privacy.

Frustration and helplessness arose when participants felt unable to manage their perceived responsibilities in conjunction with providing quality care. For instance, Alix was frustrated because she felt they were held to a standard that was unattainable. *"No one's ever been like, hey? Why are we not meeting these guidelines? What can we do so these fast track nurses meet our guidelines?" (Alix).* Alix felt blamed for being unable to provide the quality care outlined in the standards – even though there was no assessment of the policies and organization.

The challenging, fast pace of the fast track area was not for every nurse. For example, Alix shared "*I dislike fast track most of all. I feel, yeah basically your entire shift in fast track is fast."* Gemma felt that the volume of patients and fast pace of the fast track area was a *"hit morale because it's an area you can never really keep up with."* Moral distress occurred when participants felt unable to provide quality care to patients secondary to the fast pace and large volume of patients in the fast track area.

Strategies Used to Balance Quality and Efficiency.

Participants described strategies they used to balance quality and efficiency. Jimmy described the fast track area as *"busy and then hectic in the sense that you feel like you're just going without doing a lot of reassessing and you're just go go go."* Three of the participants utilized organization skills to balance quality and efficiency. Julia described a good fast track area nurse as *"being to be able to juggle a lot of things at the same time, which is somewhat contradictory to being focused, but you have to be able to manage a lot of things simultaneously."*

Five of the participants identified variability in nurses' approaches to managing the fast track area. For example, *"some nurses… are very particular about how they run ED2 in terms of like pulling patients into the hallway or into the waiting room after while they're waiting for blood work or things like that" (Melissa).* Two of the participants felt variation in some of those processes could lead to problems such as confusion or patients being missed. For instance, *"all of a sudden someone would be there and you wouldn't know anything about them, and that was a problem" (Lynn).* Nurses' organization of the fast track area was key to managing flow and the large volume of patients. *"Standardization of processes, which I think are really critical for that area to work well" (Lynn).* Standardization of certain processes, particularly managing flow, was viewed as important for minimizing confusion amongst staff and ensuring efficiency in the fast track area.

According to three participants, experienced nurses were more capable of prioritizing patient needs. For instance, *"experienced nurses know who's sick, who's not sick, who needs* *more attention" (Green).* In addition to balancing their own duties, three of the participants felt doctors relied heavily on the nurses to know what was going on and what needed to be done. For instance, Green shared *"doctors, you know, they rely on us to cue them for when everything's back to reassess their patients."* While challenging, fast track area nurses felt maintaining organization amongst the chaos was integral to ensuring patients are receiving the care they need in a timely manner both from nursing staff and physicians.

Seven of the fast track area nurses felt they had no control over their workload. Seven of the participants described the need to omit aspects of care to maintain efficiency, which could result in moral distress. For instance, Jimmy said *"I have three patients I'm trying discharge and four that I'm still giving interventions to, and I haven't reassessed and they're otherwise stable, but it'd be nice if I could go reassess them."* In the mentioned example, Jimmy wanted to provide reassess his patients, but felt unable to given time constraints and workload.

Adapting care created more time to provide care to other patients, but at the expense of quality. Lynn felt *"short cuts"* were needed *"to keep afloat"* – and, in her opinion, the shortcuts did not cause harm to patients. There was a sense of hopelessness amongst nurses whom felt they had to choose between providing quality care and maintaining efficiency. Lynn felt she *"balanced the risk, safety, benefit to just keep moving."* Lynn felt she was able to adapt her care in a way that she could balance quality and efficiency. For instance, *"does everybody get their blood pressure checked in 15 min post? No, probably not…but we are looking at patients, talking with them, making sure they have somebody with them" (Lynn).* While not the standard of care, the aforementioned practice helped offer Lynn reassurance she was providing safe care she was comfortable with given time restraints.

Care was adapted by seven of the participants to provide the best care possible to higher acuity patients. Wanting to provide safe, quality care, once participants identified a concern about patient stability; they adapted their practice to meet the patient's needs. "*I'll reassess them more, I'll keep a closer eye on them… Like there are certain things we can do to kind of cope with that, to make sure they're monitored a little bit better" (Alix).* Ensuring standards of care were followed for higher-acuity patients was prioritized above care for lower acuity patients. For instance, Keta shared *"you're with the sick patient more, you're trying to stabilize them and making sure that they're okay, but then that means that everything falls behind in the rest of the fast track area."*

Julia felt lower acuity patients do *"not require quite the same level of intensity when it comes to documentation."* Often participants did not have time to provide comfort measures such as *"making sure patients have their water and have their warm blanket" (Alix).* Alix felt *"physically unable to stay on top of everything… I don't think anyone is getting good care."* Gemma shared similar concerns: *"fast track area patients definitely get lower quality of care because they can be put in a room and left there for hours unattended because we're busy doing something else."* Keta did not find the standards of care including *"trying to reassess patients, and making sure their vitals are up to date, charting is up to date, every hour"* to be realistic.

Jimmy described his experience where "*instead of doing really good discharge teaching you'll have patients bouncing back"* because nurses lacked the time to provide quality discharge teaching. Three of the participants felt good discharge teaching is a part of quality care that should be provided to all patients. Providing good discharge teaching could help prevent patients from returning to the emergency department. For instance, Green felt *"a lot of times people are* *bounce backs or they're just super unsure about things so they just come back because they need that extra reassurance."*

Managing Flow.

In conjunction with providing efficient care participants worked to maintain the flow of patients in the fast track area. Participants felt a pressure to ensure patients were continuously being seen in a timely manner, and moved through the department. In Jimmy's experience,

> *You've got these orders you're working through, a waiting room still full, physicians with nowhere to see anybody else. And you think if I could work through these orders quicker, discharge a few, clean a few rooms, then I could move some more patients*.

Nurses felt an immense responsibility to maintain flow. For instance, Green shared, *"it's on the nurses to stay organized and keep the flow."* Participants discussed various challenges to maintaining flow including: physicians, when the acute side is full and overcrowding.

Four of the participants described the design of the fast track area as conducive to flow of patients. Five of the participants maximized space by getting patients *"to sit up in a chair and wait and get their treatments if they need to, in a chair rather than in a bed in a patient bed in our, in our fast track area" (Keta).* Julia, Lynn, and Keta felt that, while the space was designed well, it was up to the nurses to utilize the space to maintain flow. Moving patients to a chair for treatments or to await diagnostics opened the bed for new patients to be seen. In Julia's experience *"most of our patients, appreciate that we manage the space that way to maximize our patient turnover and speed at which we're able to provide care."* Utilization of the space to create the greatest amount of capacity was important in the nurses' role to maintain continuous flowing through the fast track area.

Lynn and Keta found it challenging at times to create flow given their limited resources. Keta shared *"you have so many things going on and you're trying to create movement, like,* *trying to make sure doctors are seeing the patients that are waiting outside in the waiting room."* Participants felt an immense pressure to create movement. Keta, Lynn, Julia, and Gemma found it difficult to maintain flow because demand exceeded capacity. For instance, Gemma said *"there's just never enough space for all the patients we have."* In their experience more treatment spaces were needed, whether it be rooms for patients, or a larger waiting area.

Seven of the participants speculated that the physician is a determinant for their workload and flow. In their experience it was important to have *"a physician who is mindful of the volume and the demand on the nurses" (Julia).* Fast track area nurses really enjoyed working with physicians who were conscientious of the nurses' current workload and the amount of time that orders would take to complete. For example, Gemma said that *"having docs who understand that and like prioritize giving IMs or sublingual medication, makes our life over there run a lot more smoothly."* Mindful ordering supported nursing staff in providing quality and timely care to patients.

Nurses felt efficiency was negatively impacted by the ordering unnecessary diagnostics, in particular CT scans. From Lynn's experience *"there are some physicians that are well known, that everybody's going to have IVs, a bunch of drugs, and CT scans for minor things or ultrasound."* The accumulation of orders and patients made it difficult for nurses to move patients through the department. Participants deemed a number of the interventions unnecessary, leading to frustration because of the challenge it caused for them to provide quality, timely care. Being conscientious of the current pressures on nurses, and ordering mindfully, alleviated some of the pressure on nurses and helped them to provide timely quality care.

Three of the participants felt higher acuity patients were a barrier to flow in the fast track area. Higher acuity patients *"block a bed for an extended period of time. Patients awaiting* *consults and diagnostics means we have less beds to see the less acute patients expeditiously" (Julia).* As Julia mentioned, bed blocking resulted in less capacity for the fast track area nurses to see appropriate patients in a timely manner. Nurses become *"stuck with the sick patient… which means that everything falls behind in the rest of the fast track area" (Keta)*. Flow needed to be maintained to help nurses provide quality, efficient care to patients.

Three of the participants were frustrated that some of the COVID policies made it more difficult for them to maintain patient flow. Participants felt the broad list of symptoms included in the COVID screening tool resulted in isolation for a number of their patients. For instance, Alix found it *"frustrating that the COVID screening criteria, basically every single person that comes in the fast track is deemed positive."* Frustration was related to the increased workload and barrier to flow imposed by the COVID policies, Alix felt were unnecessary. Melissa also felt similarly, *"were needing to isolate people for simple things you know even just when they're vomiting because they have abdominal pain, but they have appendicitis."* Isolation impeding flow became frustrating for nursing staff, because they were not able to complete their role of maintaining flow in the fast track area.

Sub-Theme Three: Resiliency

Keta, Gemma and Green named a variety of processes that are in place to support staff. Keta also described hope for better care through interventions such as *"a group of nurses and staff that meet to try and improve quality of care."* Participants clearly experienced moral distress from both the pressure they put on themselves to meet a quality care ideal, and the public view of the quality care provided. Alix appeared to experience ongoing moral distress. For instance *"the guidelines are a lofty goal that we'll never be able to achieve… it's not feasible in fast track, so we have bad outcomes lots of times there" (Alix)*. Alix described *"feeling like* *you're not able to give them the care they need is the most stressful part."* While Alix experienced ongoing moral distress from not being able to provide a standard of care, the other participants felt there were supports in place and they had a degree of control over their situation. The stress appeared to be situational, because Green also felt it was *"hard to say you need more resources in the fast track area, because it is the non acute area… most of the patients can wait two to four hours to be seen."* Overall, Green appeared to feel care provided was adequate. Green also shared that nurses in the emergency department could *"augment and there's never any pushback… which is really nice."* While Green experienced moral distress at times, she felt empowered and indicated there are supports in place for the nursing staff to build resiliency including the ability to increase their staffing when required. Staff were supported in their decision to increase their staffing as they saw required. Resiliency was experienced through good team members, and resetting.

Team Members.

Six of the participants identified having good team members as integral to providing quality and efficient care. Having a good team member could help offset the workload. For instance, Melissa said *"one of the biggest factors that determines how the day is going to go is the other staff you're with."* Team members included several disciplines: doctors, unit clerks, housekeepers, other nurses and volunteers, all of which were key aspects of the team in the fast track area. Alix, Green, and Jimmy really appreciated when housekeepers were aware of what was occurring in the fast track area and floated over to help clean rooms.

Good team members included administration who helped participants address challenges to balancing quality and efficiency. Four of the participants named experiences where they were supported by their manager and educators in addressing their concerns. For instance, when issues are brought up *"it's usually, what can we do to make it better, or you know at least you're being heard if you have issues" (Green).* Keta shared, *"there's always meetings with the work department to try and improve fast track or just how to improve care in the emergency department."* While staff felt helpless at times during their shifts, they felt supported by management in looking for solutions.

Melissa, Lynn, Keta, and Alix feel like good communication between team members was critical in handling the fast pace and volume of patients. Good communication was associated with better organization and quality care for patients. Both verbal and written forms of communication were integral to keeping all team members up to date with the patient plan and maintaining flow. For instance *"what you put on the chart is important, what color of ink that you put on the chart is important. All of this is communication between nurses" (Alix).* Given the heavy workload and lack of time in the fast track area, nurses became frustrated when they ended up doing work twice because of a breakdown in communication. Lynn felt that communication extended beyond team members to family members; keeping family members updated is an important aspect of delivering quality care. Good communication within the team and with patients was conducive to quality care being provided to patients and decreased workload for nursing staff.

Alix and Lynn felt that having a dedicated fast track area physician would lead to a steady pace, helping nurses to better balance quality and efficiency. Lynn shared that *"the physicians are the drivers of the work. If we have the right amount of physician resources to that area that can be working in that area."* Alix felt similarly that *"a dedicated ED2 physician…would help with flow."*

Resetting.

When Jimmy and Lynn used resets to assess what needed to be accomplished and prioritize tasks. For instance, Jimmy "*reminded himself that new order can sit in the rack for a minute while I go re-evaluate these other three patients."* Lynn would remind herself *"this isn't all about a speed contest, and you know nobody's dying out there, they'll be seen, we just have to manage and prioritize who gets seen first."* The pause gave Lynn and Jimmy time to decide how to prioritize efficiency and quality.

Summary

During the interviews fast track area nurses shared their experiences working in the fast track area. Through analyzing the data, the overarching theme of moral distress appeared, described by sub-themes including: stretched to a breaking point, balancing act, and resiliency. Participants experienced moral distress because of the numerous roles they were trying to provide to patients with inadequate staffing resources. Participants were trying to be the nurse, unit clerk, housekeeper, in addition to filling a community need for any lack of community health services, leading to an overwhelming workload and moral distress. Balancing act describe how participants strive to balance quality care and efficiency, and how they struggle with moral distress when they feel unable to provide both efficient and quality care. Resiliency describes supports and skills in place to help nursing staff manage moral distress and areas where they are resilient. In conclusion, while participants experienced moral distress, they also displayed areas of resiliency.

CHAPTER 5: DISCUSSION

The findings suggestthat emergency nurses in this study who work in the fast track area experience moral distress when they feel unable to provide quality care to patients. Wolf et al. (2016) describe that emergency nurses lose their image of themselves as a “good nurse” when they feel unable to fulfill their obligations due to time constraints and inadequate staffing. Participants from the current study describe a number of instances where they experienced moral distress because they felt unable to provide the quality of care they wanted to patients. Current study findings suggest nurses felt constrained by their obligations to fulfill a number of roles and responsibilities, to a point where their workload became overwhelming. Similar to other studies participants described moral distress underlying their experience working in the emergency fast track area, particularly during times of overcrowding when the volume and acuity of patients increases (Chen et al., 2018; Lin et al., 2019; Tubbert et al., 2016). Sub-themes supporting moral distress as a central theme emerged including stretched to a breaking point, balancing act, and resiliency. Future research and practice recommendations are described below.

Overarching Theme: Moral Distress

Wolf et al. (2016) described moral distress experienced by emergency nurses as feeling unable to meet their moral obligation to provide safe and quality care to patients. Moral distress occurred when participants from the present study felt stretched beyond the point of being able to provide quality care to patients. Similar to Chen et al.’s (2018) findings, there were moments where participants felt powerless over the mismatch between supply and demand. Nurses from the present study adjusted their care by foregoing parts of care to keep pace with demand. Wolf et al. (2016) found that, in nurses’ experiences, they would forego proper documentation because there was simply not enough time to both document care thoroughly and treat patients. Feeling stretched to the limit is a driver for moral distress in emergency nurses (Wolf et al., 2016). Findings from the current study, Chen et al. (2018), and Wolf et al. (2016) jointly show that moral distress can occur at times in the emergency department when demand exceeds the capacity of nurses. Wolf et al. (2016) described how unrealistic expectations placed on emergency nurses can lead to distress because they felt unable to provide high quality care to patients. Similar to Wolf et al.'s (2016) findings, nurses from the present study felt moral distress at times because they wanted to provide quality care to patients, but did not feel they had the time to do so. While participants from the present study experienced situation moral distress, they also described a number of processes in place to address their needs and make changes.

Concerns arose around safety and the inability to provide quality care to patients, similar to Chen et al.'s (2018) findings on nurses' experiences with overcrowding in the fast track area. However, nurses from the present study felt they were able to enact changes with the support of administration and had a good team, resulting in resiliency. Similar to Tubbert's (2016) findings Lynn and Jimmy showed resiliency through the ability to pause and take control of their workload. Overall, while participants experienced moral distress, they did not experience the degree of hopelessness nurses from Chen et al.'s (2018) and Wolf et al.'s (2016) studies experienced because supports were in place. The current site of study created a setting of resiliency through interventions such as administration support and team work.

Stretched to a Breaking Point

Participants working in the fast track area felt stretched to a breaking point by their numerous perceived roles and responsibilities, leading to moral distress. Fast track areas were developed with the goal of treating lower acuity patients more efficiently by separating them from higher acuity patients (Ferrand et al., 2018). Consistent with findings from Laker et al.

(2014) and Ward et al. (2014), participants felt the need to be flexible in the fast track area both in individual staffing resources and design. However, given the higher patient to nurse ratio in the fast track area, providing care to higher acuity patients led to participants experiencing moral distress when they felt unable to provide quality care. Fast track area nurses became overwhelmed because their staffing levels remained the same, while the volume and acuity of patients increased. Similar to findings from Chen et al.'s (2018) and Tubbert (2016), when nurses were unable to provide quality care moral distress occurred.

Inadequate Staffing

These participants felt stretched to a breaking point because of their numerous roles and inadequate staffing. Contrary to other research studies (De Freitas et al., 2020; Wise et al., 2020), in the current study registered nurses' felt a substantial amount of their time was devoted to non-nursing tasks including housekeeping and administrative tasks normally completed by the unit clerk. Current research is focussed on maximizing and expanding the scope of registered nurses so they can be utilized to their full potential (De Freitas et al., 2020). Utilizing nurses for other roles has inadvertently led to less capacity for nurses to engage in important nursing tasks and less quality patient care. Feeling unable to provide quality care to patients leads to moral distress (Tubbert, 2016; Wolf et al., 2016).

Nurses from the present study felt overwhelmed by the amount of time they were spending on housekeeping and unit clerking tasks. Lack of break coverage at the site of study led to a single nurse being left alone – without a unit clerk or housekeeper for support. Similar to the study by De Freitas et al. (2020), participants from the present study felt inadequate staffing of the fast track area made it difficult for nurses to complete basic nursing tasks.

While the current study was small and focussed on a single site, further research may need to be done to see if nurses are being utilized to their full capacity in other fast track areas. Adding support staff has the potential to reduce workload, leading to nurses feeling less overwhelmed, and as a consequence a lower incidence of moral distress. Furthermore, Wise et al. (2020) found that when there is enough availability of nurses, sharing physician duties such as ordering diagnostics can contribute to better quality care, resulting in job satisfaction (Chen et al., 2018).

Overwhelmed by High Acuity

Similar to Eriksson et al.'s (2018) findings, participants from the current study described concerns about the inability to properly care for higher acuity patients in the fast track area. Nurses shared a sense of duty to provide care to higher acuity patients (Chen et al., 2018). Caring for higher acuity patients in the fast track area was challenging for participants because they are more labor-intensive than lower acuity patients. Similar to Morrish's (2013) findings, participants from the current study felt the volume of lower acuity patients increased while nurses tended to higher acuity patients. Congruent with findings from Chen et al. (2018) and Wolf et al. (2020), participants experienced guilt and moral distress when they were unable to provide quality care to patients.

Findings from the current study were consistent with Kim et al.'s (2015) findings that serious negative outcomes were rare when higher acuity patients ended up in the fast track area. While rare, when negative outcomes occurred, they were serious with one participant sharing they walked in on a deceased patient. The participant did not identify if a debriefing occurred after the patient was found deceased. However, cases where mortality or other severe outcomes occurred at the site of study should be audited to assess if the patient being misallocated influenced outcomes.

Overwhelming Patient to Nurse Ratio

On a medical or surgical nursing floor, the patient ratio is typically four patients to one nurse. In an intensive care unit, the ratio is one or two patients per nurse. Yet, nurses working in the fast track area often cared for eight-to-fifteen patients or more at any given time, which the majority of these participants felt was manageable with lower acuity patients. Understanding the patient to nurse ratio in the fast track area, by comparison to medical and surgical floors, helps to enhance perspective on how and why fast track area nurses can become quickly overwhelmed.

Consistent with findings from Chen et al. (2018), when treating lower acuity patients, the fast track area flowed well. However, there was often a mismatch between the volume of patients and staffing at a given time, leading to moral distress (Chen et al., 2018; Tubbert, 2016; Wolf et al., 2016). Participants from the present study enjoyed working with only lower acuity patients, and felt a sense of satisfaction with the volume of patients they were able to treat in a short period of time.

Catch All Bin

Congruent with findings from Chen et al.' study (2018), participants felt a number of lower acuity patients were seeking care in the emergency department. The expanding number of lower acuity patients seeking care in the emergency department has led to an unnecessary strain on emergency nurses (Chen et al., 2018). Participants from the current study described feeling proud of the support they offered community, but felt overwhelmed by overcrowding, leading to moral distress (Lin et al., 2019; Wolf et al., 2016). Participants from the current study felt patients needed more access to primary health care and education in the community to help support the emergency department.

Findings from the current study were contradictory to research studies by Maeng et al. (2017) and Palmer et al. (2014) who found that having a primary care physician did not appear to decrease the frequency or number of visits made to the emergency department. Findings from Burns (2017) and Unwin et al. (2016) suggest a number of lower acuity patients seek care at the emergency department due to ease of access and faster results.

Participants speculated better community education could lead to a decreased number of nonurgent visits. However, Van den Heede and Van de Voorde (2016) completed a systematic review on interventions utilized to reduce emergency visits and found contradictory results on if public education can result in a reduction in emergency visits.

Contributions from current findings suggest better community resources are needed for patients, future research needs should focus on which community resources will result in a decrease in emergency visits. Given that current research is incongruent with the experience of fast track area nurses at the site of study, more research needs to be done why lower acuity patients seek care at the emergency department. The information collected from that research could be utilized to help address patient needs within the community.

The Balancing Act

Participants from the present study found it difficult to balance quality care and efficiency. Similar to findings from Chen et al. (2018), balancing quality care and efficiency became particularly difficult during times of overcrowding and while treating higher acuity patients. Participants from the present study described increasing volume and acuity of patients as factors contributing to an overwhelming workload. Congruent with findings from Chen et al.

(2018), dissatisfaction and moral distress occurred when nurses felt unable to provide quality care.

Participants from the present study found it difficult to maintain the pace of the fast track area and provide quality care, similar to findings from Wolf et al. (2016). When demands outweighed capacity, participants felt the need to omit aspects of care. Foregoing aspects of care when there is a higher patient to nurse ratio is supported by Nantsupawat et al. (2022), who found a direct correlation between increased patient load and missed aspects of care. Over time fast track area nurses from the present study have become comfortable with lowering standards of care. Comfort came from participants maintaining aspects of their practice they felt were required to provided safe care. Perspectives varied amongst participants about which aspects of care were okay to omit, leading to variations in processes and standards of care.

Standards are created to regulate the approach-to-care and ensure a minimal level of care is provided to patients (CRNA, 2022). Where there was variation in processes, concerns were raised that important aspects of care were missed. There were times where participants struggled to maintain the standards of care, given the volume of patients and varying acuity levels. Frustration arose when participants felt blamed or responsible for being unable to meet expectations they viewed as unattainable. To address the frustration, administration could work with staff towards both attainable and acceptable standards of care. Understanding universally which aspects of care are okay with omitting within the department will lead to a consistent standard of care.

Managing Flow

Findings from the current study suggest the pressure to maintain flow in the fast track area falls primarily on registered nurses. Previous studies have focussed on how the implementation of a fast track area improves length of stay and time to physician (Chrusciel et al., 2019; Copeland & Gray, 2015; Hajjarsaraei et al., 2018; Kaushal et al., 2015; Lee et al., 2015; Pierce & Gormley, 2016; Sayah et al., 2016; Yarmohammadian et al., 2017). Consistent with findings from Chen et al. (2018), participants felt it was encouraging to work with and see appropriate fast track area patients moving through the department. Given it was the nurses' job to ensure flow, parallel to other studies (Copeland & Gray, 2015; Gardner et al., 2018; Gill et al., 2018; Hajjarsaraei et al., 2018 Khalifa, 2016; Kim et al., 2017; Patey et al., 2019; Smith et al., 2018 Steward et al., 2017; Yarmohammadian et al., 2017) participants felt a pressure to maintain throughput of patients through the fast track area.

Participants from the present study offered important insights into barriers to flow in the fast track area. Similar to Wolf et al. (2016), participants felt that a number of challenges outside of nursing control led to challenges in facilitating the flow of patients. In the experience of participants, physician ordering practices were seen as a primary driver for flow of patients. Registered nurses felt the practice of over-ordering diagnostic imaging tests could negatively impact flow and increase the workload. The notion that ordering diagnostic imaging tests could negatively impact the flow of the fast track area was congruent to a study by Gill et al. (2018), which found diagnostic imaging was one of the leading factors resulting in a fast track area stay greater than 4 hours. To date, the Choosing Wisely Canada Emergency Medicine Group has focussed on reducing low-yielding tests in practice and a number of their initiatives surround diagnostic imaging (Canadian Association of Emergency Physicians, 2021). Integrating evidence from the Choosing Wisely Canada Emergency Medicine Group into the site of study practices has the potential to improve flow. Physicians, nurses, and administration could work together to identify ordering practices of low-yield that impede flow and work to decrease those practices in the fast track area.

Resiliency

Resiliency to moral distress in participants was built through collaboration amongst team members, communication, and supportive administration. Similar to Lin et al.'s (2019) findings, collaboration between team members facilitates the management of heavy workloads and resiliency. Congruent with Nugus and Braithwaite's (2010) findings, having a good team in the emergency department was crucial to balancing workload. Nugus and Braithwaite (2010) concluded a balance could be found between quality and efficiency when the emergency department consisted of a good team. Participants defined several team members as crucial for providing quality care in the fast track area; this includes housekeepers, nurses, physicians, porters, and unit clerks.

Similar to other studies (Bagnasco et al., 2018; Conroy, 2018; Lin et al., 2019) participants from the present study felt communication between team members and patients was key to reducing safety risks. Due to the large volume of patients and quick pace of the fast track area, both verbal and written communication were identified as important. Nursing staff needed to be able to quickly identify what needed to be done and where patients were at in the care continuum. Effective communication with patients, physicians and other team members facilitated efficient, quality care for patients. Effective communication includes both verbal and non-verbal forms of communication including documentation, and verbal communication to patients and other providers (Casey & Wallis, 2011). Effective communication also encompasses confirmation that everyone involved understands what is occurring (Casey & Wallis, 2011).

Contrary to Sodeify et al. (2013) findings, participants from the current study felt the administrative team was an important team member in invoking positive changes. Support from administration led to participants feeling empowered within the emergency department and supported in their goal to provide quality care. Wolf et al. (2016) found that feelings of hopelessness and stress arise when nurses do not feel supported by administration. Similar to Clark et al. (2022), current study findings support that despite challenges, job satisfaction can be drawn from feeling heard and empowered. While the administration at the current site has worked to initiate a number of positive changes, further work needs to be done. Nurses could work in conjunction with administration at the site of study to identify how a better balance can be found between quality care and efficiency, particularly when higher acuity patients end up in the fast track area. Standards and processes could be developed that both staff and administration are content with.

Resetting

Similar to results from Clark et al.'s (2021) qualitative study, more experienced nurses from the present study experienced resiliency during times of overcrowding. Lynn and Jimmy, more experienced staff from the present study used pauses to reprioritize, which patients and interventions they were going to address first. Tubbert (2016) found resiliency came from not only resetting during a busy shift, but also from looking at their work life balance, and reprioritizing to create a manageable balance. Administration could support staff by encouraging them to have a healthy work life balance to reduce stress (Tubbert, 2016).

Recommendations

Practice Recommendations

Current findings suggest participants experience moral distress when they feel unable to fulfill their perceived responsibilities. Two key areas need to be addressed at the site of the study to support a balanced workload and reduce moral distress in fast track area nurses. Participants felt they were fulfilling too many roles in the current staffing model, leading to a disconnect between their capacity and ability to fulfill their obligations. Previous studies have found higher patient-to-nurse ratios lead to lower quality care (Nantsupawat et al., 2022), which can result in moral distress (Tubbert, 2016). Administration can look at those two aspects of staffing to help create a more supportive model going forward. One example could be adding support staff such as unit clerk break coverage and a housekeeper dedicated to the fast track area during busier times of the day. Per the participants another recommendation would be to provide break coverage, with the goal of having no less than two nurses in the fast track area at all times. Having adequate resources to manage the large patient load of the fast track area is key to providing both quality and efficient care.

A repetitive theme from the current study is staff burnout and distress when they feel unable to provide an ideal quality of care to patients. Inadequate staffing, lack of resources, hospital policies and ineffective communication were described as causes of moral distress (Saver, 2022). Participants from the present study described some signs of distress and burn out including guilt and powerlessness. Creating a healthy work environment with adequate staffing is one way to help address moral distress (Saver, 2022; Wolf et al., 2016). Debriefing with staff should be encouraged after instances where they experience moral distress to understand how they could feel better supported, and what they feel could be done differently.

Participants from the current study felt empowered by management to make changes, which adds to resiliency in nurses (Lamiani et al., 2017). Moving forward, management could collaborate with staff to create achievable policies and guidelines. Participants from the present study felt overwhelmed and unable to meet the current standards of care. Collaboration would ensure a clear, achievable standard of care within the fast track area.

An assessment can be done to see if some the tasks could be redistributed so nursing staff have more time to provide quality care. Adding staff, such as housekeeping, could help create more time for nurses to complete nursing tasks or maybe even expand their role as suggested in other research studies (De Freitas, 2020; Wise et al., 2020) to help facilitate flow. Reducing the numerous responsibilities of registered nurses may lead to a more balanced workload, and the ability to provide quality care.

Flexibility to treat higher acuity patients is clearly an important aspect of the fast track area. Findings from the present study raise the question as to how the fast track area can be better adapted to provide care to higher acuity patients when necessary. Currently flexibility of the fast track area of study led to an imbalance between capacity and workload for nurses. Some resources need to be flexible, but at the same time there is need for dedication of certain resources to ensure each area of the department sustains the capacity needed to treat patients. One resource that participants found important to dedicate is a fast track area physician – which was needed to provide continuous flow. Without the dedicated physician, patients could quickly become backlogged. Making matters worse, nurses became overwhelmed with orders when a physician later came to attend to fast track area patients. Creating a better balanced workload could lead to less times where nurses feel overwhelmed, and in effect less moral distress.

Another significant finding that aligns with other research studies (Chen et al., 2018; Maeng et al., 2017; Palmer et al., 2014) is that a number of lower acuity patients seek care in the emergency department. In the current research study, nurses speculated about what they felt led to lower acuity patients ending up in the fast track area. Data could be collected to assess community needs, with the goal of addressing some of the community challenges identified by participants from the current study.

Research Recommendations

To date, there has been limited research into understanding registered nurses' experiences working in the fast track area. Findings from the current study have added insights into the moral distress participants experience when they feel unable to provide quality care. Previous studies (Chrusciel et al., 2019; Copeland & Gray, 2015; Hajjarsaraei et al., 2018; Kaushal et al., 2015; Lee et al., 2015; Pierce & Gormley, 2016; Sayah et al., 2016; Yarmohammadian et al., 2017) have shown efficiency improves when fast track areas are used as designed – for lower acuity patients. Present study findings suggest that circumstances lead to the requirement for nurses to treat higher acuity patients in the fast track area, particularly during times of overcrowding. Given inadequate staffing, treating higher acuity patients leads to an overwhelming workload and moral distress (Wolf et al., 2016).

Previous researchers (Ferrand et al., 2018; Hajjarsaraei et al., 2018; Laker et al., 2014; Ward et al., 2014) have assessed treating higher acuity patients in the fast track area and flexibility of resources such as staffing between the fast track area and acute side of the emergency department. Current findings suggest nurses feel overwhelmed when treating higher acuity patients in the fast track area. Moral distress and job dissatisfaction occur when nurses feel unable to provide quality care to patients (Wolf et al. 2016). Further research should be done to examine adequate staffing in the fast track area and how nurses can be supported to meet the increasing demands.

To support nurses particularly during times of overcrowding, more resources are required as the acuity and volume of patients increases. Further research needs to be done to understand how to create the capacity required to treat higher acuity patients in the fast track area. Potential areas of focus identified in the current study are the staffing model, dedication of certain resources, and re-examining current standards.

Conclusion

In conclusion, participants felt fast track areas work well when utilized correctly for lower acuity patients. Unfortunately, pressures to create space for patients – due to overcrowding – lead to higher acuity patients in the fast track area, and nurses experiencing moral distress. Participants from the present study described a number of roles and responsibilities fast track area nurses undertake outside of their scope. Some responsibilities described by participants were unit clerking, house keeping, and treating higher acuity patients when required. Participants from the current described their struggle with balancing quality care and efficiency in the fast track area. Moral distress occurred when participants felt unable to provide quality care to their patients (Chen et al., 2018; Tubbert, 2016). Resiliency was described through collaboration with team members and administration. Current findings suggest more research needs to be done to understand how fast track area nurses can best be supported to decrease moral distress during times of overcrowding.

REFERENCES

Alberta Health Services. (n.d.). Emergency Department (ED) Wait to see a Physician. Retrieved From https://www.albertahealthservices.ca/assets/about/publications/ahs-pub-pr-2015-16-q4-detail-ed-wait-physician.pdf

Alberta Health Services. (n.d.). Mental Health Help Line. Retrieved from Alberta Wide – Mental Health Help Line | Alberta Health Services

Alberta Health Services. (2017). Q3 Year-to-Date Performance Measure Update. Retrieved From https://www.albertahealthservices.ca/assets/about/publications/ahs-pub-pr-2016-17-q3.pdf

Allen, R. E. S., & Wiles, J. L. (2016). A rose by any other name: Participants choosing research pseudonyms. *Qualitative Research in Psychology*, 13(2), 149-165. https://doi.org/10.1080/14780887.2015.1133746

Al-Zaru, I. M., Oweis, A., & Gharaibeh, H. F. (2013). Cultural definitions of quality of care: Perspectives of 83nnovate83 patients. *Journal of Research in Nursing*, 18(4), 307-317. https://doi.org/10.1177/1744987111406671

Basu, S., Harris, A., Mason, S., & Norman, J. (2020). A longitudinal assessment of occupational stress in Emergency Department Nursing Staff. *Journal of Nursing Management (John Wiley & Sons, Inc.)*, 28(1), 167–174. https://doi-org.ezproxy.uleth.ca/10.1111/jonm.12910

Blondell, K., O'Brien, D., Williams, A., & Jelinek, G. (2006). Impact of streaming "fast track" emergency department patients. *Australian Health Review*, 30(4), 525-32. https://doi.org/10.1071/AH060525

Bonello, M., & Meehan, B. (2019). Transparency and coherence in a doctoral study case analysis: Reflecting on the use of Nvivo within a 'framework' approach. *The Qualitative Report*, 24(3), 483-498.

Bracken, S. (2010). Discussing the importance of ontology and epistemology and awareness in practitioner research. University of Worcester.

Bradshaw, C., Atkinson, S., & Doody, O. (2017). Employing a qualitative description approach in health care research. *Global Qualitative Nursing Research*, 4, 233339361774228-2333393617742282. Doi:10.1177/2333393617742282

Braun, V., & Clarke, V. (2021). To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales. *Qualitative Research in Sport, Exercise and Health*, 13(2), 201-216. https://doi.org/10.1080/2159676X.2019.1704846

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101. Doi:10.1191/1478088706qp063o

Burns, T. R. (2017). Contributing factors of frequent use of the emergency department: A synthesis. *International Emergency Nursing*, 35, 51-55. https://doi.org/10.1016/j.ienj.2017.06.001

Canadian Association of Emergency Physicians. (2013). *Emergency department overcrowding and access block [Position statement]*. Retrieved from https://caep.ca/wp-content/uploads/2016/03/cjem_2013_overcrowding_and_access_block.pdf

Canadian Association of Emergency Physicians & National Emergency Nurses Association. (2013). *Emergency Department Overcrowding [Joint position statement]*. Retrieved from https://nena.ca/w/wp-content/uploads/2014/11/ED-Overcrowding2.pdf

Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences, & Humanities Research Council. (2018). *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*. Retrieved from tcps2-2018-en-interactive-final.pdf (ethics.gc.ca)

Casey, A., & Wallis, A. (2011). Effective communication: Principle of nursing practice E. *Nursing Standard*, 25(32), 35-37. https://doi.org/10.7748/ns2011.04.25.32.35.c8450

College of Registered Nurses of Alberta (CRNA). (2022). *Standards for RNs and NPs.* CRNA. Retrieved August 27, 2022. https://nurses.ab.ca/protect-the-public/standards-for-rns-and-nps/#:~:text=The%20CRNA%20develops%20standards%20that,safe%2C%20competent%20and%20ethical%20care.

Carcary, M. (2020). The research audit trail: Methodological guidance for application in practice. *Electronic Journal of Business Research Methods*, 18(2), 166-177. https://doi.org/10.34190/JBRM.18.2.008

hafe, R. (2017). The value of qualitative description in health services and policy research. *Healthcare Policy*, 12(3), 12-18.

Charmaz, K. (2014). *Constructing grounded theory*. London: Sage Publications.

Chen, L., Lin, C., Han, C., Hsieh, C., Jo Wu, C., & Liang, H. (2018). An interpretative study on nurses' perspectives of working in an overcrowded emergency department in Taiwan. Asian Nursing Research, 12(1), 62-68. https://doi.org/10.1016/j.anr.2018.02.003

Chrusciel, J., Fontaine, X., Devillard, A., Cordonnier, A., Kanagaratnam, L., Laplanche, D., & Sanchez, S. (2019). Impact of the implementation of a fast-track on emergency department length of stay and quality of care indicators in the Champagne-Ardenne region: A before–after study. *BMJ Open*, 9(6), e026200-e026200. Doi:10.1136/bmjopen-2018-026200

Clark A.M. (1998). The qualitative-quantitative debate: moving from positivism and confrontation to post-positivism and reconciliation. *Journal of Advanced Nursing (Wiley-Blackwell)*, 27(6), 1242–1249. https://doi-org.ezproxy.uleth.ca/10.1046/j.1365-2648.1998.00651.

Clark, P., Crawford, T. N., Hulse, B., & Polivka, B. J. (2021). Resilience, Moral Distress, and Workplace Engagement in Emergency Department Nurses. *Western Journal of Nursing Research,* 43(5), 442–451. https://doi-org.ezproxy.uleth.ca/10.1177/0193945920956970

Clark, P., Hulse, B., & Polivka, B. J. (2022). Resilience, moral distress, and job satisfaction driving engagement in emergency department nurses: A qualitative analysis. *The Journal of Nursing Administration*, 52(2), 112-117. https://doi.org/10.1097/NNA.0000000000001111

Collingridge, D. S., & Gantt, E. E. (2019). The quality of qualitative research. *American Journal of Medical Quality*, 34(5), 439-445. https://doi.org/10.1177/1062860619873187

Connelly, L. M. (2016). Trustworthiness in qualitative research. *Medsurg Nursing*, 25(6), 435-436.

Copeland, J., & Gray, A. (2015). A daytime fast track improves throughput in a single physician coverage emergency department. *CJEM*, 17(6), 648-655. Doi:10.1017/cem.2015.41

Costa, L. B. M., & Godinho, F. M. (2016). Lean healthcare: Review, classification and analysis of literature. *Production Planning & Control*, 27(10), 823-836. Doi:10.1080/09537287.2016.1143131

Creswell, J. & Poth, C. N. (2018). *Qualitative inquiry & research design: Choosing among five approaches*. (4^{th} ed.). Thousand Oaks, CA: Sage

Creswell J. W. (2014). *Research design: Qualitative, quantitative, and mixed methods approaches.* Thousand Oaks, CA: SAGE Publications.

De Freitas, L., Goodacre, S., Rachel O'Hara, Thokala, P., & Hariharan, S. (2020). Qualitative exploration of patient flow in a 85nnovate85 emergency department. *BMJ Open*, 10(12) doi:http://dx.doi.org.ezproxy.uleth.ca/10.1136/bmjopen-2020-041422

De Kleijn, R., & Van Leeuwen, A. (2018). Reflections and review on the audit procedure: Guidelines for more transparency. *International Journal of Qualitative Methods*, 17(1), 160940691876321. Doi:10.1177/1609406918763214

Denny, E., & Weckesser, A. (2019). Qualitative research: What it is and what it is not: Study design: Qualitative research. *BJOG : An International Journal of Obstetrics and Gynaecology*, 126(3), 369-369. https://doi.org/10.1111/1471-0528.15198

Di Somma, S., Paladino, L., Vaughan, L., Lalle, I., Magrini, L., & Magnanti, M. (2015). Overcrowding in emergency department: An international issue. *Internal and Emergency Medicine,* 10(2), 171-175. Doi:10.1007/s11739-014-1154-8

Doetzel, C. M., Rankin, J. A., & Then, K. L. (2016). Nurse Practitioners in the Emergency Department Barriers and Facilitators for Role Implementation. *Advanced Emergency Nursing Journal*, 38(1), 43–55. https://doi-org.ezproxy.uleth.ca/10.1097/TME.0000000000000090

Doody, O., & Noonan, M. (2013). Preparing and conducting interviews to collect data. *Nurse Researcher*, 20(5), 28-32. https://doi.org/10.7748/nr2013.05.20.5.28.e327

Doyle, L., McCabe, C., Keogh, B., Brady, A., & McCann, M. (2020). An overview of the qualitative descriptive design within nursing research. *Journal of Research in Nursing*, *25*(5), 443–455. https://doi.org/10.1177/1744987119880234

Elamir, H. (2018). Improving patient flow through applying lean concepts to emergency department. *Leadership in Health Services*, 31(3), 293-309. Doi:10.1108/LHS-02-2018-0014

Emerson, R. W. (2015). Convenience Sampling, Random Sampling, and Snowball Sampling: How Does Sampling Affect the Validity of Research? *Journal of Visual Impairment & Blindness*, 109(2), 164–168.

Eriksson, J., Gellerstedt, L., Hillerås, P., Craftman, Å., Röda Korsets Högskola, & Hälsovetenskapliga institutionen. (2018). Registered nurses' perceptions of safe care in overcrowded emergency departments. *Journal of Clinical Nursing*, 27(5-6), e1061-e1067. https://doi.org/10.1111/jocn.14143

Farrokhi, F., & Mahmoudi-Hamidabad, A. (2012). Rethinking convenience sampling: Defining quality criteria. *Theory and Practice in Language Studies*, 2(4), 784. Doi:10.4304/tpls.2.4.784-792

Ferrand, Y. B., Magazine, M. J., Rao, U. S., & Glass, T. F. (2018). Managing responsiveness in the emergency department: Comparing dynamic priority queue with fast track. *Journal of Operations Management*, 58-59(1), 15-26. Doi:10.1016/j.jom.2018.03.001

Filser, L. D., Da Silva, F. F., & De Oliveira, O. J. (2017). State of research and future research tendencies in lean healthcare: A bibliometric analysis. *Scientometrics*, 112(2), 799-816. Doi:10.1007/s11192-017-2409-8

Gardner, R. M., Friedman, N. A., Carlson, M., Bradham, T. S., & Barrett, T. W. (2018). Impact of revised triage to improve throughput in an ED with limited traditional fast track population. *American Journal of Emergency Medicine*, 36(1), 124–127. https://doi-org.ezproxy.uleth.ca/10.1016/j.ajem.2017.10.016

Gasperini, B., Pierri, F., Espinosa, E., Fazi, A., Maracchini, G., & Cherubini, A. (2020). Is the fast-track process efficient and safe for older adults admitted to the emergency department? *BMC Geriatrics*, 20(1), 1–6. https://doi-org.ezproxy.uleth.ca/10.1186/s12877-020-01536-5

Gill, S. D., Lane, S. E., Sheridan, M., Ellis, E., Smith, D., & Stella, J. (2018). Why do 'fast track' patients stay more than four hours in the emergency department? An investigation of factors that predict length of stay. *Emergency Medicine Australasia*, 30(5), 641–647. https://doi-org.ezproxy.uleth.ca/10.1111/1742-6723.12964

Gray, L. M., Wong-Wylie, G., Rempel, G. R., & Cook, K. (2020). Expanding qualitative research interviewing strategies: Zoom video communications. *The Qualitative Report*, 25(5), 1292-1301.

Guba, E. G. (1992). Relativism. *Curriculum Inquiry*, 22(1), 17. https://doi.org/10.2307/1180091

Guba, E. G., & Lincoln, Y. S. (2005). *Paradigmatic Controversies, Contradictions, and Emerging Confluences.* In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (p. 191–215). Sage Publications Ltd.

Hajjarsaraei, H., Shirazi, B., & Rezaeian, J. (2018). Scenario-based analysis of fast track strategy optimization on emergency department using integrated safety simulation. *Safety Science*, 107, 9-21. Doi:10.1016/j.ssci.2018.03.025

Hurwitz, J. E., Lee, J. A., Lopiano, K. K., McKinley, S. A., Keesling, J., & Tyndall, J. A. (2014). A flexible simulation platform to quantify and manage emergency department crowding. *BMC Medical Informatics and Decision Making*, 14(1), 50. Doi:10.1186/1472-6947-14-50

Hwang, C. E., Lipman, G. S., & Kane, M. (2015). Effect of an emergency department fast track on Press-Ganey patient satisfaction scores. *The Western Journal of Emergency Medicine*, 16(1), 34-38. Doi:10.5811/westjem.2014.11.2176

Jackson, K. (2016). Y doesn't Gen Y ... Like 2 w8? *Australian Journal of Advanced Nursing*, 33(3), 29–37.

Jason. (2016) Sync.com: truly Canadian cloud storage. Retrieved from Sync.com: truly Canadian cloud storage

Jorgensen, K., Rendtorff, J. D., & Holen, M. (2018). How patient participation is constructed in mental health care: a grounded theory study. *Scandinavian Journal of Caring Sciences*, 32(4), 1359–1370. https://doi-org.ezproxy.uleth.ca/10.1111/scs.12581

Källberg, A., Ehrenberg, A., Florin, J., Östergren, J., Göransson, K. E., Högskolan Dalarna, . . . Omvårdnad. (2017). Physicians' and nurses' perceptions of patient safety risks in the emergency department. *International Emergency Nursing*, 33, 14-19. Doi:10.1016/j.ienj.2017.01.002

Kamp, K., Herbell, K., Magginis, W. H., Berry, D., & Given, B. (2019). Facebook recruitment and the protection of human subjects. *Western Journal of Nursing Research*, 41(9), 1270-1281. https://doi.org/10.1177/0193945919828108

Kaushal, A., Zhao, Y., Peng, Q., Strome, T., Weldon, E., Zhang, M., & Chochinov, A. (2015). Evaluation of fast track strategies using agent-based simulation modeling to reduce waiting time in a hospital emergency department. *Socio-Economic Planning Sciences*, 50, 18-31. Doi:10.1016/j.seps.2015.02.002

Khalifa, M. (2016). Utilizing Health Analytics in Improving Emergency Room Performance. *Studies in Health Technology & Informatics*, 225, 138–142. https://doi-org.ezproxy.uleth.ca/10.3233/978-1-61499-658-3-138

Kim, B. B. J., Delbridge, T. R., & Kendrick, D. B. (2017). Adjusting patients streaming initiated by a wait time threshold in emergency department for minimizing opportunity cost. *International Journal of Health Care Quality Assurance (09526862)*, 30(6), 516–527. https://doi-org.ezproxy.uleth.ca/10.1108/IJHCQA-10-2016-0155

Kim, S. W., Horwood, C., Li, J. Y., Hakendorf, P. H., Teubner, D. J. O., & Thompson, C. H. (2015). Impact of the emergency department streaming decision on patients' outcomes: Impact of emergency department streaming. *Internal Medicine Journal*, 45(12), 1241-1247. Doi:10.1111/imj.12918

Kim, H., Sefcik, J. S., & Bradway, C. (2017). Characteristics of qualitative descriptive studies: A systematic review. *Research in Nursing & Health*, 40(1), 23-42. Doi:10.1002/nur.21768

Laker, L. F., Froehle, C. M., Lindsell, C. J., & Ward, M. J. (2014). The flex track: flexible partitioning between low- and high-acuity areas of an emergency department. *Annals of emergency medicine*, *64*(6), 591–603. https://doi.org/10.1016/j.annemergmed.2014.05.031

Lamiani, G., Borghi, L., & Argentero, P. (2017). When healthcare professionals cannot do the right thing: A systematic review of moral distress and its correlates. *Journal of Health Psychology*, 22(1), 51-67. https://doi.org/10.1177/1359105315595120

Lee, N., Ahn, Y., Kim, Y., , J., Cho, K., Hwang, S., . . . Hong, C. (2015). Holiday fast-track reduced medical cost and length of emergency department stay: Preliminary report from a single secondary care hospital. *Hong Kong Journal of Emergency Medicine*, 22(2), 84-92. Doi:10.1177/102490791502200202

Lin, C.-C., Liang, H.-F., Han, C.-Y., Chen, L.-C., & Hsieh, C.-L. (2019). Professional resilience among nurses working in an overcrowded emergency department in Taiwan. *International Emergency Nursing*, 42, 44–50. https://doi-org.ezproxy.uleth.ca/10.1016/j.ienj.2018.05.005

Maeng, D. D., Hao, J., & Bulger, J. B. (2017). Patterns of multiple emergency department visits: Do primary care physicians matter? *Permanente Journal*, 21(2), 16-063. https ://doi.org/10.7812/TPP/16-063

Mahood, Q., Van Eerd, D., & Irvin, E. (2014). Searching for grey literature for systematic reviews: Challenges and benefits. *Research Synthesis Methods*, 5(3), 221-234. Doi:10.1002/jrsm.1106

Marks, A., Wilkes, L., Blythe, S., & Griffiths, R. (2017). A novice researcher's reflection on recruiting participants for qualitative research. *Nurse Researcher*, 25(2), 34-38. Doi:10.7748/nr.2017.e1510

Morrish, S. (2013). Streaming in the emergency department: An innovative care delivery design. *Canadian Journal of Emergency Nursing (CJEN)*, 36(1), 11–13.

Nantsupawat, A., Poghosyan, L., Wichaikhum, O., Kunaviktikul, W., Fang, Y., Kueakomoldej, S., Thienthong, H., & Turale, S. (2022). Nurse staffing, missed care, quality of care and adverse events: A cross-sectional study. *Journal of Nursing Management (John Wiley & Sons, Inc.)*, 30(2), 447–454. https://doi-org.ezproxy.uleth.ca/10.1111/jonm.13501

Neergaard, M. A., Olesen, F., Andersen, R. S., & Sondergaard, J. (2009). Qualitative description – the poor cousin of health research? *BMC Medical Research Methodology*, 9(1), 52-52. Doi:10.1186/1471-2288-9-52

Nugus, P., & Braithwaite, J. (2010). The dynamic interaction of quality and efficiency in the emergency department: *Squaring the circle? Social Science & Medicine (1982)*, 70(4), 511-517. https://doi.org/10.1016/j.socscimed.2009.11.001

Oliffe, J. L., Kelly, M. T., Gonzalez Montaner, G., & Yu Ko, W. F. (2021). Zoom interviews: Benefits and concessions. *International Journal of Qualitative Methods*, 20, 160940692110535. https://doi.org/10.1177/16094069211053522

Palmer, E., Leblanc-Duchin, D., Murray, J., & Atkinson, P. (2014). Emergency department use: Is frequent use associated with a lack of primary care provider? *Canadian Family Physician*, 60(4), e223-e229.

Patey, C., Norman, P., Araee, M., Asghari, S., Heeley, T., Boyd, S., Hurley, O., & Aubrey-Bassler, K. (2019). SurgeCon: Priming a Community Emergency Department for Patient Flow Management. *Western Journal of Emergency Medicine: Integrating Emergency Care with Population Health*, 20(4), 654–665. https://doi-org.ezproxy.uleth.ca/10.5811/westjem.2019.5.42027

Pierce, B. A., & Gormley, D. (2016). Are split flow and provider in triage models in the emergency department effective in reducing discharge length of stay? *Journal of Emergency Nursing*, 42(6), 487-491. Doi:10.1016/j.jen.2016.01.005Sayah, A., Lai-Becker, M., Kingsley-Rocker, L., Scott-Long, T.,

Ratnapalan, S., & Lang, D. (2020). Health care organizations as complex adaptive systems. *The Health Care Manager, 39*(1), 18-23. Doi:10.1097/HCM.0000000000000284

Ray, M., & Reinoso, H. (2019). A new process to improve throughput in the emergency department. *The Journal for Nurse Practitioners*, 15(10), e193-e196. Doi:10.1016/j.nurpra.2019.05.016

Robinson, K. S., Jagim, M. M., & Ray, C. E. (2005). Nursing workforce issues and trends affecting emergency departments. Nursing Management, 36(9), 46-53. Doi:10.1097/00006247-200509000-00011

Robinson, O. C. (2014). Sampling in interview-based qualitative research: A theoretical and practical guide. Qualitative Research in Psychology, 11(1), 25-41. https://doi.org/10.1080/14780887.2013.801543

Saldaña, J. (2016). *The coding manual for qualitative researchers*. Los Angeles, CA: SAGE

Sandelowski, M. (2000). Focus on research methods: Whatever happened to qualitative description? *Research in Nursing & Health*, 23, 334–340.

Santana D., Santana Lima, T. S., Lisboa C. F., Prata J., Llapa E. O., & dos Santos V. (2015). Occupational Stressors among Nurses Working in Urgent and Emergency Care Units. *Revista Gaucha de Enfermagem*, 36(1), 55–61. https ://doi-org.ezproxy.uleth.ca/10.1590/1983-1447.2014.01.39824

Saver, C. (2022). Managing moral distress. *Colorado Nurse*, 122(1), 14-15.

Sayah, A., Lai-Becker, M., Kingsley-Rocker, L., Scott-Long, T., O'Connor, K., & Lobon, L. F. (2016). Emergency department expansion versus patient flow improvement: Impact on patient experience of care. *Journal of Emergency Medicine*, 50(2), 339-348. Doi:10.1016/j.jemermed.2015.06.068

Smith, B., & Celona, C. A., Amaranto, A., Ferrer, R., Wieland, M., Abrams, S., Obusan, F., LoPuzzo, S., & Joy, V. (2018). Interdisciplinary Design to Improve Fast Track in the Emergency Department. *Advanced Emergency Nursing Journal*, 40(3), 198–203. https://doi-org.ezproxy.uleth.ca/10.1097/TME.0000000000000199

Sodeify, R., Vanaki, Z., & Mohammadi, E. (2013). Nurses'experiences of perceived support and their contributing factors: A qualitative content analysis. *Iranian Journal of Nursing and Midwifery Research*, 18(3), 191-197.

Stein, J. G. (2002). *The cult of efficiency*. Toronto, ON: Anansi.

Stevens, L., Fry, M., Browne, M., & Barnes, A. (2019). Fast track patients' satisfaction, compliance and confidence with emergency department discharge planning. *Australasian Emergency Care*, 22(2), 87–91. https://doi-org.ezproxy.uleth.ca/10.1016/j.auec.2019.01.004

Steward, D., Glass, T., & Ferrand, Y. (2017). Simulation-Based Design of ED Operations with Care Streams to Optimize Care Delivery and Reduce Length of Stay in the Emergency Department. *Journal of Medical Systems*, 41(10), 1–8. https://doi-org.ezproxy.uleth.ca/10.1007/s10916-017-0804-6

Straughair, C. (2019). Reflections on developing a conceptual framework to support a constructivist grounded theory study on compassion in nursing. *Nurse Researcher*, 27(1), 22-26. https://doi.org/10.7748/nr.2019.e1621

Troxell, P. (2014). Emergency department overcrowding globally: The impact of non-urgent utilization. *Annals of Global Health*, 80(3), 212-212. Doi:10.1016/j.aogh.2014.08.137

Tubbert, S. J. (2016). Resiliency in emergency nurses. *Journal of Emergency Nursing*, 42(1), 47-52. https://doi.org/10.1016/j.jen.2015.05.016

Unwin, M., Kinsman, L., & Rigby, S. (2016). Why are we waiting? Patients' perspectives for accessing emergency department services with non-urgent complaints. *International Emergency Nursing*, 29, 3-8. https://doi.org/10.1016/j.ienj.2016.09.003

Van den Heede, K., & Van de Voorde, C. (2016). Interventions to reduce emergency department utilisation: A review of reviews. *Health Policy (Amsterdam)*, 120(12), 1337-1349. https://doi.org/10.1016/j.healthpol.2016.10.002

Ward, Michael J., Ferrand, Y. B., Laker, L. F., Froehle, C. M., Vogus, T. J., Dittus, Robert S., . . . Pines, Jesse M. (2014;2015). The nature and necessity of operational flexibility in the emergency department. *Annals of Emergency Medicine*, 65(2), 156-161. doi:10.1016/j.annemergmed.2014.08.014

Williams, M., & Moser, T. (2019). The art of coding and thematic exploration in qualitative research. *International Management Review*, 15(1), 45-72.

Wise, S., Duffield, C., Fry, M., & Roche, M. (2020). Clarifying workforce flexibility from a division of labor perspective: A mixed methods study of an emergency department team. *Human Resources for Health*, 18(1), 17-17. doi:10.1186/s12960-020-0460-7

Wolf, L. A., Perhats, C., Delao, A. M., Moon, M. D., Clark, P. R., & Zavotsky, K. E. (2016). "It's a burden you carry": Describing moral distress in emergency nursing. *Journal of Emergency Nursing*, 42(1), 37-46. https://doi.org/10.1016/j.jen.2015.08.008

Yarmohammadian, M. H., Rezaei, F., Haghshenas, A., & Tavakoli, N. (2017). Overcrowding in emergency departments: A review of strategies to decrease future challenges. *Journal of Research in Medical Sciences : The Official Journal of Isfahan University of Medical Sciences*, 22(1), 23-23. doi:10.4103/1735-1995.200277

Yuwanich, N., Sandmark, H., & Akhavan, S. (2015;2016;). Emergency department nurs's' experiences of occupational stress: A qualitative study from a public hospital in Bangkok, Thailand. *Work (Reading, Mass.)*, 53(4), 885-897. https://doi.org/10.3233/WOR-152181

APPENDIX A

Fast Track Area Literature Review

Study	Theoretical perspectives / frameworks Worldview and assumptions	Purpose and results	Methodological approaches	Knowledge translation	Gaps, Biases and weaknesses	Strengths
Stevens, L., Fry, M., Browne, M., & Barnes, A. (2019). Fast track patients' satisfaction, compliance and confidence with emergency department discharge planning. *Australasian Emergency Care*, 22(2), 87–91. https://doi-org.ezproxy.uleth.ca/10.1016/j.auec.2019.01.004	-pragmatism	-patients satisfaction with discharge teaching done in the fast track area	-descriptive exploratory design -medical record audit and telephone interviews -single site -			
Gasperini, B., Pierri, F., Espinosa, E., Fazi, A., Maracchini, G., &	-quantitative -postpositive	Assess the safety of the fast track process in the emergency	-average age 75 yrs old -more women than men	-compared two groups one before and one after fast track	-of note in this emergency department patients were able	-compared 2010 to 2012 – could have changes to the fast track

Cherubini, A. (2020). Is the fast-track process efficient and safe for older adults admitted to the emergency department? *B MC Geriatrics*, 20(1), 1–6. https://doi-org.ezproxy.uleth.ca/10.1186/s12877-020-01536-5		department for seniors -no increases in readmissions -decreased wait time and LOS -support efficiency and safety of the FT	-observational case control -looked at efficiency measures such as length of stay -readmission rate <1% in FT group vs 6.5% in pre-FT group	implementation -no specific area for fast track patients at their site	to refuse to the fast track process	since this point in time -single site
Kim, B. B. J., Delbridge, T. R., & Kendrick, D. B. (2017). Adjusting patients streaming initiated by a wait time threshold in emergency department for minimizing opportunity cost. *International Journal of Health Care Quality Assurance (09526862),* 30(6), 516–527. https://doi-org.ezproxy.uleth.ca/10.1108/IJHCQA-10-2016-0155	-assumptions such as no transfer times between processes, an arrival distribution of patients, and no deviation of flow pattern -authors focus on the financial impact of increased wait times -postpositivist	-Retrospective study using computer simulation modules -Goal was to understand how to stream patients in a fashion that resulted in the highest level of efficiency by decreasing wait time -**findings:** found that using a wait time threshold decreased WT and LOS for lower acuity	-Retrospective study using computer simulation modules -Compared patients being seen by acuity over patients being seen by acuity, but with a time threshold where if they were over 30 mins they would be prioritized	-no knowledge translations – authors believe that while the simulation is based on one ED wait time threshold driven fast tracks could be of use universally.	-used computer simulation models -focused on wait time and length of stay -dedicated half of the ED staff to this area, but dependent on the acuity side number of beds this may not be an accurate reflection of how it would be organized.	-measures were appropriate to the study. Worked in the sense that only CTAS 4/5s were int his area and that neither should need emergent or urgent care

		patients (3,4,5) without affecting the wait time for CTAS 1,2 level patients.				
Gill, S. D., Lane, S. E., Sheridan, M., Ellis, E., Smith, D., & Stella, J. (2018). Why do 'fast track' patients stay more than four hours in the emergency department? An investigation of factors that predict length of stay. Emergency Medicine Australasia, 30(5), 641–647. https://doi-org.ezproxy.uleth.ca/10.1111/1742-6723.12964	-50% of ED patients in Australia are CTAS 4/5 -Their focus in on improving efficiency through flow in fast tracks - Postpositivist – looking at efficiency numbers and which variables affect efficiency -focus is on the national emergency access target of 4 hours	- Goal was to assess why fast track patients stay longer than 4 hours -24% of fast track patients were above the 4 h LOS target in 2014 -**findings:** These factors affected LOS negatively: time taken to: (i) order imaging; (ii) order pathology; (iii) request admission to hospital; (iv) allocate a clinician to care for the patient; and (v) handover a patient between ED clinicians	Retrospective analysis -used a gradient booster machine to predict which patients would stay longer than 4 hours -used 30% of data from each month to help with seasonal effects	-numbers came from active process. Goal was simply to assess current factors that effect LOS greater than 4 hours	-focuses on numbers alone -confounding factors such as how busy the EDs were, etc. were not assessed -specific to this sites delays - may not transfer to other sites	-one of the first studies to assess factors within fast tracks alone that affect a stay of longer than 4 hours specifically. - Did a good job of explaining the resources and organization of the fast track. -included everyone with the exception of those who LWBS

Patey, C., Norman, P., Araee, M., Asghari, S., Heeley, T., Boyd, S., Hurley, O., & Aubrey-Bassler, K. (2019). SurgeCon: Priming a Community Emergency Department for Patient Flow Management. *Western Journal of Emergency Medicine: Integrating Emergency Care with Population Health*, 20(4), 654–665. https://doi-org.ezproxy.uleth.ca/10.5811/westjem.2019.5.42027	-postpositivist perspective focusing on the numbers -want to focus on improving flow and patient satisfaction -main focus is again on meeting quality improvement initiatives in relation to efficiency	Implemented SurgeCon to see if benefits could be seen in rural ED settings **–** fast track was only part of the implementation **Findings:** improvement in LOS and time to physician	-used interrupted time series analysis -quasi-experimental research design -assessed measures at one hospital site	-yes measures were implemented at a given sites and certain variables were assessed throughout	-may not be generalizable -too many factors involved to say which ones specifically made a difference -didn't account for the cost of the initiatives	-fast track was only part of a series of implementations and modifications to the rural sites -recognizes that challenges may be different in rural areas as oppose to urban centers -mention their limitations
Kim, S. W., Horwood, C., Li, J. Y., Hakendorf, P. H., Teubner, D. J. O., & Thompson, C. H. (2015). Impact of the emergency department streaming decision on patients' outcomes. *Internal Medicine Journal*, 45(12), 1241–1247. https://doi-org.ezproxy.ulet	-postpositivist perspectives -assumed that nursing staff triage patients in relatively the same way	-a greater number of patients who were misallocated to the admission side left without being seen than those properly allocated - those misallocated to the admission side stayed	-retrospective cohort study to find out if a patient being streamed the wrong way has negative outcomes -large amounts of patients -Compared with those admitted through the discharge stream, those admitted	-used real world data from over a 2yr period -no major differences in hospital mortality between the two groups or unplanned readmission -it was older patients misallocated to the	-ensured that it was a senior trained triage nurse who was scoring the patients (did not state level of seniority however) -younger patient95n novate95t 95ed to the discharge	-retrospective so it does not reflect current practices -basing it solely on the length of stay – not care received or number of adverse events -pediatric patients were excluded

h.ca/10.1111/imj.12918		longer than those appropriately allocated despite treatment beginning faster -purpose was to find out how misallocation could affect patients	through the admission stream had a longer ED LOS, a longer IP LOS, a higher inpatient mortality and a higher rate of unplanned readmission within 28 days of discharge	admission side	stream more often -used propensity score matching to account for bias of where the patient would have been triaged -didn't account for how patients may have been triaged differently based on overcrowding	-patients who died in ED were excluded
Copeland, J., & Gray, A. (2015). A daytime fast track improves throughput in a single physician coverage emergency department. *Canadian Journal of Emergency Medicine*, 17(6), 648-655. doi:10.1017/cem.2015.41	-"Lean Thinking" -Theorize that an FTA will decrease wait times and LOS in comparison to not having one within their setting -based on the theory that by increasing patient flow they will decrease overcrowding	-wait time will decrease with a FTA without negatively affecting outcomes for higher acuity patients -if more patients are seen within their CTAS category time then safety is improved -WT and LOS decreased	-quantitative (experimental) -retrospective cohort study -used patients that LWOB seen And patients assessed in the appropriate CTAS period -fast track area were mainly CTAS4-5, lower acuity patients that were meant to go home after treatment and	-trialed the implementation of an FTA in a rural hospital without increasing staffing	-different nurses will triage patients differently -LWOB is considered a measure of overcrowding this measure did not change in their setting	-p-values were less than 0.01 -didn't change staffing levels -demographics and acuity of patients were recorded before/after the study and were around the same -calculated out the changes by CTAS

	- postpositivist point of view - implementing a fast track decreases length of stay	markedly 6 and 15mins the majority of this was seen in CTAS 4 patients -WT for CTAS 2 patients did not change, CTAS 3 patients LOS and WT increased slightly	require minimal investigations			categories in some areas
Gardner, R. M., Friedman, N. A., Carlson, M., Bradham, T. S., & Barrett, T. W. (2018). Impact of revised triage to improve throughput in an ED with limited traditional fast track population. *American Journal of Emergency Medicine*, 36(1), 124–127. https://doi-org.ezproxy.uleth.ca/10.1016/j.ajem.2017.10.016	- postpositivist -focus on the numbers -focus on improving throughput -Lean theory	-how does a change in the triage system affects outcomes such as LOS, LWOB	-had an NP evaluation area added on where the triage nurse, physician, etc. could send patients if they were not going to require an intensive evaluation -used Mann-U Whitney to evaluate the pre/post intervention periods -quantitative -clinical trial	-was a trial conducted in practice	-short 9 day evaluation period -only 120 patients included	-good start for a longer trial to see how the results are over a period of time -defined criteria for patients able to move to the NP area -did cut out the day with the snow storm due to a low volume of patients
Jackson, K. (2016). Y doesn't Gen I.. Like 2 w8? *Australian Journal of Advanced Nursing,* 33(3), 29–37.	-Gen Y patients are more likely to access the ED for routine medical problems as	-wanted to evaluate how satisfaction varied amongst generations with CTAS	-descriptive survey and questionnaires evaluated in terms of generations -Gen Y are 30-40% of the ED	-the questionnaires were given to patients whom had been in the ED	-only looked at 2 generations -only looked at patients	-gave a good description of their treatment area -use literature to support their study

	it is seen as convenient	4/5 scores in the ED -Gen Y (born between 1982-2003) patients were less satisfied due to higher expectations -Gen X (born between 1965-1981) were more satisfied than Gene Y patients -no difference was found in expectations by the 2 groups	visits at the hospital of study -every 3rd patient who met the criteria was given the opportunity to participate -collected information over a 3 month period	-a reflection of the satisfaction of the treatment streaming area within the study	from one site -were less likely to recruit patients during busy times which could have changed some of the results -streaming area was shut down before they could get the number of patients they wanted	
Hwang, C. E., Lipman, G. S., & Kane, M. (2015). Effect of an Emergency Department Fast Track on Press-Ganey Patient Satisfaction Scores. *Western Journal of Emergency Medicine: Integrating Emergency Care with Population Health*, 16(1), 34–38. https://doi-org.ezproxy.uleth.ca/10.5811/w	- **In 2012 Medicare remuneration requires good patient quality surveys** (30%) of their grade – one of the reasons that patient satisfaction has become a big part of emergency care and focus other 70% was tied to care process	-found that patient satisfaction improved with the implementation of a fast track -improve patient satisfaction score to ensure remuneration from Medicare companies	-looked at Press Ganey patient satisfaction scores from CTAS 4/5 patients -before and after cross-sectional study	-questionnaires given to real patients undergoing treatment at the given hospital	-4 day lag – t98nnovate 98ttions may have changed over time -only had a 14.8 % response rate -Fast track was created in July and questionnaires were completed in August	-all patients were given the opportunity to fill out the questionnaire Trial was completed from August to December -gave a good description of which resources were added to create the fast track -named limitations

estjem.2014.11.21768	-the need to improve patient satisfaction scores came from a risk of losing funding				-small study 140 pre and 85 post that responded	
Steward, D., Glass, T., & Ferrand, Y. (2017). Simulation-Based Design of ED Operations with Care Streams to Optimize Care Delivery and Reduce Length of Stay in the Emergency Department. *Journal of Medical Systems*, 41(10), 1–8. https://doi-org.ezproxy.uleth.ca/10.1007/s10916-017-0804-6	-queuing theory and goals of care model -patients should be streamed based on their anticipated needs -lean theory Brought in some qualitative data pragmatic	-remove steps that are not needed in patient care and create parallel streams as oppose to sequential -prioritize future targets and validate their simulation model -worked well for anticipating the needs of the given ED to help in the construction of a new implemented ED	-Created 4 care streams in the ED: Critical, Diagnostic, Therapeutic and Fast Track -discrete simulation even modelling was used to assess their ED implementation strategy -allowed staff to view the simulations – give feedback and then make adjustments based on staff feedback -quantitative using simulation modeling	-used the simulation to train staff and to help optimize organization of the system prior to the hospital opening	-only CTAS 4/5 patients in the fast track -data used simulation as comparison	-used expert opinions and policies to help inform their simulation -used a similar hospital to inform heir numbers for the simulation -comparison was made to when the hospital was first open which may have had an effect on their number of patients, etc. -named their limitations and some confounding factors
Yarmohammadian, M. H., Rezaei, F., Haghshenas, A., & Tavakoli, N. (2017). Overcrowding in emergency departments: A review of strategies to	-Lean theory -utilizing staff to their full capacity will increase efficiency -Fast Track areas result	-to assess current strategies used to decrease overcrowding in emergency departments	-computerized database search -literature review -identified different area of the system that can lead to overcrowding as	-none – although the study can be used to gain an understanding of current strategies to help decrease overcrowdin	-admitted that although the research is promising for Fast Track areas safety has not been evaluated	-used two different reviewers to decide which articles would be included and had a third person to decide if there was a difference of

decrease future challenges. *Journal of Research in Medical Sciences : The Official Journal of Isfahan University of Medical Sciences*, 22(1), 23-23. doi:10.4103/1735-1995.200277	in quality care -there are currently imbalances in needs and the resources available -pragmatic approach – looked at a broad view of the issues caused by overcrowding including staff frustrations	-fast tracks are an effective strategy to improve wait times without negatively affecting higher acuity patients' outcomes -more research is needed to evaluate patient safety and selection of patients tha100nnovate100t100riate for this area -found other strategies such as triage nurse ordering also helped to increase throughput	areas your strategy should focus on	g within emergency departments	to its full extent -the other issue that has not been addressed is how patients are selected t100nnovate100t100riate in this area	opinion in the first two researchers -did a good job of evaluating the studies for limitations and positive aspects of the studies
Smith, B., & Celona, C. A., Amaranto, A., Ferrer, R., Wieland, M., Abrams, S., Obusan, F., LoPuzzo, S., & Joy, V. (2018). Interdisciplinary Design to Improve Fast Track in the Emergency	-postpositivist perspective. Focus is again on the numbers that outline efficiency -focus is on meeting benchmarks laid out by	-door to provider time decreased from 68 to 48 mins for ESI 4/5 patients -and treat and release time for EsI 4/5 patients decreased	-care teams and Nurse practitioners were introduced to the ED fast track -Had a nurse and an advanced practitioner such as an NP, PA, or physician	Trialed in their hospital system	Staffing was a limitation that made it difficult to continue with the strategy at times -didn't complete a cost analysis –	The variables they chose were appropriate for the purposes of their study. -Did see an improvement despite an increasing number of patients

Department. *Advanced Emergency Nursing Journal*, 40(3), 198–203. https://doi-org.ezproxy.uleth.ca/10.1097/TME.0000000000000199	Medicare and Medicaid	from 216 to 162 -the number of patients visits have been increasing and so the goal is to be able to provide timely care to patients of all levels of acuity			question comes up as to how many staff are required to run this type of a system -didn't state how many staff were added to the area -didn't state how much of the increase in patients were ESI level 4/5	attending the ED
Khalifa, M. (2016). Utilizing Health Analytics in Improving Emergency Room Performance. *Studies in Health Technology & Informatics, 225*, 138–142. https://doi-org.ezproxy.uleth.ca/10.3233/978-1-61499-658-3-138	- Lean thinking – analyze and minimize insufficiencies within the system - postpositivist – focus on the numbers and efficiency -focus on LOS and LWOB	-See if health analytics can be used to help reduce inefficiencies	-retrospective analysis of different variables affecting LOS and then used that data to compare and create a FTA staffed by 2 family medicine doctors -Only CTAS 4/5 patients went into the FTA	-trialed in the ED	-used multiples months and the same time of the year for their comparison -didn't state exactly how their fast track was organized	-broke down the acuity levels of patients attending the ER -did their best to validate and show that changes in their variables were related to the changes in workflow measures although did not directly state what the minor differences in staffing were

						simply that they were relatively the same -graphed the comparison of the data nicely
Doetzel, C. M., Rankin, J. A., & Then, K. L. (2016). Nurse Practitioners in the Emergency Department Barriers and Facilitators for Role Implementation. *Advanced Emergency Nursing Journal,* 38(1), 43–55. https://doi-org.ezproxy.uleth.ca/10.1097/TME.0000000000000090	-focus is on meeting the increased demands of the healthcare system -feel that fast tracks are suitable for nurse practitioners -use the PEPPA framework.	-Demonstrate how nurse practitioners can help improve the overcrowding issue by explaining their role.	-literature review -PEPPA framework is used to explain why and how the role is appropriate for NPs	-they are attempting create a document that can be used in practice situations to understand the potential benefits and barriers to the addition of a nurse practitioner in the ED -were able to identify barriers currently in practice that need to be addressed to help facilitate nurse practitioners working in the ED setting	-A bias in favour of n102nnovate102t102roners as a nursing journal -some older studies	-outlines the role and how it was developed in great detail -met the purpose of their study
Hajjarsaraei, H., Shirazi, B., & Rezaeian, J. (2018). Scenario-based analysis of fast track strategy optimization on	-must increase efficiency while maintaining quality in care	-found LOS was reduced without affecting the time to physician for higher acuity patients	-uses an integrated safety simulation model to analyze safety within the fast	-Not used in practice yet. -Goal is develop a simulation model that can help in	-simulation based -improvement was nominal at 4mins for	-had a literature review -were able to test multiple scenarios

emergency department using integrated safety simulation. *Safety Science,* 107, 9-21. doi:10.1016/j.ssci.2018.03.025	provided (Lean theory) -believes that simulations can show how the implementation of an intervention will affect the unit -simulations allow us to accurately assess the changes so that we do not spend money on an unsuccessful change -pragmatism	-found through their simulation that operational flexibility is important for improving efficiency -understand how to best organize the fast track in order to maximize productivity while maintaining safety based on the variables of importance to them (LOS, WT, LWOB)	track and efficiency -focus on length of stay -conducted interviews and collected quantitative data to explore how to increase efficiency and factors that effect efficiency -mixed methods	creating a strategic fast track	patient wait time -doesn't account for problems you can encounter with change models in the real world	-Had a lot of research around their different methods used
Pink, E., Ding, M., Murdoch, I., & Tan, V. I. C. (2019). A survey of emergency department quality improvement activities: Effective fast track waiting area management. *Advanced Emergency Nursing Journal*, 41(2), 145.	-pragmatic -used both quantitative and qualitative methods	-to assess if moving patients to a fast track area withi103nnovate103ttment where nursing staff as oppose to the nurse at triage could assess and monitor patients with lower acuity presentations	-24 hour fast track -chairs within the fast track rooms -had a cubicle where patients could be initially assessed -moved patients from the waiting room area to the fast track area to be assessed and wait for results	-Trialed in their hospital and received positive feedback	-only an 8 week period -didn't state how they reached saturation of the data -while they spoke about efficiency originally the focus in their results section was	-shared some of the confounding factors that could have affected the study -interviewed both staff and patients

			-mixed method surveys		more based of perception and confidentiality of patients.	
Wise, S., Duffield, C., Fry, M., & Roche, M. (2020). Clarifying workforce flexibility from a division of labor perspective: a mixed methods study of an emergency department team. *Human Resources for Health*, 18(1), 1–9. https://doi-org.ezproxy.uleth.ca/10.1186/s12960-020-0460-7	-pragmatism	-Mixed methods -Goal was to understand workforce flexibility in the emergency fast track area -there's overlap between the roles of different healthcare professionals in the emergency fast track area -overlap can be successful, but the amount of flexibility into what is traditionally another healthcare providers role depends on the flexibility of the nurse, doctor, or	-used fields notes and observations -created quantitative data on the amount of time each profession spent on different tasks -qualitative interviews	-data was observed in a clinical setting	-small study – only 8 registered nurses were included -done in Australia -scope of practice can vary greatly by country and province	-were able to show quantitative data and then explain some of their findings through qualitative data collection

		nurse practitioner -Found that registered nurses spent the greatest amount of time -registered nurses took on a variety of roles in the emergency fast track				
Eriksson, J., Gellerstedt, L., Hillerås, P., & Craftman, Å. G. (2018). Registered nurses' perceptions of safe care in overcrowded emergency departments. *Journal of Clinical Nursing* (John Wiley & Sons, Inc.), 27(5–6), e1061–e1067. https://doi-org.ezproxy.uleth.ca/10.1111/jocn.14143	-qualitative descriptive	-understanding nurses' perspectives on caring for patients with an extended length of stay in the emergency department -described the emergency department as an unsafe place to care for patients with an extended stay as they are not equipped for it -lack of proper equipment for extended	-qualitative descriptive -interviews -registered nurses with at least 1 year of experience	-no evidence of knowledge translation	-only contained the RNs perspective, small number of participant, although adequate for the type of study that was completed	-5 emergency departments -good description of their methods -correlated their research ith results from other studies

		stay patients in particular related to mobility and hygiene -extended length of stay patients increased their workload and led to blockages in ED patients coming in -created feelings of inadequacy and powerlessness				
Chen, L.-C., Lin, C.-C., Han, C.-Y., Hsieh, C.-L., Wu, C.-J. (Jo), & Liang, H.-F. (2018). An Interpretative Study on Nurses' Perspectives of Working in an Overcrowded Emergency Department in Taiwan. *Asian Nursing Research*, 12(1), 62–68. https://doi-org.ezproxy.uleth.ca/10.1016/j.anr.2018.02.003	-Charmaz's grounded theory -symbolic interactionism	-understand nurses' experiences working in an overcrowded emergency department -registered nurses saw emergency departments as a place where specialized needs could be met- this perception did not align with those in the community who came to the	-registered nurses with one year experience -individual interviews were completed with participants	-no talk of knowledge translation, however the study was completed based on nurses working in an emergency department	-single site was used	-included an explanation of why the method they used was the best method for the purposes of their study -well described methodology

		emergency department for non-urgent care needs -nurses described overcrowding as a "traffic jam" -found the unpredictability of the emergency department stressful and challenging -during times of overcrowding there was hope when there was still movement of patients versus when the patients were stuck in one area with nowhere to go. -health policy – nurses felt that while streaming increased throughput it also led to a perception that emergency				

		departments can be used for nonurgent needs -there were concerns about patient safety during times of overcrowdin g -felt powerless in being unable to meet the continuous demands that outweighed the supply of nurses				
Strada, A., Bravi, F., Valpiani, G., Bentivegna, R., & Carradori, T. (2019). Do health care professionals' perceptions help to measure the degree of overcrowding in the emergency department? A pilot study in an Italian University hospital. *BMC Emergency Medicine*, 19(1), N.PAG. https://doi-org.ezproxy.uleth.ca/10.1186/s1	-quantitative methods were used to compare scores	-Assess the differences between healthcare providers perceptions of overcrowdin g and NEDOC scores that are used to measure overcrowdin g. -nurses' subjective view of overcrowdin g lined up better with the NEDOC scores that	-single site -questionnaires were provided to participants and then the participants scores were compared with the NEDOC scores -only included participants with at least 2 years of experience – nurses and doctors	Done at a real site. Have not trialed it beyond the questionnair es that they used.	-single site	-categorized the results into different healthcare provider groups and did measures where they were grouped together. -included a number of healthcare providers -described all of the statistical methods they used.

2873-019-0259-9		physicians perceptions of overcrowding. -NEDOC scores over estimate the subjective healthcare provider scores of overcrowding -NEDOCs may not be suitable for measuring overcrowding				
Morrish, S. (2013). Streaming in the emergency departmen109 nnovatenovative care delivery design. *Canadian Journal of Emergency Nursing (CJEN)*, 36(1), 11–13.	-experienced emergency nurse and clinical educator	-worked well to include multiple stakeholders in planning -warned by Toronto that some healthcare team members quit with the introduction of a streaming area -staff also wanted to decrease	-qualitative descriptive -single site -focus on the streaming area – not quite fast track, but where they place CTAS level 3 patients -perspectives on going from a single emergency department to having it divided into 3 sections – main department, streaming area (CTAS 3), fast	-found that wait times decreased and physicians were able to see patients faster -looked at other hospital emergency department streaming areas to aid with the design for their hospital	-worked in the emergency department as an RN for years	-methodological congruency -15 interviews -variety of staff members -went to a healthcare facility that was not their own

		patient wait times -teamwork was important – the physicinas trusted the RNs judgements in who needed to be seen first and allowed the RNs to help direct flow in the streaming area -it was difficult when the nurse in the streaming area didn’t have help from the other staff -found that having a few nurses working only in that area that “specialized in working the fast track area was helpful. -not at nurses could	track (CTAS 4/5)			

		handle the 1:12 ratio -requires experienced nurses who know when a patient needs a higher level of care -privacy could be a concern and so they tried to ensure that results were only shared in the rooms versus when patients were sitting in the streaming chairs in the main area -negative impacts if the wrong patients are sent to the streaming zone then it can become backed up -better to have a dedicated physician, some physicians				

		are better suited to the streaming area than others secondary to the multitasking that is needed -require dedicated resources for the area such as blood pressure cuffs -patient care and communication were important to staff working in the streaming zone. -staff buy-in was key to the success of the streaming zone				
De Freitas, L., Goodacre, S., Rachel O'Hara, Thokala, P., & Hariharan, S. (2020). Qualitative exploration of	Pragmatic critical realist approach	-figure out what effects flow from patient/staff perspectives -depending on the acuity of	Qualitative -observations and field conversations	-studied an emergency department -didn't say anything about member-checking	Single site	-multiple researchers/different careers -used some direct quotes to support findings

patient flow in a caribbean emergency department. *B MJ Open*, 10(12) doi:http://dx.doi.org.ezproxy.uleth.ca/10.1136/bmjopen-2020-041422		the patient each area within the ED had specific resources for each acuity group -initiating basic investigations at triage improves flow -specific area to assess ambulatory patients appeared to reduce time looking for space -one barrier to flow was a lack of material resources for nursing staff to use -nursing staff shortages led to role sharing and physicians helping out nursing staff as well as nursing staff				

		working multiple streams -didn’t use advanced nursing skills – in this case one of the staff members stated it would not help due to the nursing shortage				

APPENDIX B

Manager E-mail

University of Lethbridge

FIAT LUX

Faculty of Health Sciences

4401 University Drive
Lethbridge, Alberta, Canada
T1K 3M4

Phone 403.329.2699
Fax 403.329.2668

http://www.uleth.ca/hlsc

Date

Hello _______,

I am a master's in nursing student at the University of Lethbridge. For my thesis I have decided to focus on understanding the nurses' experience of working in the fast track area and will be using a qualitative descriptive study design.

I will be conducting between one interview with registered nursing staff that choose to participate. I anticipate that each interview will last a maximum of 60 minutes. These interviews would be conducted outside of work hours and away from the worksite. The goal of the interview is to understand their experience of working in the fast track area with the goal that understanding their experience. The goal of the research is to gain an understanding of the experiences of registered nurses working in the fast track area with a focus on design and quality of care. My intent is that the research findings will inform strategies to support staff who are assigned to the fast track area in the emergency department. I have received ethics approval from the Health Research Ethics Board at the University of Alberta. I plan to publish the findings of this study in relevant scholarly journals and may potentially submit to have my research presented at a future emergency nursing conference.

It would be greatly appreciated if we could have one of the unit clerks send an e-mail to staff approved by ethics to see if any of your staff are interested in participating my research. I would greatly appreciate if I could hang up a few posters in the emergency department staff room too. If you have questions about the study you may contact me at fasttrackthesis@gmail.com or 403-894-7166 or my supervisor Mark Zieber at 403-329-2659 or at m.zieber@uleth.ca. This research has been reviewed for ethical acceptability and approved by the University of Alberta Human Participant Research Committee.

Sincerely,

Kennedy Cox, RN, BN

Ethics ID: Pro000XXXXX

APPENDIX C

Recruitment E-mail

Email Subject Line: Univ. of Lethbridge Study – Emergency Registered Nurses' Experience of Working in the Fast Track Area

Dear Emergency Nurses,

My name is Kennedy Cox. I am a student currently enrolled in the Master of Nursing program at the University of Lethbridge. For my thesis, I have chosen to research the experience of emergency registered nurses working in the fast track area. I am inviting emergency nurses to participate in an interview that will take approximately 60 minutes to complete. The interview will either be conducted in a private room at the University of Lethbridge, through Zoom, or by telephone, depending on COVID and your preference.

If you have questions or are interested in participating in the study please contact me at fasttrackthesis@gmail.com or 403-894-7166 or my supervisor Mark Zieber at 403-329-2659 or at m.zieber@uleth.ca. Please do not use your Alberta Health Services e-mail to express your interest or communicate as Alberta Health Services is allowed to track the e-mails sent through their system. You may also contact the Office of Research Ethics at the University of Lethbridge at research.services@uleth.ca or 403-329-2747 if you have questions about your rights as a participant. This research has been reviewed for ethical acceptability and approved by the University of Alberta Human Participant Research Committee.

Thank you in advance for your consideration.

[Kennedy Cox]

[The Monitoring Process in Fast Tracks]

[University of Lethbridge]

[403-894-7166]

[fasttrackthesis@gmail.com]

Ethics ID: Pro000XXXXX

APPENDIX D

Recruitment Facebook Post

PARTICIPANTS NEEDED FOR RESEARCH ON THE EMERGENCY DEPARTMENT FAST TRACK AREA

I am looking for nurses to participate in a qualitative research study on emergency registered nurses' experience working in the fast track area.

You would be asked to participate in a one-on-one interview that will be about 60 minutes long with the possibility of a follow up meeting to verify findings.

Participation is confidential. Only the researcher and supervisor will have access to your name.

Please do not comment or send messages through Facebook, but instead reach out to the thesis e-mail below.

For more information about this study, or to volunteer for this study, please contact: [Kennedy Cox] [Master's of Nursing Student] [University of Lethbridge] Email: [fasttrackthesis@gmail.com]

Ethics ID: Pro000XXXXX

APPENDIX E

Poster

University of Lethbridge

FIAT LUX

Faculty of Health Sciences

4401 University Drive
Lethbridge, Alberta, Canada
T1K 3M4

Phone 403.329.2699
Fax 403.329.2668

http://www.uleth.ca/hlsc

PARTICIPANTS NEEDED FOR RESEARCH ON THE EMERGENCY DEPARTMENT FAST TRACK AREA

I am looking for nurses to participate in a qualitative research study on emergency registered nurses' experience working in the fast track area.

You would be asked to participate in a one-on-one interview that will be about 60 minutes long with the possibility of a follow up meeting to verify findings.

Participation is confidential. Only the researcher and supervisor will have access to your name.

Please do not comment or send messages through Facebook, but instead reach out to the thesis e-mail below.

For more information about this study, or to volunteer for this study, please contact: [Kennedy Cox] [Master's of Nursing Student] [University of Lethbridge] Email: [fasttrackthesis@gmail.com]

Ethics ID: Pro000XXXXX

APPENDIX F

Consent Form

PARTICIPANT CONSENT FORM

Title of Study: Registered Nurses' Experiences Working in the Emergency Fast Track Area

Principal Investigators: Kennedy Cox 403-894-7166
Dr. Mark Zieber at 403-329-2659

Why am I being asked to take part in this research study?

You are being asked to participate in this study because of you have experience working in the emergency fast track area. This research study is being done because registered nurses' experiences working in the fast track area is an important part of the research on fast track areas and is currently limited.

This form contains information about the study. Before you read it, a member of the study team will explain the study to you in detail. You are free to ask questions about anything you do not understand. You will be given a copy of this form for your records.

What is the reason for doing the study?

Currently there is limited research on registered nurses' experiences working in the emergency fast track area. The goal of the study is that the data collected will help to inform management and policy makers on how registered nurses working in the fast track area can be best supported during times of overcrowding, or where higher acuity patients end up in the fast track area.

What will I be asked to do?

If you agree to be in my study, you will be asked questions about your experience working in the fast track area. There will be 1 interview lasting about 60 minutes and there may be a second meeting for validation of the findings.

The interview will be done through Zoom, in person, or by telephone depending on your preference. If the interview is done on Zoom you will have the choice to have your camera on or off. Audio will be recorded.

With your consent, allow storage of study information in a secure data repository to facilitate future secondary analysis.

How long will I be in this study? Explain the duration of the study or how long the study will last. This will help participants decide if they have the time to participate.

Participation will include 1 interview that will take a total of about 60 minutes. There may be a second meeting lasting no longer than 60 minutes for a validation of findings.

Participation in total will include 60-120 minutes of your time.

What are the risks and discomforts?

There are no foreseen harms for participating in the study. However, being in any study can bring harm in unknown ways to you as the participant. Should any of the topics we talk about bring up any undue emotional stress I will have the number for the crisis line and counsellors should you need them.

It is not possible to know all of the risks that may happen in a study, but the researchers have taken all reasonable safeguards to minimize any known risks to a study participant.

If you choose to do an in-person interview, we will both wear masks, maintain 6 feet of distance, and there will be hand sanitizer present. The interview will be changed to an online format or cancelled if either of us are experiencing COVID symptoms or feeling unwell.

What are the benefits to me?

There may not be any direct benefit to you from participating in this study. However, this study will help researchers learn more about registered nurses' experiences working in the fast track area. Hopefully this information can be used to help inform management and policy makers of registered nurses' experience when considering future policies and how to best support nurses working in the fast track area.

Do I have to take part in the study?

Being in this study is your choice. If you decide to be in the study, you can change your mind and stop being in the study at any time, and no one will be mad at you. There will be no consequences from withdrawing from the study at any point. If you decide to withdraw from the study, you can also choose to have your information withdrawn from the study up until the point that all of the data is aggregated into themes.

You do not have to answer any questions that you are not comfortable with during the interview.

Will my information be kept private?

During the study we will be collecting data about you. We will do everything we can to make sure that this data is kept private. No data relating to this study that includes your name will be released outside of the researcher's office or published by the researchers. Sometimes, by law, we may have to release your information with your name so we cannot guarantee absolute privacy. However, we will make every legal effort to make sure that your information is kept private.

Any recordings or transcriptions from Zoom will be downloaded, encrypted and placed on a password protected laptop and in Sync which is a Canadian owned cloud storage company with two way encryption. Recordings may also be backed up on a password protected usb drive.

After the study is done, we will still need to securely store your health data that was collected as part of the study. At the University of Lethbridge, we keep data stored for a minimum of 5 years after the end of the study.

For future uses study data will be kept in a de-identified state after the 5 years.

What if I have questions?

If you have any questions about the research now or later, please contact Kennedy Cox 403-894-7166 or Dr. Mark Zieber 403-329-2659.

If you have any questions regarding your rights as a research participant, you may contact the University of Alberta Research Ethics Office at 780-492-2615. This office has no affiliation with the study investigators.

How do I indicate my agreement to be in this study?

By signing below, or by allowing your consent to be recorded, you understand:

· That you have read the above information and have had anything that you do not understand explained to you to your satisfaction.

· That you will be taking part in a research study.

· That you may freely leave the research study at any time.

· That you do not waive your legal rights by being in the study

· That the legal and professional obligations of the investigators and involved institutions are not changed by your taking part in this study.

SIGNATURE OF STUDY PARTICIPANT OR VERBAL CON____

Name of Participant

_________________________________ ______________________

Signature of Participant Date

SIGNATURE OF PERSON OBTAINING CONSENT

_________________________________ ______________________

Name of Person Obtaining Consent Contact Number

SIGNATURE OF THE WIT____

Name of Witness

_________________________________ ______________________

Signature of Witness Date

Under the International Conference on Harmonization, Good Clinical Practice (ICH GCP 4.8.9), where it is known that the participant cannot read (e.g., visually impaired or illiterate), the signature of an impartial witness independent of the trial must be obtained. The witness must be present for the consent process. The witness signature reflects that they believe the participant was presented with sufficient information to assure a truly informed consent.

A copy of this consent form has been given to you to keep for your records and reference.

APPENDIX G

Information Letter

INFORMATION LETTER

Study Title: Registered Nurses' Experiences Working in the Emergency Fast Track Area

Date

Dear Participant:

Thank you for your interest in this research study. The following information is provided to ensure that consent is granted based on your understanding of the information at hand. The purpose of this study is to gain insight from the perspective of frontline nurses on how you engage in monitoring patients in the emergency fast track area. To do this I will be conducting interview and either taking notes, using a recording device or both during the interview. The interviews will either be through Zoom, by telephone, or in person in a private room at the University of Lethbridge. Depending on COVID you as the participant will be able to choose which you prefer. To maintain confidentiality, you may select a pseudonym at the beginning of the interview that will be used to keep track of the information you provide throughout the study. Data collected during this study will only be shared with my graduate supervisor at the University of Lethbridge. I will not use your given name anywhere in the collected information with the exception of the assent form, and a master copy list of the participants names with their pseudonym, which only my supervisor and I will have access to.

This research will require anywhere from 1 one-on-one interview lasting approximately 60 minutes each. There may be a follow up meeting where I ask you if the findings are accurate. The purpose of the interview is to understand, your experience of working in the fast track area. I want to understand how your workload is different in the fast track area and more information about what you experience what stands out to you when it comes to your experience of working in the fast track area.

We will do our best to reduce risks or discomforts related to this research. Should a situation arise where you feel that you need somebody to talk to, a list of counsellors will be provided. A possible risk within this research is that your employer could find out that you have participated. To protect your identity to the best of our ability as stated earlier the pseudonym you chose will be used throughout the research. Only my supervisor and I will know the names of those that have participated and your names will not be released.

I have created a separate e-mail called fasttrackthesis@gmail.com that you can use to contact me. Please do not use your Alberta Health Services e-mail to express your interest or communicate as Alberta Health Services is allowed to track the e-mails sent through their system. Your participation in this research is entirely voluntary. You are not obligated by any means to participate in this research and should you choose not to participate there will be no consequences. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification. You may choose not to answer any question, or you may withdraw from the interview at any time for any reason without any consequences. If you do this, the consent form will be put through a paper shredder and the recording will be deleted from the tape recorder and laptop.

Several steps will be taken to protect your confidentiality. The interview will be completed in a private room at the University of Lethbridge, by Zoom, or by telephone, whichever option you are most comfortable with. The interview will take place at a time that works best for you as a participant. Participants who agree to be interviewed will not be identified by name, but with the pseudonym you provide at the beginning of the research. All of the data collected in this study will be kept in a safe at my home office or on a password-protected computer, and only the researcher and my supervisor will have access to them. Any data with identifiable information will be encrypted. The data collected during the interview will be retained for five (5) years from the completion of the study before being deleted.

The results of this study will be presented in academic papers. At no time, however, will your name be used or any identifying information revealed unless you have given consent.

If you require any additional information about this study, please contact me at 403-894-7166 or fasttrackthesis@gmail.com or my supervisor Mark Zieber at 403-329-2659 or m.zieber@uleth.ca. Questions regarding your rights as a participant in this research may be addressed to the Office of Research Ethics, University of Lethbridge (Phone: 403-329-2747 or Email: research.services@uleth.ca).

Thank you for your consideration.

Kennedy Cox

APPENDIX H

Participant Demographics

This form is used in order to help describe the demographics of participants in my research. Providing only your false name (pseudonym) on this form will help to protect your identity. This form will be kept in a locked safe in my home office and will be destroyed 5 years after this research is complete with all of the other materials used. This form will be destroyed with all the other materials used for this research after 5 years. If you are uncomfortable with answering any of these questions, then you may skip one or all of them. These were the demographics chosen as they were decided to be the most pertinent to the study.

The false name (pseudonym) you choose for this study: _________________________

Your biological sex: ________________________

Your age range (please circle):

Less than 30 years

30 to 40 years

40 to 50 years

50 to 60 years

More than 60 years

Years of experience in the emergency department (please circle):

1 to 5 years

5-10 years

10-15 years

More than 15 years

Last time you worked in the emergency fast track area (please circle):

1-2 days ago

3-7 days ago

More than 1-4 weeks ago

More than a month ago

APPENDIX I

Interview Guide

Date:

Place:

Interviewer:

Interviewee:

Interviewer:

If you feel uncomfortable and want to stop or pause the interview at any point just tell me. Just a reminder before we begin that you may decline to answer any of the questions without giving a reason why, and you can withdraw from this study at any time. If you withdraw your personal information and data collected up to that point, including audio recordings, consents, and researcher notes will be destroyed upon your request. You can also take a break at any point in time or stop the interview without giving a reason. Any questions or concerns before we begin?

Questions:

1. How would you describe your experience of working in the emergency fast track area?
2. Does your workload in the fast track area effect the quality of care you are able to provide? If yes, then how?

   How would you describe your workload in the fast track area versus other areas of the emergency department?
3. What do you perceive as factors effecting your experience of working in the fast track area?
4. Does the design of the emergency department have any effect on your work? If yes then how does the design effect your experience?

   What works well and what does not work well?
5. Do you have any further information that you would like to share?

Thank you again for your time, and I want to remind you that your name will be kept confidential and your answers will be used only for the purposes of this study. You will have access to the final results prior to dissemination of the material to any research articles.

APPENDIX J

Data Analysis Steps

Step	Description
St–p 1 - Read through the interview.	For my initial step I will read through the interview in their entirety multiple times to familiarize myself with the data (Braun & Clarke, 2006).
Initial coding as described by (Braun& Clarke, 2006)	Initial coding using thematic analysis will be completed. I will code the data using verbatim words of participants. In coding I will be looking for recurrent codes or areas that describe the nurse's experience with patient monitoring in the fast track area (Williams, & Moser, 2019).
Analytic Memos	Saldaña (2016) states that analytic memos are used to describe how and why you chose the code that you did for a segment. Using these notes will allow me to reflect on the analysis and construction of data while coding. During my analysis I will write memos regarding questions that arise from the data (Charmaz, 2014). Analytic memos can be used to analyze my own language I am using and to assess for biases in my own writing (Charmaz, 2014). Each word I choose is chosen based on my own experiences and biases. I need to be aware how my choices throughout the research process help to construct the theory and the influence that they have on my research.
Codes divided into categories and the categories are edited as needed.	After initial coding I will begin breaking the codes into categories by grouping together similar ideas. (Braun & Clarke, 2006). Charmaz (2014) warns that the researcher must engage in reflexivity throughout the research process to ensure that we are not forcing our own preconceived biases onto the data. For example, I will use my analytic notes to reflect on why I chose to code words using a certain language or to group them in a certain way as all of these choices will be reflected how the data emerges into a theory. I need to recognize that my voice is only one of many adding to the theory and that I have to include all voices in the final product.
Refine and Redefine Categories	I will code and re-categorize my data as needed. Theoretical sampling will help me to refine and define my categories (Bradshaw et al., 2017).
Themes	The categories will then be broken down into tentative themes (Braun & Clarke, 2006).

APPENDIX K

Budget

Thesis Budget	
Object	**Anticipated Cost**
Zoom Pro Licence Subscription	$200.00
Refreshments	$75.00
Tape Recorder (already own)	$0
NVIVO Program	$130.00

APPENDIX L

Audit Trail

February 11, 2022

Having worked in the emergency department fast track area I feel that I would be naïve to say that I have no biases. I feel that these biases were the strongest when I began working on my literature review while I was still working in the emergency fast track area. One day I was working in the fast track area and had one particularly sick patient, along with approximately 14 other patients that my partner and I were responsible for. On busier days in the fast track area I felt as though I was not providing my patients with the high level of care and monitoring that is expected from myself as a registered nurse. I found that I had to find a balance between being thorough with my assessments, while also being timely. While working in the fast track are the goal seemed to be getting patients through as quickly and safely as possible to make room for new patients coming through the door. At times it was difficult to balance the many tasks at hand and safety. I had moments where I felt like I was not meeting the standards I have set for myself. For example, if I became side tracked with one patient and then realized there was another patient that I had meant to assess 15 minutes prior. A bias that I have from this part of my experience working in fast track areas was that at times they were not safe as I felt I was not able to meet the basic standards set out by Alberta Health services for monitoring my patients.

I realized early on that this is one of my biases and may not be the experience of other nurses. I have spent time pondering other perspectives on the aspect of safety within fast track areas. Some of the studies I read talked about the triage nurses and how they were not able to properly monitor all of the patients in their waiting room as there were too many. Reading about the triage nurse experience and a number of articles/papers on the scarce amount of resource availability in healthcare made me reconsider my harsh judgement on the safety of patients within the fast track area. Seeing patients lined in the hall with EMS awaiting an acute bed and reading articles about patients who were not picked up by EMS in time gave me more to consider. In looking at the bigger picture, having higher acuity patients in the fast track area where there is a higher patient to nurse ratio may not be ideal, but may be the best solution available.

Another perspective that came up in some of the articles is that certain personalities are better at working in the fast track area than others. The article described ideal fast track workers as ones that were fast and able to make decisions quickly without a number of tests. The articles talked about more experienced nurses being ideal in the fast track area, because it is important to know when something needs to be expedited. Perhaps, I just liked being a little more thorough that what we are able to do in the fast track area, given the time limits. I am really interested in understanding other nurses experiences about fast track areas. I will do my best during interviews to maintain an open mind and ensure that I am not asking questions based on my biases, although of course some of my curiosity and questions may come from an area of my own experience. I want to be conscientious of my own biases when interviewing so that I can try to ensure that the additional questions I ask are based on the participants comments, rather than solely on my own biases. After my initial interview I plan to do another reflection on how the interview went, what went well, what didn't and how I can do better in future interviews.

In the Chen article I felt I could relate to the nurses when they spoke about feeling as though the emergency department was used at times for issues that were inappropriate for the level of acuity that we as nurses feel the emergency department should be used for. I had moments working in the department on busy days where I was frustrated by some of the lower acuity complaints that were clogging up rooms that higher acuity patients needed. One of my initial biases at the time was that patients with lower acuity complaints that did not require emergency care should be redirected elsewhere.

My perspective on lower acuity complaints has changes with my experiences over the last couple of years. As a relativist I believe that everyone has different perspectives that are shaped through our past experiences amongst other aspects. In my current career I work with senior citizens and there is currently a physician shortage within the city. Unfortunately there are not enough doctors for the population of our city. In following up with some of my senior patients with multiple comorbidities, some were becoming quite sick because they had nowhere to go for care and did not want to go to the emergency department with a minor complaint. Over time those minor complaints could turn into major issues. In reflecting I realized that while some people truly have nowhere to seek care other than the emergency department and it is often best if we can address their concerns sooner over later. Putting myself in patients shoes what may seem minor to us could be considered an emergency to them and something that needs to be addressed immediately. My perspective on lower acuity patients has shifted and this is a bias of my own I need to be aware of during my research. I cannot project my experience or perspective on others and am interested to learn more about their experience with lower acuity patients.

I have used this space to reflect on some of the larger biases I have in regards to the emergency fast track area with the hope that being aware of my biases will help to minimize their effect on my research.

February 18, 2022

I feel that my first interview went okay. I could have made it flow better when I wen through the consent form at the beginning of the interview. I was lucky in that my participant was quite open with their dialogue and shared well thought out answers without being prompted for more information. One thing that I need to work on before the next interview is pulling out key points and having the participant expand further on those points. I reviewed my research proposal prior to the interview. However, since it has been a while since I wrote the proposal I think that it would have been useful to review the information more thoroughly. Prior to the next interview I want to be very clear in my mind where the gaps in the current research are on the topic and what I want to focus on in the interviews. I plan to review the interview that I currently have to see where I could have asked more probing questions. I believe there are times in the interview where I could have done a better job of having the participant expand on their experience. I also should have been clearer on what I meant by experience when the participant asked and which areas of their experience I wanted to focus on for the interview. I think my biggest pitfall was not steering the interview more and expanding on the important points that the participant brought up. I need to find a way to probe those areas better in my next interview.

Another thing that I would like to try with my next interview is leaving a little bit longer pauses. I also could have nodded more and encouraged the participant more with their answers. Overall, I have many things that I should work on for my next interview. I plan to do a practice interview with one of my friends or family members prior to the next interview to practice some of these strategies. Another priority before my next interview is being very clear on what I want to focus on in the interview and learning how to expand on points that are important to the participant. For example, during my interview I could have expanded on what the participant meant by safety and quality of care.

February 23, 2022

I have transcribed and read through each of the interviews a couple of times. In the second interview I did try to reassure the participant more, but I realized that it may have led me to ask leading questions. The hardest part of the second interview was trying to adapt to the interview, take some notes for cues on important information to ask more about, and actively listening to the participant. In my third interview I am going to focus on actively listening and doing a better job of asking more questions about parts of the experience that seem important to the participant. During my first session of coding I have tried to pull out any phrases that focus on the participants experience, quality of care, and the fast track design.

March 2, 2022

In going through and transcribing the interviews I have noticed that there were elements of the discussion that seemed important to participants that I should have done a better job of asking them to expand further on. I am struggling with figuring out a way to multitask better during the interviews as I think that I am trying to focus on too many improvements to my interviewing skills, while also trying to actively listen to the participant. During my next interview I will instead focus on one aspect of improvement for the interview. In this case to get richer data I will focus on noting elements that seem important to the participant and ensuring that I expand and ask further about those topics.

I have done a read through of the transcripts and am now beginning to code data. During coding I have focused on any elements where they participants described emotions, aspects of the fast track design, quality of care, and other items of the participants' experiences that seemed important to them. To start I have tried to organize the codes into like categories with the plan that once I have the important information coded I can go back, look at the codes and categories, and do a better job of organizing and refining the data.

March 8, 2022

Today I began reading through the codes and categories that have been created to date. I reviewed categories with less codes to see if they could be placed appropriately under other codes that have already been created. Currently I am starting work with refining and defining codes a bit better. Aware that I have a few interviews still to go and that these codes could change I find that organizing while I go may help to refine my focus as I come closer to the end of the study. Being more aware of the data and what different nurses have already said about the fast track area I feel, helps me to ask better follow up questions when interviewing participants. The nurses that I have interviewed so far have done a great job of describing and expanding on their experience of working in the fast track areas, and I have coded a lot of important information, but I do feel I need to begin to narrow down those categories a little bit better so that I can better sort data within the upcoming interviews. I have been categorizing the data according to repetitive experiences that come up in the different interviews.

April 4, 2022

I reviewed my current coding with my supervisor and am now going back through all of the transcripts to increase my coding and narrow down the length of the phrase utilized in each code. When reviewing the transcripts I did decide against including the information about one of the participants being a part of the design team for confidentiality purposes.

April 27, 2022

In analyzing the data and going back through the codes and categories I am at times having difficulty deciding where a given category best fits. Sometimes I feel like depending on who is interpreting and analyzing the research some of the categories may be placed under different themes. I am now trying to decide the best fit for the different categories. For example a couple of the participants spoke about overwhelming workload. Some of the concerns of overwhelming workload fit with when higher acuity patients ended up in the fast track area. I have decided that when the nurses speak specifically about workload and concerns for care in regards to higher acuity patients ending up in the fast track area then that fits with my flexibility theme best. The reason that I made the aforementioned decision is that talking about the higher acuity patients and workload plays into the fast track area nurses' experience with treating higher acuity patients in the fast track area. To talk about the flexibility that they allow for to treat higher acuity patients in the fast track area I feel the need to talk about their concerns because that is part of their experience with the flexibility that they are allowing for.

After reading through the transcripts again and the different tentative themes and codes I went back and moved prioritization to the section about nursing workload because I didn't feel that there was enough within that category in relation to the higher acuity patients to be a stand alone paragraph in the section about flexibility in the department.

May 1, 2022

As I go back through to write about the results I am finding that in looking up the larger part of participant's quotes and then information surrounding the quote the context can change a bit. In going through I have been renaming categories and moving them around if they fit better with another theme or may even fit better as part of another category. Some of the categories did not have much supporting evidence, but could be combined with other categories to create a more robust picture of some of the concepts that are coming up.

APPENDIX M

Demographics

Age	Number of Participants
< 30	1
30-40	5
>40	2

Experience	Number of Participants
1-5 years	3
5-10 years	3
>10 years	2

Last Time Working in the Fast Track Area	Number of Participants
1-2 days ago	2
3-7 days ago	4
1-4 weeks ago	2