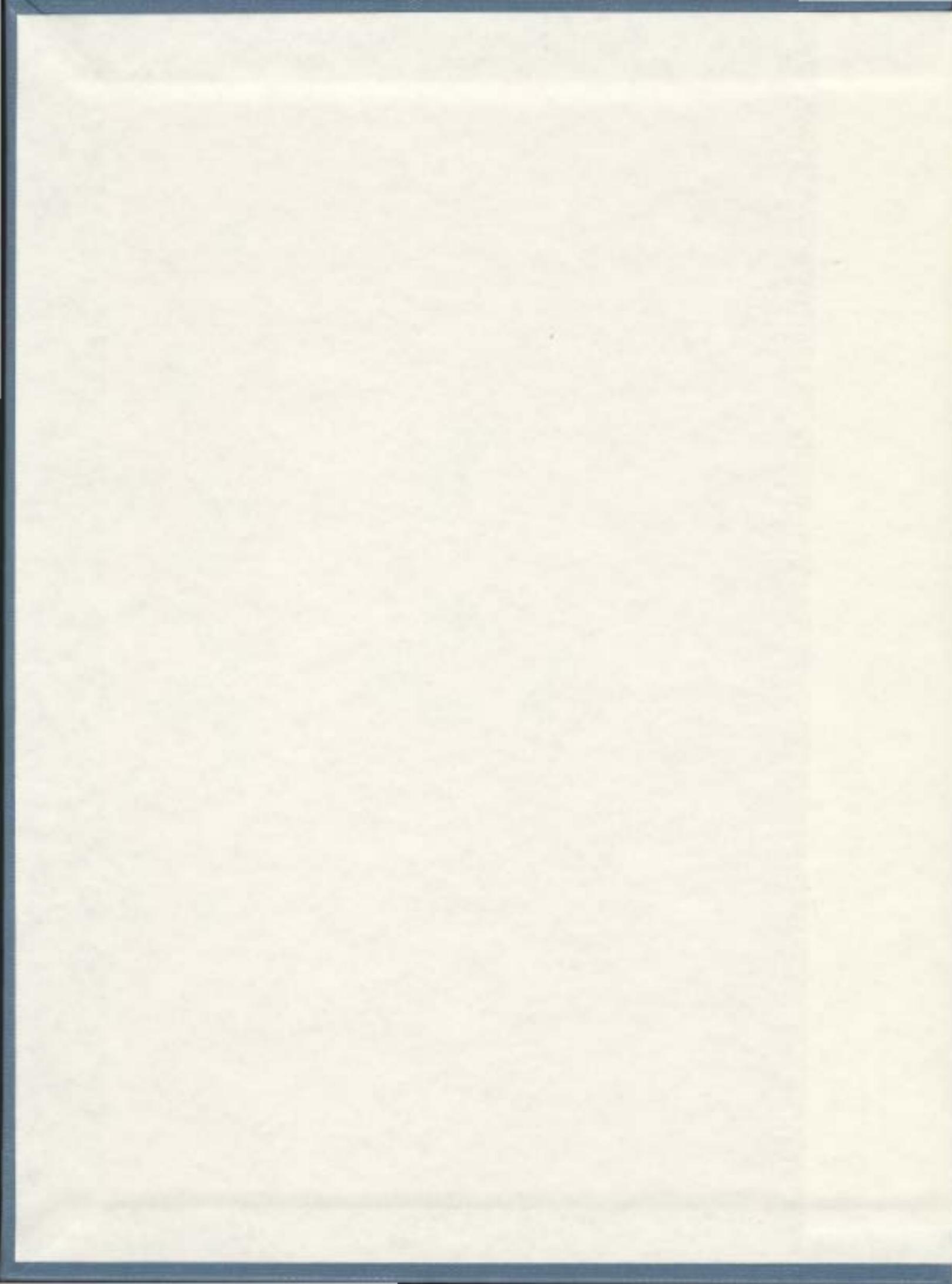


HOME CARE NURSES' APPRAISALS AND COPING
STRATEGIES IN A CRITICAL INCIDENT

LISA CHRISTINE BOWER



HOME CARE NURSES'
APPRAISALS AND COPING STRATEGIES
IN A CRITICAL INCIDENT

by

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Abstract

There is considerable literature concerning how home care nurses react to and cope with stress. However, there is little research pertaining to home care nurses and critical incident stress. The purpose of this descriptive, retrospective study is to identify how home care nurses appraise, react, and cope with critical incidents and the resulting stress from these events. Lazarus and Folkman's (1984) transactional model of stress, appraisal, and coping guided this study.

A total of 25 home care nurses completed each of the four instruments used in the study. Data collected with the instruments were summarized and the written descriptions of the critical incidents were analyzed using content analysis. From the content analysis, critical incidents were classified into one of six categories or themes: patient death, abuse, sexual harassment, urgent situations, organizational limitations of care, and potential threat to personal health.

Home care nurses experienced physical and emotional reactions in the immediate days and evenings following the critical incident. The majority of the emotions were negative. At the same time, home care nurses also used a variety of coping strategies. The four most frequently used coping strategies were seeking social support, planful problem solving, self-controlling, and positive reappraisal.

The study has implications for nursing educators, administrators, and researchers who have a pivotal role in guiding and supporting home care nurses in coping with the experience of a critical incident. A greater understanding of the meaning that critical incidents have for home care nurses may contribute to improving nursing practice for this group of nurses.

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Chapter One

Introduction

Most nurses would agree that nursing is a stressful profession. There is a significant amount of research regarding the stress that nurses encounter in their daily work (Bergen & Fisher, 2003; McVicar, 2003). Studies on stress in nursing seem to demonstrate that stress occurs regardless of the area of nursing practice (Edwards, Burnard, Coyle, Fothergill, & Hannigan, 2000; McVicar; Wilkes & Beale, 2001). However, what is perceived as a stressor in one area of nursing may not be perceived as a stressor in another area of nursing (Foxall, Zimmerman, Standley, & Bene, 1990; Healy & McKay, 2000). Individual nurses may also appraise stress differently than their colleagues within the same area of nursing practice (Burns & Harm, 1993).

Once a nurse has perceived certain events or situations as stressful, he or she usually employs individual coping mechanisms to deal with the stress (Burnard, Edwards, Fothergill, Hannigan, & Coyle, 2000; Butterworth, Carson, Jeacock, White, & Clements, 1999). However, some significant events can cause such intense emotional and physical reactions that the nurse's usual coping mechanisms are overwhelmed. These types of situations are known as critical incidents (Appleton, 1994; Caine & Ter-Bagdasarian, 2003). Recent literature illustrates that critical incidents are observed in other areas of acute care nursing (Wolf & Zuzelo, 2006) and are not just confined to areas where patient acuity is highest, such as emergency or the intensive care unit (Appleton; O'Connor & Jeavons, 2003). There is no specific nursing research that addresses what home care nurses perceive as critical incidents, how they react to, or how they cope with these incidents. This research is an attempt to address that deficit.

Background

There is evidence in the nursing literature that home care nurses experience stress in their daily practice (Boswell, 1992; Salmond & Ropis, 2005; Stewart & Arklie, 1994; Walcott-McQuigg & Ervin, 1992; Wilkes et al., 1998). Stressors such as workload, dissatisfaction with the work environment, and poor quality of care were identified in the research. However, what is not evident is how home care nurses identify with the stress of a critical incident.

Critical incident stress is the strong physical, cognitive, emotional, and behavioural stress reaction a person experiences after a critical incident (International Critical Incident Stress Foundation, Inc., 2001). A person perceives the significant event as being very traumatic and their usual coping skills are ineffective. The stress reaction may last days, weeks, or months, and if a person does not attend to the stress of the critical incident, he or she is at risk for developing burn out or other stress disorders (Bell, 1991; Shannon, 1991; Walker, 1990).

Approximately fifteen years ago, there was evidence of nurses being included in discussions relating to critical incidents, critical incident stress, and the management of critical incident stress (Back, 1992; Bell, 1991; Freehill, 1992; Shannon, 1991). Most of the literature was anecdotal, describing the need for critical incident stress management and debriefings, to reduce the effects of critical incident stress. The literature did not discuss nurses specifically, but rather referred to them under the title of emergency professionals (Bell; Freehill). Emergency professionals included police officers, firefighters, paramedics, and hospital emergency physicians and nurses. The consensus of the articles was that critical incidents were individually significant events that generated a

strong emotional response (Shannon; Walker, 1990). Most of the articles that discussed critical incident stress management and emergency professionals identified serious injury, death, and violence as examples of critical incidents (Bell; Freehill). These commentaries recognized that critical incidents created an overwhelming stress response in the individual, and the individual's normal coping strategies were inadequate.

In the early 1990s, researchers began to study critical incidents in nursing. Burns and Harm (1993) studied what traumatic situations emergency nurses perceived as critical incidents. In 1994, Appleton expanded on this work and included general medical/surgical nurses in order to explore what events they appraised as critical events. Nearly ten years later, O'Connor and Jeavons (2003) investigated Australian nurses' perceptions of critical incidents. The nurses in O'Connor and Jeavons' study worked in a variety of areas in the hospital and had a wide range of qualifications. Death, violence, and extreme challenges in caring for particular patients, were all common critical incidents identified in the three different samples of hospital nurses (Appleton; Burns & Harm; O'Connor & Jeavons).

The above investigations revealed what hospital nurses appraised as critical incidents. Although the events were infrequent, emergency nurses in two studies (Burns & Harm, 1993; O'Connor & Jeavons, 2003) rated the death of a child as potentially the most critical incident that a nurse may experience, and other events involving children also ranked high on the lists of potential critical incidents. Moral distress was appraised as the most common category of critical incidents by general duty nurses (Appleton, 1994). Moral distress has been used by others to examine critical incident reports (Wolf & Zuzelo, 2006). In order for the nursing community to understand and respond to critical

incidents and the stress that is associated with the incidents, nurses need to explore what is perceived as a critical incident within their area of practice.

Significance of the Study

As more medical and health services that formerly required an individual to stay in acute care moved to home care programs, patients seen in the community have greater acuity and their health needs are more complex. To care for these individuals and their families and meet these complex needs, home care nurses haven taken on additional roles and responsibilities without the immediate support that is usually available in an acute care institution. This may result in more home care nurses experiencing critical incidents and the stress associated with these events. However, our understanding of what home care nurses experience in the way of critical incidents, the stress associated with these incidents, and how they cope is limited.

This research is important to nurses working in home care. It will contribute to an understanding of what type of events home care nurses appraise as critical incidents and how they react and cope with these significant events. It will also be important to community nurse educators and administrators who want to support home care nurses when they experience a critical incident. A better understanding of critical incidents in home care nursing and the stress associated with it can help enhance management of this stress for these nurses.

Conceptual Framework

The theoretical framework used to guide this research inquiry is Lazarus and Folkman's (1984) transactional model of stress, appraisal, and coping. The authors define stress as "...a particular relationship between the person and the environment that is

appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being” (Lazarus & Folkman, p.19). Appraisal involves reflecting on an altercation between a person and his/her environment and identifying the reason and to what degree the altercation may be considered stressful. Coping involves how the person handles the altercation between person and environment that is appraised as stressful. The individual and the environment are in an active communal connection, which explains why Lazarus and Folkman consider their model transactional.

Cognitive appraisal is necessary to understand the variety of reactions different individuals have to their environment. Lazarus and Folkman (1984) have identified three kinds of cognitive appraisal: primary appraisal, secondary appraisal, and reappraisal. An individual determines if an event is irrelevant, benign-positive, or stressful during primary appraisal. If there is no change in a person’s well being, the event is considered to be irrelevant. If an appraisal is a positive interaction between person and environment, it is deemed a benign-positive appraisal.

According to this framework, there are three kinds of stressful appraisals: harm/loss, threat, and challenge. A harm/loss incident may involve major loss of personal being or a person significant in an individual’s life. In threat, the person may feel impending loss or harm may occur. A challenge is an opportunity for gain. Although these are all different types of stress appraisals, they are not mutually exclusive. A change in job may be perceived as both a threat and a challenge. The individual may realize the potential for new knowledge and career development but may also be threatened by the loss of self-confidence and uncertainty about his/her performance in the new environment.

Secondary appraisal involves an individual deciding what coping mechanisms are available and which ones would be most advantageous in relation to the identified altercation between person and environment. Secondary appraisal and primary appraisal interrelate as the level of threat is evaluated and the type of personal reaction occurs (Lazarus & Folkman, 1984).

Reappraisal occurs after the initial primary and secondary appraisals, in response to new information from the environment, or in response to the person's reactions to the stressor. The reappraisal is in essence a continuation of the original appraisal, as the individual continues to react and attempts to cope with the stressor.

Coping is the final aspect of Lazarus and Folkman's (1984) theory. Coping is a dynamic process that involves changing an individual's cognitive or behavioural styles to adapt to stimuli that have been appraised as stressful for that individual. According to the authors, there are two types of coping: problem-focused and emotion-focused. Problem-focused coping is similar to traditional problem solving whereby the person tries to manage the environment that is causing the stress. Emotion-focused coping deals with the emotional distress caused by the stressor and it includes such mechanisms as distancing and social support.

Lazarus and Folkman (1984) posited that coping is a process with three elements. The first element is surveillance and evaluation that is focused on what the person actually believes or does, rather than what they should do. The second element is the exploration within a specific context of what the person believes or does. The change in coping reflections and actions as the stressful experience develops is the final element of coping as a process.

Lazarus and Folkman (1984) suggested that appraisal and coping processes effect three adaptational outcomes: social functioning, morale, and somatic health. Social functioning is being satisfied with interpersonal relationships while morale is how an individual feels about him or herself. Somatic health involves the body's response to intense emotional responses. A home care nurse may have positive levels of social functioning when it comes to family and friends but low levels of morale at work due to a recent critical incident.

As critical incidents are considered to be stressful, Lazarus and Folkman's (1984) framework will be used to assist in exploring how home care nurses appraise, react, and cope with stress caused by critical incidents.

Research Questions

- 1.) What events do home care nurses appraise as critical incidents?
- 2.) How do home care nurses react to events appraised as critical incidents?
- 3.) How do home care nurses cope with events appraised as critical incidents?
- 4.) What effect do events appraised as critical incidents have on home care nurses, both personally and professionally?

Definition of Terms

Critical incident.

A critical incident is an experience that triggers strong reactions in an individual. These emotional reactions to the situation may exceed an individual's usual coping mechanisms, thereby impeding one's ability to perform successfully either at work or at home. The definition of a critical incident is specific to the individual as is how that individual responds to the incident. Someone may consider a traumatic event a critical

incident while another individual may not (Appleton, 1994; Burns & Rosenberg, 2001; Caine & Ter-Bagdasarian, 2003; O'Connor & Jeavons, 2003).

Critical incident stress.

Critical incident stress is the overwhelming stress response that is generated after a person experiences a critical incident. Symptoms of critical incident stress may appear hours or days after the incident and are classified as cognitive, emotional, physical, or behavioural (Caine & Ter-Bagdasarian, 2003; Fraser Health Authority, 2002).

Home care nurse.

A home care nurse is a registered nurse who provides nursing care to individuals and their caregivers in a home environment. Home care nurses are considered “generalists” in their nursing practice although there is a growing expectation to be a “specialist” in a variety of nursing practice areas. Home care nurses are increasingly requiring more specialized knowledge in palliative care, medical/surgical care, geriatrics, pediatrics, mental health, and primary health. Home care nurses are responsible for developing care plans with their clients to assist and support them in dealing with their health challenges. These health challenges range from acute to chronic to terminal. Home care nurses have similar knowledge, skills, and expertise as their colleagues in hospitals. However, the emphasis with home care nursing is to teach clients how to manage their health challenges at home. Some authors refer to home care nurses as community health nurses (Boswell, 1992; Stewart & Arklie, 1994).

Purpose

The purpose of this study is to explore and describe how home care nurses appraise, react to, and cope with critical incidents in their workplace.

Chapter Two

Literature Review

The literature reviewed for this study will be divided into two sections. The first part focuses on home care nurses' appraisal of stress and how they cope with stress. The second part investigates nurses' appraisals of critical incidents. Additional literature is also presented relating to research on support techniques in these areas.

Appraisal of Stress and Coping

There is significant evidence to support the fact that nurses experience stress in the workplace. McVicar (2003) completed a literature review using CINAHL, MEDLINE and COCHRANE to locate articles published between 1985 and April 2003 that covered workplace stress in nursing. In the review he included nurses working in diverse practice areas. Home care nurses were not identified as a special group in the review so it is not known if they were included. He suggested that workplace stressors could be categorized under six broad themes: 1) workload/inadequate staff cover/time pressure; 2) relationship with clinical staff; 3) leadership and management style/ poor locus control/ poor group cohesion/ lack of adequate supervisory support; 4) coping with emotional needs of patients and their families/poor patient diagnosis/death and dying; 5) shift work; and 6) lack of reward. McVicar concluded that although there were few comparative studies done regarding stress and area of nursing practice, consideration should be given to nurses' stress factors differing between practice areas. He also cautioned that there is considerable variation among individuals in the perception of stress in their workplace. Personal factors that affect perceptions can influence how the nurse copes with stress. McVicar briefly discussed nurses' use of emotion and problem-focused coping to deal

with stress. He concluded by suggesting that distress in the nursing workplace is complex, and more research is needed to recognize how individuals react when they are encountering distress and how they cope with stress. Organizations will be better prepared to support nurses once there is greater understanding of stress and coping in individual nurses.

In two investigations Healy and McKay (1999, 2000), investigated sources of job stress, levels of job satisfaction, and the effects of coping strategies among a group of nurses. Of the 129 nurses that responded to the *Nursing Stress Scale* questionnaire and written descriptions, 7 were from the community. Level of job satisfaction was measured using the *Job Satisfaction Scale* from the *Nursing Stress Index*, mood was measured using the *Profile of Mood States*, humour was measured using the *Coping Humour Scale*, and coping was measured using the *Ways of Coping Questionnaire* developed by Folkman and Lazarus (1988). Based on qualitative and quantitative data, workload and nursing staff were identified as the most significant stressors. The types of stressful situations that were categorized by the researchers as nursing staff and workload included situations involving inexperienced staff, conflict, and criticism from other nurses, concern about others' work practices, lack of support, inadequate staffing, and busy shifts. The top three coping strategies used in order of frequency were "planful problem solving" (20%), "seeking social support" (19%), and "self-control" (15%). Escape-avoidance was the coping strategy that was used the least often. The investigators concluded that situational circumstances are important in determining appraisals of stress and coping strategies, but they did not specifically identify or attempt to correlate differences in job stress and coping strategies between areas of nursing practice.

There has been limited research done in the area of stress specific to home care nurses. Studies conducted by Boswell (1992), Salmond and Ropis (2005), Stewart and Arklie (1994), and Walcott-McQuigg and Ervin (1992), produced some consistent patterns related to work stress in home care nurses. These studies also provide some evidence related to the current knowledge of stress associated with home care practice in comparison to other environments where nursing takes place. Limited research has been done on violence and aggression against home care nurses (Büssing & Höge, 2004). Verbal aggression by patients was the most frequent stressor the nurses experienced.

Walcott-McQuigg and Ervin (1992) surveyed 67 community health nurses over a three-month period using the community health nurses' perceptions of work-related stressor questionnaire to identify major sources of stress. The three highest ranked categories of stressors according to this sample were management dynamics, life events, and knowledge and technical skills. Examples of stressors categorized as "management dynamics" from this sample included factors related to work overload, uncooperative family members and clients, unfamiliarity with situations, inability to reach physicians, and personal situations. Further analysis of intensity of stressor scores illustrated that younger nurses and nurses with less community health nursing experience had more stress related interference with job performance. The authors suggested that employers may reduce nurses' stress by reducing caseloads, providing extensive orientation for new employees, providing maps of areas in which nurses work, and paid time for continuing education.

Boswell (1992) studied work stress and job satisfaction in 51 community health nurses using the *Nurse Job Satisfaction Scale*, the *Work Satisfaction Scale* and the *Job*

Stress Scale for her data collection. The three areas that these community health nurses described as most stressful were “quality of care”, “time to do one’s work”, and “task requirements”. The data also suggested a correlation between reductions in job stress and perceptions of improvements in quality of patient care, sufficient time to complete the required tasks, and increased proficiency at the tasks assigned. Boswell recommended developing methods of coping specific to the area of nursing practice and the stressors the nurses have identified.

To determine if job stress was related to well-being Salmond and Ropis (2005) examined job stress with the *Job Stress Survey* and the *Affect Balance Scale* among 58 home care nurses and 31 medical-surgical nurses. The top ten stressors for home care nurses starting at number one were excessive paperwork, meeting deadlines, frequent interruptions, insufficient personnel to handle an assignment, insufficient personal time, noisy work area, working overtime, inadequate salary, assignment of increased responsibility and making critical on-the-spot decisions. Home care nurses described further stressors particular to their situation that included maintaining their organizational plan, driving in traffic, bad weather, noisy office particularly in the morning, and constraints on their decision making due to guidelines they were required to follow.

Stewart and Arklie (1994) used the *Staff Burnout Scale for Health Professionals*, the *Nursing Job Satisfaction Scale*, the *Norbeck Social Support Questionnaire* and the *Nursing Stress Scale* to explore whether stressors specific to the community health environment required focused support programs. In this sample, there were three main sources of stress identified by the 101 community health nurses who participated in the study. Insufficient time for care, poor work environment, and difficult clients all appeared

to contribute to the majority of stress in this sample of community health nurses. Additional sources of stress included perceived lack of support from supervisors and heavy workload. Nurses also mentioned hazardous driving conditions, lack of role definitions, multiple programs and conflicts with other service providers as additional stressors. Illness and strain were the primary outcomes of burnout. The major sources of job satisfaction were enjoyment of work and satisfaction of care given to clients and families. The data supported the authors' hypothesis that as job stress increased, level of burnout increased and level of job satisfaction decreased.

These four studies demonstrated consistent identification of certain factors as being highly prevalent in the home care environment and sources of significant stress including quality of care, workload, and having sufficient personal and institutional resources to perform required tasks. These studies also highlighted certain stressors specific to the home care environment including challenging interactions with families and transportation-related issues. The above research provided evidence supporting the need for separate research related to home care nurses. For example, Boswell (1992) noted that when the same instrument as had been used with home care nurses was used in a separate study to identify workplace stressors in a hospital environment, lack of team respect and feelings of incompetence were discovered to be the most pronounced areas of stress. These stressors differed from those identified for home care nurses. In addition, Salmond and Ropis (2005) found some consistency between medical-surgical and home care nurses, with both groups identifying excessive paper work as the highest stressor; however, many other top stressors were identified by medical-surgical nurses but not by home care nurses. These other stressors included fellow workers not doing their job,

poorly motivated co-workers, covering work for another employee, conflicts with other departments, and inadequate support by a supervisor. The clear differentiation between the potential stressors of the two populations supports the need for further research in the area of home care nursing as it relates to stress and coping strategies.

Due to the limited amount of research specific to home care nurses that has been conducted in North America, other research was reviewed in countries where similar nursing care structures could be identified. During this expanded literature review, research related to stress that was conducted in the United Kingdom (Evans, 2002; Rout, 2000; Snelgrove, 1998) was identified as an additional source of literature. According to the careers section of the National Health System (NHS) website (2006, Role of a district nurse, para. 4) district nurses:

...assess the health care needs of patients and families, monitor the quality of care they're receiving and be professionally accountable for delivery of care....

patients can be of any age, but often many of them will be elderly, while others may have been recently discharged from hospital, be terminally ill or have physical disabilities.

The definition of district nurses is similar to the definition of Canadian home care nurses used in this study. There are some studies that explored occupational stress in district nurses. Evans (2002) investigated what district nurses perceived to be the most stressful aspects of their work and with what intensity they experienced the stressors. She used the *Community Health Nurses' Perceptions of Work-Related Stressors Questionnaire* and three open ended questions to ascertain if there were stressors the nurse experienced not included on the questionnaire, to identify why the nurse rated

stressors as high intensity, and to discover the most stressful aspects of the job on a weekly basis. The 38 out of 50 nurses who completed the survey identified many of the top ten stressors as being associated with workload. These included lack of time to complete work during scheduled working hours, heavy workload that did not allow appropriate attention to each case, inadequate number of staff leading to extra work, extra work requirements, and completing documentation. Other stressors ranked in the top ten included climate change in the National Health System, critical/terminally ill patients, family responsibilities, lack of teamwork with other departments, and lack of adequate information. There was some discrepancy within the data when it came to nursing leadership. Quantitatively the respondents indicated that it was low on the list of stressors but in the qualitative data they expressed frustration and feelings of resentment at not being included in decision making processes. Despite the small sample size in the study, these findings were similar to North American research published regarding home care nurses and stress.

Another study from the United Kingdom identified similar sources of stress for primary care professionals. Specifically, major sources of stress were identified as time pressure, administrative responsibility, having too much to do, factors not under their control, interruptions, keeping up with National Health Service changes, and lack of resources by 79 district nurses (Rout, 2000). The author used a shortened version of the *Ways of Coping Checklist* to identify the coping strategies used by this population of district nurses. The most widely used coping strategy was “talked to someone about how I was feeling”. The next two most widely used responses were “just concentrated on what I had to do next” and “talked to someone who could do something about the problem”.

Snelgrove (1998) reported four apparent sources of overall stress for 143 health visitors, district nurses, and community psychiatric nurses working in a community environment. The lack of uniformity in the health care responsibilities of study participants provided a more diverse view of the types of stressors that can be encountered in the community environment. The first source of stress identified by all participants was the emotional demands of dealing with a client's physical and psychosocial problems. The second was coping with unpredictable events such as having problems in isolated areas or a physical attack. The third source of stress was change in the working environment and the last sources of stress were concerned with content of the work decision-making, role ambiguity, and unsatisfactory visits. Snelgrove used the *General Health Questionnaire-12* to assess stress levels and a 47-item questionnaire compiled for the study to identify sources of stress and job satisfaction among the nurses. Although the top sources of stress from the overall study participants were somewhat divergent from the other studies discussed above, the top source of stress that was identified by the 56 district nurses who participated in the study was lack of time for visits. This latter source of stress is consistent with other research findings. The author concluded that, although there were similar stressors in all three occupational groupings of nurses, some variability was identified. Snelgrove cautioned about treating nurses as a uniform group when assessing occupational stress within the nursing profession.

The study by Snelgrove (1998) is important because she makes a differentiation in stress levels particular to the area of practice location and degree of practice responsibility. The study recognizes that high levels of perceived support by supervisory staff can reduce the impact of some sources of stress in the populations studied; however,

there are certain factors, such as isolation, which cannot be addressed by such organizational changes. As the population she studied operated within the home care environment, there appears to be a higher level of importance, and perceived stress, placed on factors associated with personal accountability in the provision of client care. Snelgrove thus provided a clear source of differentiation between other studies on occupational stress in nursing with the identification of the work environment as a component to sources of stress.

Butterworth et al. (1999) also administered the *General Health Questionnaire-28* along with the *Maslach Burnout Inventory*, *Cooper's Coping Skills*, *Nurse Stress Index*, *Minnesota Job Satisfaction Scale*, and a demographic questionnaire to 586 nurses in England and Scotland. The sample involved both ward nurses and community psychiatric nurses. The study was part of a project to evaluate the effectiveness of clinical supervision in nursing. It is not apparent from the findings how many nurses worked in the hospital and how many in the community. The authors did conclude based on results of the *Nurse Stress Index* that working in the community was more stressful than working in the hospital in terms of how emotionally draining the work was for the nurses. However, the community nurses did report lower feelings of depersonalization than the ward nurses. This study echoed findings of an earlier study that found psychiatric nurses to have higher stress levels in the community than in the hospital (Fagin, Brown, Bartlett, Leary, & Carson, 1995).

In addition to the studies specific to home care and district nurses listed above, research related to community psychiatric nurses was reviewed as another potential source of information regarding the sources of stress in the community environment. In

1995, Fagin et al. studied 250 community psychiatric nurses and 323 ward-based psychiatric nurses. A variety of instruments were used to assess occupational burnout, general health, job satisfaction, self-attitude, and coping skills. The community psychiatric nurses had significantly higher scores on the *General Health Questionnaire-28*, indicating increased psychological distress. Despite having higher levels of stress, community psychiatric nurses also had greater scores of job satisfaction than the ward-based psychiatric nurses. Nurses participating in the study identified the lack of community facilities to which to refer clients caused them the greatest stress. The other significant stressors identified by the piloted questionnaire were waiting lists for services and having to independently deal with suicidal clients. Lack of community facilities and long waiting lists for services are both stressors imposed by inadequacies in the community care system. Dealing with a suicidal client independently may also be viewed as a stressor related to organizational limitations because the nurse's workload may not allow for assisting colleagues with difficult clients. Community psychiatric nurses primarily used task strategies and identification of work aims as coping strategies. Peer support was identified as the third most frequently used coping strategy. Nurses who use solution-based strategies such as task strategies to cope with stress may find that the lack of resources decreased their ability to effectively implement this coping strategy. In this way, community and institutional factors can contribute to stress by reducing the effectiveness of potential coping strategies.

Another study using the *General Health Questionnaire* by Coffey (1999) measured stress in community mental health nurses. Eighty forensic community mental health nurses completed *The Maslach Burnout Inventory*, *The General Health*

Questionnaire, and *The Community Psychiatric Nurse Stress Questionnaire*. This sample of nurses identified ten items that they considered to be stressful. Similar to the study by Fagin et al. (1995), the source of greatest stress was a lack of resources to which to refer clients in the community. Other sources of stress in descending order of importance included having too many interruptions in the office, giving talks or lectures to other groups or staff, working with uncooperative clients, feeling that there was not sufficient back-up from the hospital, long waiting lists for clients to access services, managing workload efficiently, visiting unsafe areas, lack of cooperation from other health care workers, and dealing with suicidal clients on their own. The author noted that dealing with violent clients did not make the list of top ten stressors in this study.

Although certain factors listed in the two studies above are specific to psychiatric nurses, other sources of stress identified in these studies, such as those related to safety in the working environment and the sufficiency of appropriate resources are highly relevant to home care nurses.

Palliative care is a unique aspect of home care nursing. According to the World Health Organization website (2006, Palliative Care, para.1), "palliative care is an approach which improves the quality of life of patients and their families facing life-threatening illness, through the prevention, assessment and treatment of pain and other physical, psychosocial, and spiritual problems". Due to the dynamic nature of palliative care and the loss of life, it can potentially be a specific source of significant stress for home care nurses.

As early as 1985, Gotay, Crockett, and West began to research nurses' perceptions of roles and stress in palliative care. The researchers interviewed ten home care nurses

involved in the palliative home care program in a Canadian city. The participants were also given the *Impact of Event Questionnaire* to complete which was used to investigate the impact of stressful incidents between nurses, clients, and their families. Although the authors cautioned about interpreting the results due to the small sample size, they found that nurses new to the palliative home care program had higher levels of stress. Gotay et al. also mentioned that the home care nurses identified more than one coping strategy used to deal with the stress. Social support, such as talking with family or co-workers, was the most common coping mechanism. Other nurses identified group sport activities or individual activities as coping strategies. Several nurses felt that additional team support would be beneficial. The authors recognized that social support networks can be difficult to initiate because of the independent nature of home care nurses' work.

Payne (2001) addressed stress and coping as factors of burnout in female hospice nurses. Eighty-two nurses and nurses' assistants from nine hospices completed the *Nursing Stress Scale*, *Maslach Burnout Inventory*, and the *Ways of Coping Scale*. The top ten most frequent stressors for the nurses in descending order were death and dying, inadequate preparation, workload, conflict with doctors, conflict with nurses, lack of support, and uncertainty. In descending order, planful problem solving, seeking social support, self-controlling, accepting responsibility, positive reappraisal, distancing, confronting, and escape-avoidance were the top eight most frequently used coping strategies reported by hospice nurses. Payne suggested that the findings of the sample should be interpreted with caution because of the combination of qualified and unqualified nursing staff.

Wilkes et al. (1998) stressed the importance of identifying what community health nurses perceived as stressful when it came to caring for clients requiring palliative care in the community. Twenty-one nurses completed the questionnaires and seven from the sample volunteered to be interviewed. When nurses documented what stress meant to them, four major categories were identified: inability to cope, lack of control/lack of time, lack of knowledge and inadequacy/overload. Sources of stress included poor family dynamics, the family wanting the nurse to be a part of the family unit, workloads, and the expectations of others. Another significant stressor for community health nurses delivering palliative care in the home setting was the client and/or family's denial of the possibility of no cure. In the interviews the nurses shared some of the strategies they used to cope with the stress of caring for their clients. Most nurses discussed and shared their experiences with another person, whether it was another nurse, bereavement counselor, or another member of the palliative care team.

In a more recent study of Australian palliative care at home, Wilkes and Beale (2001) interviewed and compared stress in seven urban and five rural community nurses. The major stressors identified by both groups of nurses were their relationships with the family, the family dynamics, and the family's burden of care. Inability to provide adequate symptom relief, communication with general practitioners and other health care providers, and workload were also all major sources of stress for both urban and rural nurses. Rural palliative home care nurses also identified working in isolation including lack of after-hour services and distance between patients as additional major stressors in their jobs. The nurses coped using informal debriefing with colleagues or family. A biweekly meeting to discuss issues had been introduced by some urban community health

teams to assist in coping and the urban nurses had access to a bereavement counselor. The rural nurses relied on a more organized support network amongst themselves to cope with stressors.

Three out of the four studies above incorporated participant interviews as a form of data collection. Due to the sensitive nature and emotional intimacy involved in caring for those with a terminal illness, descriptions of the challenges associated with the nurse-client relationship during palliative care may be best captured in discussion rather than questionnaires. The stressors identified in the studies related to palliative care provide additional examples of potential stressors in home care nursing practice. The additional dimension of palliative care provides a unique source of stress that can be more specific to a particular incident or issue than the sources of stress identified in other studies on home care nursing. The stressors identified in studies by Boswell (1992), Stewart and Arklie (1994), and others provide indications of the general stressors that are encountered in home care nursing practice which are cumulative in their impact on the nurse and are addressed through general coping strategies that are integrated into a nurse's regular routines. Palliative care provides a heightened emotional situation that can cause related stress in relation to the experiences of the family and the nurse.

Despite the above examples of studies involving work-related stress for home care nurses, none of these studies examined a specific type of stress, i.e., critical incident stress. Critical incident stress differs from the general stress that a nurse may experience for a couple of important reasons. First, an individual may have several defined coping strategies in place to address general stress. Second, critical incident stress is triggered by a specific traumatic incident that causes an unusually strong emotional response and may

render the coping strategies previously adopted for general job-related stress as ineffective.

Critical Incidents in Nursing

Burns and Rosenberg (2001) suggested that “an incident becomes ‘critical’ through the process of identifying the meaning of an event and its ability to cause a change within the individual” (p.22). They posited that critical incidents have been defined in the literature as either an event, a professional’s performance, or as a professional’s reaction. A critical incident, as an event, is a difficult or stressful experience. However, what may be a traumatic experience for a person at one point in time may not be a critical incident for another person or for that same person at a different point in time (Burns & Rosenberg). A critical incident defined as a professional’s performance centres on distinguishing what specific behaviours of the professional resulted in a particular outcome. The professional is required to reflect on the outcome of his or her performance in order to appraise an event as critical. A critical incident characterized as a professional’s reaction originates in the professional’s atypical powerful emotional response to a situation. Burns and Rosenberg believed that current literature failed to integrate all three definitions of critical incident. The authors believed that the lack of a comprehensive exploration of the definition of critical incident prevented an understanding of the role that personal meaning played in appraising a critical incident.

Burns and Rosenberg (2001) interviewed six emergency nurses and analyzed the interviews using thematic content analysis. When the nurses were asked why the incident had stood out in their minds, three themes were identified; helplessness or loss of control,

identification with the victim, and strong sensory imaging. Five out of six nurses reported the critical events had changed their nursing practice by causing them to become more cautious practitioners. Four out of the six nurses admitted their perspective on life changed after experiencing the event.

Although certain information can be drawn from Burns and Rosenberg's (2001) study, the types of events experienced by emergency nurses are likely to differ from home care nurses due to the difference in the work environment. For example, critical incidents experienced in an emergency room are more likely to be experienced within the context of a group, which would cause certain reactions and perceptions to differ from those experienced by a home care nurse who would be working in isolation. In addition, the critical incidents addressed in the above study could involve a condition known as posttraumatic stress disorder (PTSD). PTSD is a condition whereby the individual experiences or witnesses a frightening event that arouses intense feelings of fear or helplessness, often associated with strong sensory imagery (Fagan & Freme, 2004). Events that are similar to or cause PTSD are not the only types of events that could be perceived as critical incidents. For example, a situation that involves a nurse making a difficult decision or feeling threatened may also be a critical incident in the perception of the nurse involved; however, it is unlikely that such an incident would involve strong sensory imagery as described in the study interviews. These types of incidents could be classified as incidents involving ethical distress. Ethical distress involves "situations in which nurses cannot fulfill their ethical obligations and commitments, or they fail to pursue what they believe to be the right course of action, or fail to live up to their own expectations of ethical practice..." (Canadian Nurses Association, 2003, p. 2). Failing to

live up to personal expectations of ethical practice may be attributed to a mistake in judgment or incidents completely out of the nurse's control.

Seven articles were located that identified what nurses specifically appraised as critical incidents (Appleton, 1994; Burns & Harm, 1993; Duxbury, 1999; Mitchell, 2001; O'Connor & Jeavons, 2003; Perry, 1997; Wolf & Zuzelo, 2006). These articles were reviewed to determine the consistency with which nurses assessed critical incidents in relation to concepts developed by Burns and Rosenberg (2001).

Burns and Harm (1993) studied emergency nurses' perceptions of critical incidents using data from questionnaires and interviews. The incidents that were identified by the 682 participants surveyed as potentially the most critical were death of a child and death/suicide of a coworker. Disasters and caring for someone critically ill or dying with whom they had a close relationship were events also perceived to be critical incidents. This data were further supported by qualitative data from the 26 nurses that were interviewed. Burns and Harm had a substantial sample size and the perceptions of critical incidents in the quantitative and qualitative data were congruent. However, there were limitations in the methodology. The authors listed eighteen traumatic events and respondents were asked to what degree they considered the events as critical. Burns and Harm did not incorporate other events the participants appraised as critical incidents on the list even though violence was perceived by the respondents to be a critical incident. Burns and Harm also only asked respondents if they had experienced the critical incident in the last year. Asking respondents to identify when and how often they had experienced the perceived critical incidents would have enhanced the understanding of critical incidents and emergency nurses.

In 1994, Appleton explored what medical and surgical general duty nurses appraised as critical incidents. Nurses were asked to describe a critical incident they had experienced and how they felt about the incident using the *Emotional Appraisal Scale*. She also explored how these same nurses coped with the critical incident using Lazarus and Folkman's revised *Ways of Coping Questionnaire* (Folkman et al., 1986). The events that the 50 general duty nurses identified as critical were divided into six categories. The categories included moral distress, lack of responsiveness from a health care professional, violence toward a nurse, emergency situations, patient death, and actual or potential contact with infectious body fluids. A large percentage of these nurses indicated that fatigue and insomnia were physical reactions to the event they appraised as critical. Emotional reactions included feelings of anger, disappointment, frustration, disgust, fear, anxiety, and worry. The top four coping mechanisms used by the nurses were seeking out social support, self-control, positive reappraisal, and problem solving. Appleton is an advocate for self-definition of critical incidents, meaning that when an incident occurs, one nurse may appraise it as critical while another nurse may not.

In a larger scale study O'Connor and Jeavons (2003) ranked responses to critical incidents from 192 full time nurses, that included nurse managers, clinical nurse specialists, and nurse educators that were employed at a teaching and research hospital. *The Critical Events Questionnaire* developed for the study had 29 items, and questions 30 and 31 were open-ended responses to allow nurses to add events not already included on the questionnaire. *The Critical Events Questionnaire* represented five categories of critical incidents and included death or injury of patients/colleagues, personal threat/violence, aspects of patient care/management, emergencies, and involvement in an

incident that attracted excessive media coverage. No reliability or validity was reported for the questionnaire.

The most frequently experienced critical incidents in the last year reported by the respondents in O'Connor and Jeavons' (2003) study were emergency situations such as cardiac or respiratory arrest. The other two most frequently experienced incidents were classified as other events and violence, and included verbal abuse, threats, and physical abuse by a patient or by a family member. If this category of violence was combined with verbal abuse, threats, and physical abuse by one staff member towards another staff member, violence was the most frequently experienced critical incident. Although these critical incidents were reported to occur most frequently, they were not necessarily considered the most stressful critical incidents. Emergency situations such as cardiac or respiratory arrest were the most stressful critical events the respondents experienced in the last year. This was followed by dealing with multiple traumatic events within a short time period as the number two most stressful event, and the combination of both categories of violence was the third most stressful event the participants experienced in the last year.

Perry (1997) asked a mixed group of post-registration nursing students to reflect on an incident they perceived as critical at work. Forty-one nurses consented to their assignments being analyzed by research tutors to search for common themes. Perry noted that the incidents described by the students were not necessarily emergency situations but rather events that were significant for the student. The main types of critical incidents reported by the students were life-or-death situations, which included resuscitation events and resuscitation decisions, differences of opinion that included differences between

nurse/nurse, nurse/doctor, nurse/patient and doctor/doctor, and suboptimal practice which included poor care, unprofessional behaviour, and ineffectual management. There were also three separate important elements that emerged from the critical incidents. The first was differences of opinion between nurse/nurse, nurse/manager, nurse/doctor and nurse/patient. The second category was workload issues that included staff shortages (in general and specifically those with experience), and poor managerial support. The third category was ethical dilemmas that included advocacy, accountability, duty of care, and consent. Although some students were able to use the assignment as an adjunct to other coping strategies, other students did not feel comfortable exploring some of the most important aspects of the event. Other students rationalized their actions when they wrote about the critical incident they experienced. Perry suggested that since the assignments were marked this was a weakness of the study, as post-registration nurses may have written what they thought would get them a good grade on the assignment.

Patient aggression was identified by Duxbury (1999) as a critical incident and studied in both mental health and general nursing settings. A total of 34 mental health nurses working in an inpatient setting and 32 general nurses working in medical/surgical settings responded to the researcher by answering the question “in your own words, please describe one or more incident(s) which has involved a patient being violent” (Duxbury, p. 110). Content analysis of the qualitative data demonstrated that the most commonly experienced types of aggression were verbal and physical abuse and that similar types of aggression were experienced by both mental health nurses and general duty nurses. Mental health nurses usually associated a patient’s aggression with the patient’s mental state. General duty nurses had a tendency to associate patients’

aggressive events with a physical anomaly such as pain or hypoxia. However, general duty nurses did acknowledge that a patient's aggression could be related to an underlying mental health problem. Mental health nurses appeared to cope with patient aggression by taking control of the situation while general duty nurses coped by relying on the medical staff and mental health teams for intervention. The author called for further research of this type of critical incident using a larger sample population and a greater variety of practice settings to gain a richer understanding of the phenomena of patient aggression.

In 2001, G. J. Mitchell conducted a qualitative study to investigate critical incidents. G. J. Mitchell studied 22 critical incident reports submitted by students who were registered nurses pursuing further education and focused his efforts on three main areas of the critical incidents. The first area was "the main person or persons involved in the critical incident" and included nurse/patient, nurse/patient's family or caregiver, nurse/doctor, nurse/social services, nurse/nurse, and nurse/police. The second area was "causes of the critical incident" that included aggression (both verbal and physical), suicidal behaviour (actual and threatened) and lack of support. The third area was "what was learned from the critical incident" that included a need for debriefing after critical incidents, better communication between ward team, value of nurse in partnership with other agencies, identification of roles and responsibilities, expressing concerns to management, and attending a clinical supervision course. G. J. Mitchell admitted to a potential conflict of interest because he was the course instructor as well as the researcher. Also, the study sample was small and included only nurses who worked with the psychiatric mental health population.

One of the main premises of Burns and Rosenberg (2001) was the importance of the meaning given to the critical event by the person who experienced the incident. The variety of incidents that are considered critical in the studies listed above supported their premise regarding the nature of critical incidents. The underlying themes identified by Burns and Rosenberg were generally apparent in the types of critical incidents identified by participants in the studies reviewed. Helplessness or loss of control was experienced in many of the critical incidents identified by study participants including physical or verbal abuse toward the nurse, death, and emergency situations involving a patient. These types of incidents involved a nurse being placed in an unexpected situation that may further decrease the perception of control by the nurse. The second theme identified in critical incidents was an ability to relate to the victim. In situations involving physical or verbal abuse or in situations involving the death of a coworker, the ability to relate to the victim would be heightened as the critical incident directly involved a member of the health care team. From the information presented in these studies regarding the nature of critical incidents evaluated by participants, it was unclear whether the incidents identified involved strong sensory imaging. As the description of these incidents was not indicative of this theme, it is unclear whether this criterion has an important role in the determination of an incident as being defined as critical.

Wolf and Zuzelo (2006) recruited 20 nurses working in either Canada or the United States to participate in a study that required the nurses to recount “never again” stories that the researchers defined as critical incidents. These nurses who worked in different areas in acute care and had varied years of experience as nurses gave written accounts of difficult patient situations that faced them in their practice. Using Collaizi’s

phenomenological method the researchers grouped the incidents the nurses reported as being fatal, close calls, dehumanizing, or isolating. All of these incidents created moral distress for the nurses involved and caused a great deal of stress for the nurses.

As mentioned in certain situations an incident may be considered critical because of the resulting ethical distress. In these types of incidents, a nurse may have been placed in an important decision-making role in relation to a patient or situation. The decision that the nurse made may have caused a level of ethical distress that had an impact on the nurse's future actions and that caused him or her to review past actions for consistency. Given the high level of responsibility involved in a situation, a nurse may consider an incident critical because of the professional vulnerability and potential for loss of professional reputation. When being placed in a situation of professional control, as would be the case in incidents involving a home care nurse working in isolation, there is a greater degree of personal accountability and that in turn places a higher level of importance on the competence of the nurse involved. These types of incidents are expected to have a different profile than the types of incidents that would be classified as PTSD. Research related to these types of critical incidents is extremely limited.

Several non-research articles were found that illustrated the importance of recognizing critical incidents and critical incident stress in nursing (Caine & Ter-Bagdasarian, 2003; Hollister, 1996; Laws & Hawkins, 1995; Martin, 1993). In a discussion of coping with critical incidents, Martin maintained that critical incidents were not exclusive to emergency and trauma teams. She supported debriefing sessions for all nurses involved in traumatic events, regardless of their area of practice whether it was pediatrics, oncology, or medical/surgical. Often the critical incident stress management

program was initiated after the critical incident to assist nurses in dealing with the critical incident stress that can cause physical, cognitive, emotional, and behavioural reactions.

Nurses are recurrently exposed to critical incidents in caring for ill and dying clients in a multitude of settings (Laws & Hawkins, 1995). The stress caused by these critical incidents can have a profound negative effect on a nurse's life. If the critical incident stress is not addressed, the nurse could later suffer longer term stress disorders. To reduce the impact of critical incident stress on nurses, Laws and Hawkins suggested a formal approach to debriefing called critical incident stress debriefing. These authors believed that implementing critical incident stress debriefing could minimize the effect of stress on nurses.

Hollister (1996) is another proponent of critical incident stress debriefing in the community. She acknowledged there are added difficulties in debriefing in the community in comparison to the hospital because of traveling and coordinating the debriefing team. Hollister also believed community health nurses should be knowledgeable about the signs and symptoms of critical incident stress because clients involved in traumatic events that are discharged early from hospital could potentially suffer from critical incident stress. If the community health nurse who is visiting the client has an understanding of critical incident stress, measures could be taken to ensure the client is referred to support services earlier rather than later. Hollister also acknowledged the importance of debriefing for health care workers who may have experienced feelings of helplessness associated with not doing enough for patients. Although this article is primarily patient-focused, it supported the need for critical incident stress debriefing; a support practice that has broader implications than

identification of critical incident stress in patients. As seeking social support is identified as a significant coping strategy used by nurses in addressing critical incident stress, the understanding of critical incident stress by a nurse will allow other nurses to identify such stress in colleagues and ensure that the use of such a coping strategy is effective. The potential limitation to the critical incident stress debriefing proposed by Hollister is that this type of debriefing involves a group of individuals involved in an incident. As home care nurses often work in isolation, this type of debriefing may have limited application in many circumstances.

Caine and Ter-Bagdasarian (2003) identified four components of a critical incident for nurses and other health care professionals, such as the traumatic event, each nurse's reaction to the event, each nurse's performance, and the meaning each nurse gives to the event. Stress from a critical incident results in cognitive, physical, emotional, and behavioral changes in a person. If a nurse does not manage the critical incident stress, he/she may develop acute stress disorder. Acute stress disorder is diagnosed if an individual experiences symptoms such as depersonalization, detachment, or flashbacks. Acute stress disorder usually occurs within a month after the critical incident and may last from a couple of days to 4 weeks. If the acute stress disorder lasts longer than one month, the nurse may be diagnosed with posttraumatic stress disorder. Caine and Ter-Bagdasarian posited that critical incident stress debriefing can mitigate critical incident stress, thereby reducing the potential for nurses to develop stress related disorders.

Summary

The first half of the literature review focused on stress that nurses experienced working in the community. The majority of the studies indicated that although there were

some similar sources of stress, community health and home care nurses' appraised stress differently than their colleagues that work in other areas of nursing. Multiple issues around workload and dealing with difficult clients and families were stressors for community health nurses. Many research articles out of the United Kingdom with district nurses echoed the findings of the North American research. A stress unique to home care nurses was associated with palliative care in the home. Home care nurses who were involved with clients dying at home, found dealing with families, workload, and client/family refusal of palliative status significant sources of stress. Home care nurses also used a variety of mechanisms to cope with stress. More than one study identified support networks as an important coping strategy for home care nurses.

The second part of the literature specifically addressed the complexity involved in defining and classifying critical incidents. A variety of incidents were considered critical by participants in the various studies reviewed. In addition, there was significant variety by study participants in the identification of a particular incident as being critical. Based on these factors, many authors agreed that an event is considered critical if the nurse perceived it to be. The consistent theme in this research was the important role of personal meaning and perception in the appraisal of an incident as critical. A second and more critical limitation of the literature review performed for the current research was the noted absence of literature exploring critical incidents in a home care setting. As personal meaning and perception played a strong role in the defining of an incident as critical, significant variation from known themes for such incidents may exist within home care. Furthermore, feelings of helplessness and lack of control and the identification with the victim may be emphasized by the home care setting. The change in the role of the nurse

from the more controlled hospital environment and the closer integration of the nurse with the caregivers that can occur in the home setting, may both impact the critical incident appraisal and implementation of coping strategies. The proposed study will contribute to nursing research in the area of home care nursing and critical incidents.

Chapter Three

Methodology

The description of the methodology used for the study is outlined in this chapter. Participants and methods of recruiting are identified; the four data collection instruments are presented in order to outline how data were collected; and an explanation of the data analysis is provided as well as ethical considerations. A descriptive, cross-sectional, retrospective design was used to guide this study because the home care nurses would have already experienced the critical incident. A descriptive design provides an opportunity to explore, describe, and record aspects of an experience.

Participants

The potential participants for the study were any home care nurses employed by the Vancouver Coastal Health Authority and specifically those who worked in Vancouver Community. Any home care nurse who had experienced a critical incident while working as a home care nurse was invited to participate. The home care nurses were not asked to identify if the critical incident had occurred while they were employees of the Vancouver Coastal Health Authority. Once ethical approval was obtained from Memorial University of Newfoundland Human Investigation Committee and the Vancouver Coastal Health Research Institute, participant recruitment commenced.

Recruitment

An email was sent to each manager responsible for the home care nurses at each of the seven urban community health sites (Appendix A). In the email I requested five to ten minutes be allocated to me at a home care nurses meeting to do a presentation about the research. The purpose of the presentation was to provide a background on critical

incidents in nursing, define critical incidents and provide examples, emphasize the lack of research involving critical incidents and home care nurses, and explain the study and request participation (Appendix B). Once I received permission to talk with the home care nurses I presented the study to them at their monthly meeting at each of the seven urban community health sites. These presentations occurred over a one-month period. After each presentation, I answered any questions or clarified any concerns. The home care nurses were encouraged to contact me with any other questions.

Data Collection Instruments

There were four instruments used to collect data in this study.

Participant information sheet (1992b)(revised with permission).

General demographic information was collected using the participation information instrument (Appendix C) that was developed by Appleton (1992b) for her research involving medical/surgical nurses' appraisal and coping strategies in a critical incident. Age, gender, number years of experience, and number of years in present position were demographics that Appleton recorded. I also added a category of employment status because I wanted to explore if a home care nurses' employment status contributed to the experience of a critical incident. Casual nurses may miss inservices and meetings because they are doing the work of the regular staff that is attending the inservices and meetings. I was curious to know if the lack of attendance at inservice meetings was related to casual nurses appraising events as critical.

Critical incident information form (1992a)(revised with permission).

The instrument on critical incidents (Appendix D) was also designed by Appleton (1992a) and one revision was done to Appleton's original form. Question number three,

which relates to when the critical incident occurred, was changed to reflect the hours worked by home care nurses. Appleton's potential answers included 8 hour and 12 hour day/evening/night shifts that were appropriate for staff nurses who worked in the hospital. I changed the hours of shifts to include weekday and weekend day/evening shifts as well as night on-call shifts to reflect the situation of the nurses in my study.

Emotional appraisal scale (Folkman & Lazarus, 1986).

This instrument (Appendix E) was used to measure the emotional reactions home care nurses had to a critical incident. The instrument was also used by Appleton (1993) to measure the reaction of the medical/surgical nurses to a critical incident. *The Emotional Appraisal Scale* (Folkman & Lazarus, 1986) is a 16-item checklist with a 5-point Likert scale (0 = not at all; 4 = a great deal). The 16 emotions are categorized into four emotional scales. The disgusted/angry scale includes anger, disappointment, disgust, and frustration. The worried/fearful scale includes worry, anxiety, and fear. The confident/secure scale includes confidence, security, and in control. Exhilaration, relief, happiness, pleasure, eagerness, and hopefulness are included in the pleased/happy scale (Folkman & Lazarus).

The *Emotional Appraisal Scale* is based on the premise that "... the perspective of a cognitive emotion, the quality and intensity of any emotion—*anxiety, jealousy, sorrow, joy, relief*—is generated by its own particular appraisal" (Folkman & Lazarus, 1985, p. 153). *The Emotional Appraisal Scale* was first developed by Folkman and Lazarus to study the emotional responses of students over an examination period. The threat emotion scale included the emotions worry, fear, and anxiety, and had an alpha coefficient of .80. The challenge emotion scale that incorporated the emotions confidence, hope and

eagerness, had an alpha coefficient of .59. The alpha coefficient for the harm emotion scale was .84, and the emotions comprised in the harm emotion scale were anger, sadness, guilt, and disgust. The final scale was the benefit (mastery-gain) emotion scale and incorporated exhilaration, pleasure, happiness, and relief; and .78 was the alpha coefficient for this scale. Folkman and Lazarus (1985) concluded that both threat and challenge emotions as well as harm and benefit emotions could be experienced at the same time. The authors of this study concluded from their research, that emotions change as a person's appraisal of a stressful situation also changes.

The *Emotional Appraisal Scale* Folkman and Lazarus used in their 1986 study that followed weekly stressful encounters of 75 married couples, was reported to have slightly higher internal consistency data. The alpha coefficient for the disgusted/angry emotion scale was .87, the pleased/happy scale was .80, the worried/fearful was .81, and the confident/secure was .82. Appleton (1993) did not include any reliability or validity reports in relation to the *Emotional Appraisal Scale* (1986) and her study.

Ways of coping scale (revised) (Folkman, Lazarus, Dunkel-Schetter, DeLongis & Gruen, 1986).

The revised *Ways of Coping Scale* (Folkman et al., 1986) (Appendix F) was chosen for this study to quantify how home care nurses coped with the critical incidents that they experienced. Appleton (1993) used this questionnaire to study hospital staff nurses' coping after experiencing a critical incident. The foundation for the questionnaire is derived from Lazarus and Folkman's cognitive-phenomenological theory on stress, appraisal, and coping (Lazarus & Folkman, 1984). The authors believe that coping is a process that relies on what a person thinks or does in a specific situation. The instrument

includes a variety of coping and action strategies that a person may use to deal with demands of a stressful experience (Folkman & Lazarus, 1986). The authors theorize that some strategies are problem-focused while others are more emotion-focused. Problem-focused strategies include collecting information and formulating a plan while emotion-focused strategies include searching for social support and distancing.

The revised version of this scale is a result of using the instrument to study a variety of populations (Folkman & Lazarus, 1985; Folkman et al., 1986). Folkman and Lazarus (1985) used this version of the questionnaire to study the coping processes of college students over an examination period. The students completed the questionnaire at three different time intervals to measure how they were coping. A minimum of 94% of the participants used both emotion and problem-focused coping strategies at each of the three stages (Folkman & Lazarus). There are eight subscales from the 66 items: eleven items for problem-focused coping, five items for wishful thinking, six items for distancing, four items for emphasizing the positive, three items for self-blame, three items for tension-reduction, three items for self-isolation, and seven items for social support. The reliability alpha coefficients for the subscales are .85 for problem-focused coping, .84 for wishful thinking, .71 for distancing, .65 for emphasizing the positive, .75 for self-blame, .56 for tension reduction, .65 for self-isolation, and .81 for seeking social support. The revised *Ways of Coping Questionnaire* (Folkman et al., 1986) has a 66 item 4-point Likert scale (0= not used to 3= used a great deal). The 66 items are divided into 8 subscales. The subscales are as follows; six items for confrontive coping, six items for distancing, seven items for self-control, six items for seeking social support, four items for accepting responsibility, eight items for escape-avoidance, six items for planful

problem solving, and seven items for positive reappraisal (Folkman et al., 1986). The higher the score for each subscale, the more it is used as a coping strategy.

There was evidence of internal consistency as reliability alpha coefficients were .70 for confrontive coping, .61 for distancing, .70 for self-controlling, .76 for social support, .66 for accepting responsibility, .72 for escape-avoidance, .68 for playful problem-solving, and .79 for positive reappraisal (Folkman et al., 1986). This study involved 75 married couples that reported a weekly stressful experience. Again, Appleton (1993) did not include any validity or reliability reports in relation to this instrument and her study.

Data Collection

After each presentation to the home care nurses, the four data collection instruments as well as the participation information and consent letter were left at each agency for the manager or manager's designate to distribute to all home care nurses, regardless of whether or not they had attended the presentation. Both permanent and casual nursing staff was invited to participate. Among the seven urban health care sites, there were a total of 125 permanent and 40 casual home care nurses. This created a potential convenience sample of 165 home care nurses. A total of 32 questionnaires were returned, and 25 were appropriate for the research study. The seven questionnaires that were not included in the data analysis were for the following reasons. One respondent included two descriptions of critical incidents on the form, but only filled out the *Emotional Appraisal Scale* and the *Ways of Coping* questionnaires once. Another respondent described cumulative stress rather than a critical incident. The other five surveys were excluded because they described a critical incident that occurred elsewhere

than the home care setting. Since nurses experiencing a critical incident was my population of interest and I did not know how many of the home care nurses had experienced such an incident, I have no estimate of a true response rate. Fifteen percent of the nurses (25 out of 165) working in home care experiencing a critical incident seemed a low incidence rate.

The respondents were given a three-month period to complete and return the surveys. Once the surveys were completed, the respondents put them in envelopes provided. The envelopes were addressed to me as the investigator at one of the community health agencies, and the respondents were instructed to use the internal mail system for the community, set up by Vancouver Coastal Health (Vancouver Community).

A reminder email was sent to the manager's designate to forward to the home care nurses one month before the end of the data collection period. The email reminded the home care nurses about the research and encouraged potential participants to contact the investigator if they required another survey. A final reminder email was sent to the manager's designate two weeks before the end of the data collection period again reminding the home care nurses of the survey and that additional surveys were available if they were required.

Data Analysis

The quantitative data from the questionnaires were coded and entered into a data file by the investigator. Descriptive statistics such as means, ranges, frequency distributions, and standard deviations were calculated using Statistical Package for Social Science (SPSS 11.0 Student Version) and IDEA Data Analysis Software (IDEA 2004 SP2 Built Version 6.10.204).

The open-ended questions from the *Critical Incident Information Form* were also coded. I reviewed the responses three times to gain a comprehensive understanding about the participants' experiences. The responses were then categorized according to similar themes. According to Speziale and Carpenter (2003), researchers categorize themes to give organized meaning to the qualitative data. The categories were reviewed by two other individuals on my thesis committee, one with experience in qualitative analysis and the other with experience in critical incidents. There was complete agreement among all the reviewers on the appropriateness of the categorization of the qualitative responses.

Ethical Considerations

Before the study could be initiated, approval for the research was sought from two ethical committees. First, the study was approved by the Human Investigation Committee (HIC) for researchers and graduate students in health sciences disciplines at Memorial University of Newfoundland. Secondary to approval from the HIC, the thesis proposal met the criteria for research study from the Vancouver Coastal Health Research Institute (Vancouver Community).

There are three main ethical principles that guide research involving human subjects and these are beneficence, autonomy, and justice (Speziale & Carpenter, 2003). The ethical principle of beneficence refers to the concept of "do no harm" so as to protect the respondents. Confidentiality of information is one way of protecting the participants from harm. The questionnaires were anonymous and participants returned the questionnaires without a return address to preserve confidentiality. Only my thesis committee members and myself read the written accounts of the critical events.

In asking nurses to reflect on a critical incident there is also a potential to cause emotional distress. Therefore, in this study, participants may have experienced some psychological harm from having to remember and record the critical incident and it was important to recognize this potential and offer assistance should it occur. I did not want to expose my participants to additional stress as I recognized how stressful critical incidents can be for some individuals. Therefore, I provided contact information whereby respondents could seek counseling if necessary (Appendix G).

Another ethical principle, autonomy, relates to the respect for human dignity and a right to full disclosure. The ethical standards of ensuring informed consent from participants falls under the framework of the principle of autonomy. During the nurses' meetings, potential participants were asked if they had any questions to guarantee that adequate information about the study was being disseminated to them. Written information was also given to potential participants. I wanted them to make an informed decision about whether or not to participate. The respondents were also notified that they may not benefit directly from the research, which is important to disclose so they could make an informed decision about participating in the study and not have any expectations that could not be met by taking part in the study (Appendix G). I provided my telephone and email contact information, as well as contact information for a member of the Vancouver Coastal Health Research Institute who was not directly involved with the study (Appendix G). Home care nurses were notified that participation in the research was completely voluntary and that their employment would not be affected in any way whether they chose to respond or not to the survey (Appendix G). Informed consent was implied by the return of the anonymous questionnaires.

The third ethical principle is justice, which includes the right to privacy and equitable treatment. Raw data was double checked after it was transcribed in a computer file to ensure accuracy of the participants' responses. Privacy was maintained by assigning a code to each participant during content analysis. Quotes from the written descriptions of certain critical events were not included in the writing of the thesis if a participant's identity might be revealed. Likewise in tabulating the quantitative data I did not include single responses. Rather data were collapsed or regrouped in categories so as to be non-identifying. Sometimes this resulted in having different categories than usually seen in other research, such as categories for age of respondents and years nursing experience.

Chapter Four

Findings

Chapter four presents the findings from the study. The sections include a description of the participants, events appraised as critical incidents, reactions to critical incidents, coping with critical incidents, and the impact of critical incidents.

Participants

I distributed 165 questionnaires to both permanent and casual home care nurses; 125 permanent nurses and 40 casual nurses. Thirty-two nurses completed and returned the questionnaires on critical incidents in home care nursing and twenty-five responses were applicable to the study as indicated in the previous chapter. It is not known how many of the nurses who had experienced a critical incident did not want to complete a questionnaire for whatever reason. In addition some nurses may not have defined certain events as critical incidents and therefore did not consider themselves as potential participants, while some nurses may not have had such experiences. Of the twenty-five home care nurses who returned usable questionnaires, 21 were female, 2 were male, and 2 did not include gender. Therefore, 84% of respondents were female, 8% were male, and 8% did not answer the question. These percentages on gender are roughly comparable to the overall British Columbia nursing population according to the 2005 Registered Nurses Database (Canadian Institute for Health Information, 2006). In 2006, the Canadian Institute for Health Information published a report titled "Workforce Trends of Registered Nurses in Canada". The report based on 2005 data indicated that 95% of nurses in British Columbia were female, and 5% were male.

The home care nurses ranged in age from 24 to 62, and the majority of respondents were in the 48 - 54 age category (see Table 1). Only 8% of nurses were 35 years of age and under. However, according to the Canadian Institute for Health Information (2006), 15.6% of nurses in British Columbia in 2005 were younger than 35 years of age. It is interesting to note there were no nurses under the age of 24 in this study sample.

The older age categories are more representative of the nursing population in British Columbia. The Canadian Institute for Health Information (2006) reported that 42.6% of nurses were over the age of 50 in British Columbia in 2005. This particular study sample shows 52% of the respondents are above the age of 48.

Table 1

Age of Home Care Nurses

Age	Frequency	Percent (%)
24 - 31	2	8.0
32 - 39	3	12.0
40 - 47	7	28.0
48 - 54	8	32.0
55 - 62	5	20.0

There are several reasons for the low percentage of nurses under 35. Until recently, hiring practices of this health authority dictated that nurses were required to have a nursing degree and two years of practical nursing experience before being considered for employment as a home care nurse. Currently, managers generally prefer

home care nurses to have some nursing experience in an acute care setting before becoming home care nurses, mainly because of the increased autonomy required for home care nursing practice. Another reason that home care nurses may be slightly older is the nurses' stage of life. Young nurses without children and families may not have their home life affected as much by having to work 12-hour shifts that are required in many hospitals. As nurses start to have families, the hours offered by home care nursing practice may be more conducive to their lifestyle. There are also no night shifts required for home care nurses that may appeal to the older nurse.

Table 2 shows the years of experience the respondents had as a registered nurse. Eighty percent of participants have been nursing for more than 10 years. No nurses had less than four years of experience as a registered nurse. This may illustrate again that because of the independence required with home care nursing practice and previous hiring policies, management employs nurses who have already gained some nursing experience, rather than employing new graduates.

Table 2

Years of Nursing Experience

Years of Experience	Frequency	Percent (%)
4 - 6	3	12.0
7 - 9	2	8.0
>10	20	80.0

The majority (48%) of the home care nurses had been in their present positions for greater than 10 years. Only one nurse indicated that he/she had been in his/her present position for less than one year (Table 3). Thus most of the nurses had a fairly long tenure as home care nurses.

Table 3

Years in Present Position

Years	Frequency	Percent (%)
<1 - 3	6	24.0
4 - 6	5	20.0
7 - 9	2	8.0
>10	12	48.0

Sixty percent of the home care nurses who completed the survey worked permanent full-time. Thirty-two percent worked permanent part time, and eight percent worked casual part time. In British Columbia in 2005, 51.5% of nurses worked full time, 30% worked part time and 18.5% worked casual (Canadian Institute for Health Information, 2006). According to the Workforce Trends of Registered Nurses in Canada Report, the amount of hours the casual nurses worked was not specified.

Critical Incident Experience

Question 1: Events Home Care Nurses Appraise as Critical Incidents

The respondents were asked to describe a critical incident, answers were reviewed and the content analysis identified six categories of critical incidents. The six categories in order of frequency were patient death, abuse, sexual harassment, urgent situations,

organizational limitations of care, and potential threat to personal health (see Table 4). The patient death category was used for incidents where a client death was particularly stressful or significant to the nurse either because of the circumstances surrounding the death or the reactions and emotions of the family and friends. The abuse category includes all incidents in which the nurse was subject to verbal aggression, physical threats, or written intimidation from a client or other members of the client's family. Sexual harassment is used to categorize all incidents in which a client or family member displayed behaviours with overt, unwelcome sexual connotation. The urgent situation category includes incidents in which a nurse experienced an unexpected event that required the assistance of emergency personnel due to the haste required to react and the limitations of the nurse's own abilities. The organizational limitations of care category were incidents associated with ethical distress when the nurse's ability to provide appropriate client care was negatively impacted due to organizational factors that exceeded the control of the nurse. The potential threat to personal health category includes all incidents in which a nurse is in actual or potential contact with infectious bodily fluids. Certain of these categories are more likely to be the type in which a nurse may suffer from post traumatic stress disorder (PTSD), whereas others are more likely to be associated with ethical distress. For example, urgent situations are critical incidents more likely to be associated with PTSD and organizational limitations of care are related to ethical distress. The examples used in each section to illustrate the categorization of the critical incidents have had minor changes to increase clarity.

Table 4

Categories of Critical Incidents

Category	Frequency	Percent (%)
Patient death	6	24.0
Abuse	5	20.0
Sexual harassment	4	16.0
Urgent situation	4	16.0
Organizational limitations of care	3	12.0
Potential threat to personal health	3	12.0

Patient Death.

Six critical incidents were included in this category and five of the six incidents in this categorization involved clients receiving palliative care. The situation surrounding the death was either particularly traumatic for the caregivers or the client and/or had great significance to the individual home care nurse. This resulted in the client's death being perceived by the nurse as a critical event. Several nurses reported that the worst part of the critical incident was the unexpectedness of the death, even though the client was receiving palliative care. The unexpected death could be associated with a loss of professional control. The following is an example of an unexpected death in a client receiving palliative care.

I was assigned to drop off supplies to a palliative client that was stable and [he was] expected to live for many more months. He had a large family including a wife and children and he was middle-aged. The visit became more lengthy as he was doing well and he and his wife were very positive about things. During my visit he became extremely short of breath

and appeared to have suffered a pulmonary embolism. 911 was called and he died a few hours later in the emergency room. I accompanied his family to the emergency room and spent the evening dealing with their grief --- acute and extreme. I had never previously met this family.

In the palliative care setting, exposure to death and family grief are experienced often by a home care nurse. This situation has been appraised as a critical incident because of the helplessness and lack of control that the nurse felt in addressing the sudden death. Another example of extreme grief of a client's caregiver is described below:

Got a call from "friend" of a palliative patient who stated he passed out getting into bed. Stated she [was] wondering if he fell or maybe [he was] in a coma as he was not responding. [I] Went on home visit as friend was quite upset and crying. When in apartment, discovered that patient had died hours before while trying to get in bed and was in rigor. Friend very upset as patient hadn't been able to get into bed after being up for smoke or to void. "Very sad" situation. Emotional support given to friend, called doctor to pronounce [death] and discussed funeral home with friend. She kept crying and was upset she left him alone and upset at situation.

In this example cited above, the home care nurse had to deal with the immediate grief of a client's caregiver and also the knowledge that the client was alone in death.

Abuse.

Five out of the twenty-five written descriptions were classified under the category of abuse. These incidents constituted a range of events, including both verbal and physical actions, which were perceived as abuse by the investigator. One home care nurse was yelled at by a patient during a routine dressing change and another nurse was yelled at over the phone. Another client threatened to hurt the home care nurse during a visit. In all of these reported incidents the nurses felt that the clients had overstepped the boundaries of the nurse-patient relationship; a relationship that ought to be defined by

mutual respect and consideration. One nurse described a scenario where she felt both verbally abused and physically threatened by the client's caregivers.

I was visiting a palliative client on my way home (had already seen that day) to make sure the subcutaneous medications were okay. Found an error in one syringe and explained to family member that I was going to change medication and reassured them that client was okay. Family member proceeded to start yelling "You don't know what you are talking about". I was in the bathroom at the time where the medications were kept. Within 3-4 minutes, 4 other members of the family started swearing and yelling at me "You have a fucking attitude". I felt attacked and family members followed me out the door as I left.

Nurses in home care work with a variety of clients and are required to enter the patient's domain where events and incidents can be distorted and the nurse does not have the safety of calling in a co-worker when he/she feels discomfort with a particular situation. The critical incident for one nurse relates to feelings of being wrongfully accused after a patient tried to intimidate him.

My job was to drop off some supplies to a client with known mental health problems. He was angry and upset while I was visiting and I left quickly. Next day he accused me of pushing him and he filed a police report. I was asked to go down to the police station to give my account-my manager supported me thru [sic] this ordeal and no charges were laid.

This is another example of how events can be distorted when a home care nurse enters the client's domain, and how vulnerable the nurse is to negative repercussions as a result of the client's version of the situation.

Sexual harassment.

Vulnerability is exceptionally relevant to home care nurses who experience situations involving inappropriate sexual behaviour. Sexual harassment or situations involving behaviours with sexual connotations by clients or client family members were not reported by Appleton (1994) as being identified by hospital nurses as critical

incidents. O'Connor and Jeavons (2003) sample of hospital nurses listed sexual harassment/assault under the category of "other event" on the *Clinical Events Questionnaire* and therefore it was not ranked with the other 29 critical incidents.

However, there were four examples of incidents of sexual harassment that were appraised as critical for the home care nurses in this investigation. One nurse reported feelings of shock and fear with her experience:

As a home care nurse I went to visit a man in his early 20s to dress his pilonidal sinus. He answered the door with just a towel around him (which is normal because he was told to sitz bath before I came). I followed him to the back of the house to his bedroom. I did his care. When I went to leave the front door was blocked by four naked young men standing in the front door (they must have been hiding when I came in).

This nurse was exposed to great risk and would have been utterly defenseless if the young men had decided to attack. Home care nurses do not expect to be assaulted when they enter a client's domain. Another home care nurse expressed feelings of unexpectedness at the actions of a patient's family member.

During bereavement follow-up to a client's husband, I was pinned against the front door by the husband and then he attempted to "kiss me on the mouth". I was able to push him away from me and leave.

These descriptions were categorized as sexual harassment, rather than as abuse, due to the extreme sexual connotation involved in the incidents. A third nurse conveyed feelings of personal violation when her critical incident occurred:

While doing a routine dressing change to a 90+ year old man. Upon completion he grabbed my breasts. This was totally unexpected as this gentleman was well respected as a client and community member.

The fourth nurse described a sexual harassment incident when she visited a male client for routine wound care. On the client's walls were photos of naked women and his

questions were personal and unwelcoming. The nurse reported feeling unsafe and powerless which reinforces the vulnerability of home care nurses.

Urgent situations.

There were four critical incidents that were classified as urgent situations based on the descriptions provided by the home care nurses. Because of the nature of the situation, the nurse was required to call on help not routinely used or to take measures to gain entry to the home that in ordinary situations she would not use. The home care nurses identified feelings of being alone and feeling helpless in these situations but realized that extraordinary actions were required. For example:

I was unable to reach a client by telephone (she often didn't answer the phone) so I decided to go to her home. When I knocked on the door she called out saying that she was on the floor. She crawled out from the washroom to the living room (I could see her through the mail slot) but was unable to get up. The door was locked so I called 911. The fireman/police/paramedics did a forced entry and the client was taken to hospital. I left a message for the son at work-when he arrived he was angry that the window had been broken to gain access.

Initially, the home care nurse had not been concerned when she was not able to contact the client. The situation became critical when the nurse realized the client required urgent assistance that the nurse could not provide due to the client's inaccessibility. The nurse did not know how long the client had been in need of help, and had to act promptly to get appropriate support. The nurse felt powerless to help the client and sought appropriate assistance, only to be ridiculed by the family for her decisions. In this instance, this nurse's distress was intensified by the son's reaction to the situation. This was not the only example of a home care nurse having to call emergency services.

I visited a client in the single room occupancy program in the downtown eastside. It was a two nurse visit due to area safety. Following the visit, nurses walked down the hallway when a resident called out for help. Nurses responded with

single room occupancy manager and found a (unknown to nurses) resident with his throat slashed (self inflicted). Nurse held pressure on neck wound while the other called 911. It took approximately 15 minutes before emergency medical services arrived. Two weeks later, [I] found out resident survived.

The nurse who described the above critical incident further reported that during the situation it occurred to her the wound might not have been self inflicted and the nurses might have been in danger if there was another party involved with a weapon. The situation was beyond the home care nurse's usual scope of practice because home care nurses are not usually required in their daily work to provide emergency first aid to people who are not known to them through an appropriate referral process. The home care nurse experienced a loss of control in this situation. Again, this situation required the nurse to act immediately to provide care to the client who was rendered helpless at the time.

Organizational Limitations of Care.

Having the appropriate level of care for a client can be an important safeguard against a critical incident occurring. However, for a number of reasons this may not always happen. At times the client situation is not always assessed correctly and then the client is not offered the appropriate level of care. Occasionally it is because of unavailability or shortages of services in the health system. Other times it is the result of a lack of communication or poor communication regarding the required level of care. Regardless of the reason, these critical incidents were termed "organizational limitations of care" because it is some factor in how the care was organized that led to the incident and left the nurse not prepared. Three nurses identified critical incidents that were associated with limitations of care due to the organizational structure of the health

authority in which they worked.

While admitted to hospice facility, client was in delirium and attempted to harm himself. Staff was unable to communicate with client. As a result, physician discharged client from hospice and sent client to an acute care hospital's emergency room. Emergency room had no bed. Acute care staff sent client home even though client was closed to the community program. Staff told the family that someone would place client the next day in another health care setting. As a result, family took the client home with no resources for the weekend.

This situation caused great stress for the nurse because the "client and family did not receive equitable and ethical care". The home care nurse felt that because of the language barrier and the family's knowledge deficit of the health care system, they had no voice.

In another situation, a home care nurse had to deal with a family's misinterpretations.

Young adult with terminal cancer diagnosis sent home for palliation. Father of the client contacted health unit to inform home care nurse that client was now at home. The hospital failed to inform the health unit. Family was under the impression the client was sent home to regain strength for further chemo. Upon assessing client-it was found she was 20% on the Palliative Performance Scale, not swallowing and dying. As primary home care nurse-I had to implement all services ASAP and educate family on palliation.

Both of the above situations involved poor communication between the acute setting and the community, resulting in the nurse experiencing ethical distress as it related to perception of what constituted appropriate client care. This situation was critical for the nurse involved because she experienced helplessness and a loss of control when the young client who was dying was sent home without supports in place. Not only were there no resources ready for the client to be back at home, but in addition the family's perception of the client's prognosis was misunderstood. The family's misunderstanding of palliation intensified the nurse's distress.

The other situation in this category involved a home care nurse having to advocate for a palliative client with lung cancer. The home oxygen program helps people with low blood oxygen levels to receive oxygen in their home free of charge (Vancouver Coastal Health, 2006). In this case, the doctor ordered the oxygen and it was implemented for the client. Then the home oxygen program concluded the client did not qualify for home oxygen. The home oxygen program discontinued the client's oxygen, resulting in the client and family experiencing significant stress and anxiety. The home care nurse spent a lot of time and energy consulting with clinicians, managers, and the client's general practitioner to have the oxygen resumed, but it was futile. Two months later, the client was reassessed and deemed to meet the home oxygen program's guidelines, so the oxygen was reintroduced. This home care nurse was helpless to provide adequate care for her client because of limitations within the organization's guidelines.

Potential threat to personal health.

From an occupational health and safety point of view nurses are exposed to a number of risks that would put their own health at risk. With the potential for contracting HIV/AIDS and other infectious diseases, nurses need to observe cautions to protect their physical health. Despite this practice around observing caution, accidents can still occur. The final category of critical incidents described by home care nurses is potential threat to personal health. Twelve percent of critical incidents were categorized as potential threat to personal health as they involved potential or actual needle stick injuries.

[I] had been in to see this client several times, so this visit was not unusual. Only client and I were present. She had large lower leg dressings. As I unraveled the tensor from her leg there was a blood filled syringe tucked under the tensor. The client quickly grabbed it and threw it behind the couch. I did not know if it (the syringe) was capped or not-but this client had been adamant that she was not

using IV drugs. A lot of anxiety over the possibility of getting a needle stick injury from a very ill client.

In the above incident it was the unexpected and surprising actions of the client that made the nurse evaluate the incident as a critical incident. The nurse realized that it could have been a needle stick. The next description comes from a nurse who had an actual needle stick injury because of the unpredictable state of the client being cared for at that time.

I had put a subcutaneous butterfly needle in the arm of an immigrant palliative patient. It had been left in too long and there was pus under the Opsite 3000. When the Opsite was removed, the needle fell out onto the bedclothes. The patient was delirious, agitated and flailing herself about and the family who were already angry and anxious were blaming "us" for this. After calming her down I reached down to retrieve the butterfly set and the needle impaled itself into my finger.

This home care nurse was also susceptible to physical harm because she was trying to settle an agitated client by herself. This home care nurse stated that the worst part of the critical incident was the family's refusal to allow the general practitioner to order any lab tests to find out if the client was carrying any diseases such as hepatitis or HIV/AIDS. The nurse was then subjected to waiting to find out if any adverse circumstances to the nurse's personal health resulted from the accident.

Analysis of summarized results.

Based on the information presented, I have classified the critical incidents into the following six categories: patient death, abuse, sexual harassment, urgent situations, organizational limitations of care, and potential threats to personal health. These categorizations were based on the information presented in the nurse's comments and the descriptions as presented by the respondents.

There was great variation in the length of time that had passed since the home care nurses had experienced the critical incident. One home care nurse documented that the

critical incident was experienced only one day ago. For other home care nurses, the critical incident was experienced more than 10 years ago (see Table 5). Two home care nurses included in the sample population did not respond to the question. Twenty-eight percent of home care nurses stated the critical incident occurred less than one year ago, while 28% of home care nurses reported they experienced the critical incident 5 or more years ago.

Table 5

How Long Ago Critical Incident Occurred

Length of time	Frequency	Percent (%)
Less than 1 year	7	28.0
Between 1 and 4 years	9	36.0
Between 5 and 10 years	4	16.0
More than 10 years	3	12.0
Unknown	2	8.0

Of the incidents that occurred within the last year, one incident occurred only one day prior to the completion of the questionnaire. It is important to note that the individual involved in this incident may still have been in a heightened emotional state and may still have been in the process of appraising the incident, reacting to the incident, and actively implementing coping strategies. Due to the acuteness of the state of stress at this early date, the completion of the questionnaire may have acted as a form of crisis intervention and the full implementation of various coping strategies may not have been completed, as

this is expected to occur over a period of time after the event. The recency of the event is expected to have some impact on the responses of the individual.

Eighty-eight percent of home care nurses reported that the critical incident occurred on a weekday day shift (0815-1700), and 12% reported that the critical incident occurred during a weekday evening shift (1245-2130). The frequency of occurrences between the two groups is generally consistent with the staffing levels for home care nurses in the region.

There was some evidence that the critical incidents challenged the personal beliefs of the home care nurses. A little less than half (48%) of home care nurses reported that the incident challenged their beliefs. The other 52% indicated that the critical incident did not challenge their personal beliefs. The differentiation between PTSD-type critical incidents and critical incidents involving ethical distress may account for the divergence between the participants on the challenges to personal beliefs.

Ninety-six percent of home care nurses agreed that the critical incident occurred without warning. A little over half (52%) of home care nurses stated that the critical incident involved dealing with something new. Examples of situations that were new to the home care nurse were policies that the home care nurse was not previously aware of, dealing with intense reactions of the client or caregiver not previously known to the home care nurse, feelings of violation, being wrongfully accused, and death of a young adult.

There was an element of uncertainty with the critical incidents noted by 72% of the respondents. Examples of uncertainty for home care nurses included uncertainty about personal safety, ambiguity about outcomes of decisions made by organizations,

unexplained deaths, uncertainty about the welfare of the client, and lack of confidence with respect to policies.

Despite the critical incidents occurring both suddenly and with uncertainty, 88% of home care nurses were comfortable with the decisions they made during the critical incident. One nurse indicated that she was not comfortable with the decision made and elaborated on this by writing about being firmer in setting limits with the client. Another home care nurse wished she would have left the situation and returned with another nurse. The third nurse who was not comfortable with the decision she made during the critical incident reported she wished she had reprimanded the client for his actions at the time of the incident.

Forty-four percent of participants recalled having other stressors in their lives at the same time as the critical incident. One home care nurse reported professional stress, seven reported personal stress and three reported both personal and professional stress.

Question 2: Home Care Nurses Reactions to an Event Appraised as a Critical

Incident

One of the questions on the *Critical Incident Information Form* (revised) (Appleton, 1992a) asked home care nurses about the physical reactions they experienced for a day or two following the critical incident, which are listed in Table 6.

Table 6

Physical Reactions to the Critical Incident

Physical Reaction	Frequency	Percent (%)
Nausea	4	18.0
Headache	4	18.0
Fatigue	12	55.0
Insomnia	12	55.0
Others	4	18.0
No physical reactions	3	12.0

Three home care nurses did not experience any physical reactions that they could recall. The critical incidents in which no physical symptoms were identified occurred one or more years ago, and one factor that may affect the response is the ability of the nurse to recall exact physical reactions. Home care nurses reported anxiety, teariness, nervousness, dreams, and wandering around the house being very unproductive. Some nurses reported other psychological symptoms in this category such as intrusive thoughts, sadness, anger, worry, and disbelief.

The other type of reactions reported in the first few days following the critical incident were emotional. The emotional reactions of the home care nurses were evaluated using Folkman and Lazarus's *Emotional Appraisal Scale* (1986). Home care nurses experienced a variety of emotions in the first few days following the critical incident. Emotions in the disgusted/angry scale (disgust, anger, frustration, and disappointment) had scores ranging from 0 to 16 out of a potential score of 16; the worried/fearful scale

(worry, fear, and anxiety) had scores ranging from 1 to 12 out of a potential score of 12; the confident/secure scale (confident, secure, and in control) had scores ranging from 0 to 10 out of a potential score of 12; and the pleased/happy scale (pleased, happy, exhilarated, eager, hopeful, and relieved) had scores ranging from 0 to 9 out of a potential of 24. A higher score on the *Emotional Appraisal Scale* reflects increased intensity of the emotion experienced by the home care nurses during the days following the critical incident. The home care nurses had total scores that ranged from 11-31, out of a possible maximum score of 64 (M=21.16).

Table 7

Detailed Scores on Emotional Appraisal Scale

Score	Frequency	Percent (%)
Worried/Fearful Scale		
0-2	1	4.0
3-5	9	36.0
6-8	7	28.0
9-12	8	32.0
Disgusted/Angry Scale		
0-2	4	16.0
3-5	4	16.0
6-8	5	20.0

Score	Frequency	Percent (%)
9-12	6	24.0
13-16	6	24.0
Confident/Secure Scale		
0-2	8	32.0
3-5	11	44.0
6-8	4	16.0
9-12	2	8.0
Pleased/Happy Scale		
0-3	18	72.0
4-7	5	20.0
8-11	2	8.0
12-15	0	0.0
16-20	0	0.0
21-24	0	0.0

The emotions that were experienced the most intensely by the home care nurses came within the disgusted/angry scale (M=7.92, S.D.=5.02). The second group of emotions that were experienced the most intensely by the home care nurses fell within the worried/fearful scale (M=6.84, S.D.=2.93). The confident/secure emotions (M=3.96, S.D.=3.05) and the pleased/happy emotions (M=2.44, S.D.=2.77) were experienced with

less emotional intensity. There is significant variation in the scores on the disgusted/angry scale because 48% of home care nurses had intense feelings of anger, disappointment, frustration, and disgust (with scores of 9 or more) and 32% experienced the same emotions much less intensely, (with scores of 5 or less) causing a wide deviation in the scale's results. Very few home care nurses in this study experienced any feelings of happiness, relief, hopefulness, exhilaration, eagerness or pleasure in the time following the critical incident. The two instances with the highest reported feelings of this nature involved a long-term palliative patient death and an urgent situation that was satisfactorily resolved.

Question 3: Home Care Nurses Coping with a Critical Incident

The strategies home care nurses used to cope with a critical incident were quantified using the *Ways of Coping Questionnaire* (revised) (Folkman et al., 1986). The home care nurses reported coping methods during the first few days and evenings following a critical incident. The home care nurses' scores ranged from 8 - 97 (M=37.4), out of a maximum score of 150. The four coping subscales used the most by these participants in descending order of use are seeking social support, planful problem-solving, self-controlling, and positive reappraisal.

The coping subscale "seeking social support" involves seeking informational, emotional and tangible support. "Planful problem-solving" is associated with intentional problem-solving attempts to change the situation, combined with a methodical effort to resolve the problem. Efforts to control one's actions and feelings defines the coping subscale of "self-controlling". "Positive reappraisal" describes generating positive meaning by concentrating on personal development (Folkman et al., 1986).

Table 8

Scores on the Ways of Coping Scale

Score	Frequency	Percent (%)
Seeking social support (Mean = 8.6; Standard deviation = 3.58)		
0 – 3	2	8
4 – 7	9	36
8 – 11	8	32
12 – 15	6	24
16 – 19	0	0
Planful problem-solving (Mean = 6.56; Standard deviation = 3.93)		
0 – 3	6	24
4 – 7	9	36
8 – 11	7	28
12 – 15	3	12
16 – 19	0	0
Self-controlling (Mean = 5.40; Standard deviation = 3.42)		
0 – 3	11	44
4 – 7	7	28
8 – 11	6	24
12 – 15	1	4
16 – 19	0	0

Score	Frequency	Percent (%)
Positive reappraisal (Mean = 4.96; Standard Deviation = 3.76)		
0 – 3	8	32
4 – 7	13	52
8 – 11	3	12
12 – 15	0	0
16 – 19	1	4
Confrontive coping (Mean = 4.04; Standard deviation = 2.62)		
0 – 3	12	48
4 – 7	12	48
8 – 11	1	4
12 – 15	0	0
16 – 19	0	0
Distancing (Mean = 3.92; Standard deviation = 4.08)		
0 – 3	17	68
4 – 7	2	8
8 – 11	3	12
12 – 15	3	12
16 – 19	0	0

Score	Frequency	Percent (%)
Escape-Avoidance (Mean = 2.08; Standard deviation = 2.48)		
0 – 3	19	76
4 – 7	5	20
8 – 11	1	4
12 – 15	0	0
16 – 19	0	0
Accepting responsibility (Mean = 1.84; Standard deviation = 2.41)		
0 – 3	20	80
4 – 7	3	12
8 – 11	2	8
12 – 15	0	0
16 – 19	0	0

There were two questions on the *Critical Incident Information Form* (revised) (Appleton, 1992a) that the participants could answer that related to debriefing. Eight home care nurses participated in a debriefing subsequent to the critical incident. Of the 17 who did not participate in a debriefing, 9 indicated they would have liked a debriefing session following the critical incident.

One nurse indicated there was a “debriefing” about the incident only after the client was accepted back as a home care client. The client had originally been discharged

from the home care nurse program after the critical incident. The discussion took place after the client was in need of home care services again. This would not be considered a debriefing due the time lapse between the incident and the discussion.

Question 4: The Effect Critical Incidents have on Home Care Nurses Personally and Professionally

The critical incident had a negative impact on interpersonal relationships for some nurses. Sixteen percent indicated that the incident had a negative impact on their relationships with colleagues at work. A further 20% of home care nurses indicated that their relationship with family and friends was negatively impacted. Two participants did not answer whether or not interpersonal relationships with friends and/or family was negatively impacted. The participants were not required to provide any details about the extent of the negative impact on their interpersonal relationships.

The critical incident occurred for 92% of the home care nurses at their current position. Of the home care nurses who participated in the survey, 20% responded that they considered leaving their position as a result of the critical incident. One home care nurse did leave her position after a critical incident involving a threat to personal health.

Summary

The purpose of the qualitative aspect of this study was to explore what stressful situations home care nurses appraise as critical incidents. The quantitative aspect of this study identified how home care nurses reacted and coped with the incidents they appraised as critical. The literature review included studies that discussed what home care and other nurses appraise as stressful aspects of their practice and how they cope with that stress. Studies that address critical incidents in nursing are mainly limited to nurses who

practice in the acute care setting. The transactional model of stress and coping by Lazarus and Folkman (1984) was the conceptual framework used to conduct this study.

In the present study a descriptive, cross-sectional, retrospective design with four instruments was used to solicit the data. Twenty-five home care nurses working in the same city all completed the *Participant Information Sheet* (revised) (Appleton, 1992b), *Critical Incident Information Form* (revised) (Appleton, 1992a), *Emotional Appraisal Scale* (Folkman & Lazarus, 1986), and *Ways of Coping Scale* (revised) (Folkman et al., 1986).

Critical incidents were categorized using thematic content analysis. There were six categories of critical incidents identified. Six critical incidents were categorized as patient death, five as abuse, four as sexual harassment, four as urgent situations, three as organization limitations of care, and three as potential threats to personal health.

The home care nurses identified physical reactions they experienced in the first few days and evenings following the critical incident. Fatigue and insomnia were the physical reactions reported by over half of the respondents. Only three of the nurses reported no physical reactions. There were also emotions that home care nurses experienced over the first few days and evenings following the critical incident. Emotions from the disgusted/angry scale were experienced with the greatest intensity followed by emotions from the worried/fearful scale.

In terms of coping, home care nurses used numerous coping strategies according to the *Ways of Coping Scale* (revised) (Folkman et al., 1986). In descending order seeking social support, planful problem-solving, self-controlling, and positive reappraisal were the four most commonly used coping strategies. Despite these coping strategies, 16% of

nurses indicated that the critical incident had a negative impact on their relationship with their colleagues and 20% with their friends and family.

Thirty-two percent of home care nurses participated in a debriefing session following their critical incident. Fifty-two percent indicated they would have liked to participate in a debriefing session following their critical incident.

Chapter Five

Discussion

Chapter five contains a discussion of the findings of the study and how this study contributes to the literature on critical incidents and home care nurses. The sections include discussion about the events appraised as critical incidents, timing of the critical incidents, reactions to the critical incidents, coping with the critical incidents, and effects of the critical incidents.

Events appraised as critical incidents

Six themes were identified from the written descriptions of critical incident given by the home care nurses: patient death, abuse, sexual harassment, urgent situations, organizational limitations of care, and potential threat to personal health. The themes identified were consistent with other literature pertaining to critical incidents (Appleton, 1993; O'Connor & Jeavons, 2003); however, there were some unique aspects to the types of incidents identified. Each of these six themes will be compared to the literature.

Patient death.

The highest percentage of traumatic events appraised by the home care nurses as critical events were associated with patient death. Many researchers (Evans, 2002; Gotay et al., 1985; Wilkes & Beale, 2001) have acknowledged that stress in home care nursing can be associated with patient death. Findings by other authors (Appleton, 1994; O'Connor & Jeavons, 2003; Wolf & Zuzelo, 2006) have indicated that nurses working in acute care settings have appraised patient death as a critical incident. Events are considered critical if there are intense emotions and personal meaning for the nurse (Burns & Rosenberg, 2001). Due to the intimate nature of palliative care work, home care

nurses spend significant time and energy working with clients in need of palliative care and with their caregivers. When the death does not go as anticipated or there is significant grieving or remorse on the part of the caregiver, this can be emotionally stressful for the home care nurse. This is congruent with Lazarus and Folkman's (1984) theoretical framework because the home care nurse appraises the situation as stressful due to the loss of professional control. This situation is further appraised as stressful by the influence of personal factors of commitment and beliefs (Lazarus & Folkman). If the home care nurse believes a "good death" is important, a death that does not go as anticipated might be appraised as stressful.

Abuse.

Abuse, or any incidents in which the nurse was subject to verbal aggression, physical threats, or written intimidation, was appraised as a critical incident by 20% of the home care nurses surveyed. Health care workers, especially nurses, are 16 times more likely to be attacked at work than other workers such as police or prison guards (Canadian Nurses Association, 2002). According to WorkSafeBC (2006), more than 105 nurses in British Columbia missed work on a daily basis due to a work related injury in 2004. Five percent of those injuries were due to violent and aggressive behaviour. Thirteen percent of those injured nurses do not work in acute or residential care and included home care nurses. Findings from studies in other countries such as Sweden and Australia suggest that nurse abuse in the form of violence and aggression is also problematic (Arnetz, Arnetz, & Peterson, 1996; O'Connell, Young, Brooks, Hutchings, & Lofthouse, 2000).

Violence continues to be a problem in the nursing workplace (Jackson, Clare, & Mannix, 2002; Rippon, 2000). Nabb (2000) reported that nurses are at risk for being

attacked not only by patients but by visitors as well. Increasing workload, visitors' expectations, lack of information and poor discharge planning were all identified as factors that contribute to anger and potentially to violence by visitors (Nabb). Duxbury (1999) reported that in critical incidents involving aggression, verbal aggression was one of the most problematic. Over ten years ago, hospital nurses appraised violent events as the fourth most frequently experienced critical incidents (Appleton, 1994). In 2003, O'Connor and Evans rated violence as the third most stressful incident and the most frequent stressful incident when nurse/patient, nurse/caregiver, and nurse/fellow staff member conflicts were combined.

Appleton (1994) also reported critical incidents involving verbal abuse and threats between fellow staff members but no home care nurses reported any significant altercations with fellow employees in this study. This investigator speculates that this is due to home care nurses' more isolated and autonomous working environment. Home care is a practice environment that takes nurses away from colleagues and interdependence on each other for patient care. As a result of home care nurses spending more time at clients' homes or in their automobiles, staff conflict resulting in episodes of abuse is limited.

It was noted from the sample that there are particular aspects to home care nursing that may increase the potential exposure to abuse as a critical incident. For example, the isolation experienced by the home care nurse may increase the perceived risk of threat from the actions of clients or their caregivers as the nurse is not in direct contact with other health care members. Equally important is the fact that nurses working in the home care environment do not have the social support from coworkers that could mediate the

effects of the clients' actions (Büssing & Höge, 2004). While patient abuse does occur, some reports can be unfounded and one of the respondents noted that she/he was accused of abusing a patient. This type of incident, which threatens the professional reputation of the nurse, is also at risk of increased occurrence due to the isolation of the nurse in this practice.

Abuse is relevant to the stress appraisals harm/loss or threat. In some situations, home care nurses experience harm when they are verbally abused and this in turn affects their self-esteem (Lazarus & Folkman, 1984). When a client or family verbally or physically intimidates the home care nurse, the nurse may appraise the situation as a threat.

Sexual harassment.

Sexual harassment was another behaviour that resulted in critical incidents. Other authors have described sexual harassment involving nurses visiting the client's home (Madison & Minichiello, 2001). They reported such incidents as a community based nurse describing how a patient put his arm around her waist and tried to kiss her and a patient's husband trying to kiss a nurse to "thank" her for caring for his wife. This study emphasized the personal nature of home nursing when you are invited into someone's home and the trust that develops between the client, the family and the caregivers. The nurse who experienced the client's husband trying to kiss her responded by running out. She then had episodes of denial when she did not want to believe it happened. She also blamed herself for being in that position. These researchers did not study the physiological impact the sexual harassment event had on the nurse. In Büssing and Höge's (2004) study that focused on home care nurses they included sexual harassment in

their physical violence scale and “offense with sexual connotation” with verbal aggression, however there was no breakdown as to the frequency of the incidents that occurred and that were overtly sexual in nature.

Sexual harassment is not new to the nursing profession (Robbins, Bender, & Finnis, 1997; Rippon, 2000), although the consensus from these researchers indicates it is an area of nursing that still requires much more investigation. There is much discussion about what defines sexual harassment, how it is reported or studied, and the implications of this particular nursing stressor (Fiedler & Hamby, 2000; Valente & Bullough, 2004). Predominantly in nursing, it is a male physician, patient, family member, or coworker who is responsible for the act that is considered to be sexually inappropriate by the female nurse.

Robbins et al. (1997) described the problem of sexual harassment in nursing as having two significant contributing factors. The first was conspiracy of silence with the victim and the second, organizational collusion to inaction. Nurses are taught early in nursing school they have a duty to care. The nurse then experiences great turmoil and internal conflict when she experiences sexual harassment because of her engrained obligation to provide care for her patient. This may result in a nurse not reporting the incident.

The four critical incidents classified as sexual harassment in this study involved a variety of situations of a sexual nature. The incidents ranged from a display of offensive photos with unwelcome questions, to inappropriate physical contact, to a potential sexual assault. Regardless of the severity of the sexually based behaviour, it is essential to consider the meaning the nurse gives to the incident. An incident of a sexual nature is

appraised as critical if the nurse experiences a strong emotional response and her customary coping mechanisms are ineffective.

Nurses practicing in the home care setting are more vulnerable and, therefore, may be at greater risk for sexual harassment due to the fact that the nurses are both practicing in isolation and in a less controlled environment. Clients and caregivers are comfortable in their own surroundings and, therefore, may be more aggressive in demonstrating sex-based acts than if they were in an institutional health care setting. The examples presented suggest that the client or other members present in the client's domain are aware of the isolation and lack of situational control by the nurse and this results in behaviour that may not have been demonstrated in a hospital environment.

Similar to abuse, sexual harassment can be appraised as harm/loss or threat. If a client or caregiver makes inappropriate sexual advances towards the home care nurse, the nurse may appraise herself as being harmed. If the sex acts are more overt in nature, the home care nurse may feel that her safety is being threatened.

Urgent situations.

Home care nurses' appraisal of urgent situations as critical incidents is similar to the research involving emergency situations appraised as critical incidents. (Appleton, 1994; O'Connor & Jeavons, 2003). Appleton (1994) identified emergency situations as the fourth most common category of critical incidents. Twelve percent of general medical/surgical nurses appraised emergency situations as critical (Appleton, 1993). The nurses in another study (O'Connor & Jeavons) declared emergency situations were the most frequent and the most stressful critical incidents they experienced. Urgent situations

or those identified as “close calls” were also reported in Wolf and Zuzelo’s (2006) study of critical incidents in a small group of nurses from acute care settings.

Urgent situations in the present study differed from those identified as emergency situations by Appleton (1993) because of the lack of direct support available from other health care professionals. The nurse in the home environment may feel vulnerable due to isolation from colleagues. In addition, the nurse may not be able to control the situation to the extent he or she would be able to exert control in a hospital setting. For example, home care nurses are not privy to the resources that hospital nurses have in urgent situations (i.e., crash carts and readily available trained personnel). Home care nurses may lack the competence or confidence to perform certain of the tasks or assessments required in an urgent situation. As generalists, usually recruited from medical/surgical areas of nursing practice, they do not have the skills, judgment, and knowledge of emergency nurses that may be required in urgent situations. These factors may also increase feelings of isolation and therefore contribute to urgent situations being appraised as critical incidents by home care nurses.

Urgent situations are associated with the stress appraisal harm/loss because the client or caregiver may have experienced harm, requiring the home care nurse to take immediate action (Lazarus & Folkman, 1984). The home care nurse may also feel his or her professional reputation may be jeopardized or harmed due to the nurse’s inability to be in command of the situation.

Organizational limitations of care.

Organizational limitations of care were appraised as a critical incident by 12 % of home care nurses in this study. This category of critical incident was not identified in any other literature discussing critical incidents. In relation to organizational limitations of care, one possible explanation as to why these home care nurses appraised these events as critical incidents is that they were confronted with the events they had no control over and, therefore, experienced insecurity and apprehension in coping with the event. This type of loss of professional control can be associated with an aspect of the definition of critical incident proposed by Burns and Rosenberg (2001). These authors posited that a professional may perceive an incident as critical subsequent to reflecting on his or her performance that created a specific outcome. If the home care nurse was not satisfied with his or her professional performance and there was a negative outcome in the situation, the home care nurse may appraise the incident as critical. Negative outcomes in difficult situations may be the result of factors beyond the control of the home care nurse, resulting in the nurse experiencing ethical distress.

Ethical distress was identified due to the nature of home care nursing practice. The nature of home care nursing practice dictates that the nurse has to be self-reliant and competent in critical thinking. Home care nurses are expected to be self-sufficient because they cannot rely on others during the visit to the client's home. The home care nurse is expected to be autonomous in his or her practice because he/she is required to independently make decisions regarding their client's care. Therefore, if an organization's policies place restrictions on a nurse's practice, the nurse may experience increased feelings of isolation and distress when they are forced to challenge the policies that are in

conflict with values or beliefs held by the nurse. The home care nurse feels intense pressure to “fix” the problems that the organization had created.

Within Lazarus and Folkman’s (1984) framework, these critical incidents can be associated with the harm/loss stress appraisal. All three events involved the home care nurse experiencing a “loss” of faith in an organization they trusted and prided themselves in working for. The stressor was further compounded by the client and family’s feeling of “loss” in not understanding the limitations imposed by the organization.

Potential threat to personal health.

Three home care nurses identified potential threats to personal health as critical incidents. Appleton (1994) also demonstrated evidence in her research that nurses consider potential threats to personal health as critical incidents. Both Appleton, and O’Connor and Jeavons (2003) categorized these types of critical incidents as actual or potential contact with infectious body fluids. Critical incidents involving a threat to personal health could also include any type of accidental exposure to blood or body fluids, not just needle stick injuries. This may be of particular significance to home care nurses who are not only caring for a variety of patient’s drainage tubes, but are also starting to perform more invasive nursing skills at home; for example, draining chest tubes and paracentesis catheters. These infrequent procedures may put home care nurses at greater risk for exposure to potential threats to personal health. In addition, the infrequency of such procedures places greater stress on nurses due to the lack of confidence in their competence in these areas of nursing practice.

According to the British Columbia Nurses Union 6, 800 health care workers are injured from a needle or sharp every year (2006). If the devices are contaminated, they

can transmit one of twenty blood borne pathogens to the injured worker (British Columbia Nurses Union, 2006). With these statistics, it would explain why home care nurses appraise potential threats to personal health as a critical incident. Home care nurses experience apprehension and insecurity about whether or not they have been exposed to a blood borne pathogen as a result of an accident. The appraised threat to personal health and safety falls within Lazarus and Folkman's (1984) theoretical framework. If a home care nurse is unfortunate enough to obtain a needlestick injury, the critical incident may be appraised as harm/loss.

Timing of the critical incident.

Home care nurses reported that 88% of the critical incidents they experienced occurred on a weekday day shift (0815 – 1700). These results differ from those of Appleton (1993) who reported that 66% of the critical incidents reported occurred during evening and night shifts when there were fewer resources such as physicians and managers available. The results were not similar in this study as there are less resources available to home care nurses on evenings and weekends, and the majority of critical incidents still occurred during weekday daytime hours. An explanation for this may be that the majority of home care nurses' working hours occur during weekdays from 0815-1700. A community health site may have up to a dozen home care nurses working during the day but only one home care nurse covering two sites in the evening. Home care nurses generally work less weekends and evenings throughout their rotation than hospital nurses.

Reactions to critical incidents

The findings that home care nurses had emotional reactions to their critical events echo the findings of the emotional reactions of medical/surgical nurses who had

experienced a critical incident (Appleton, 1993). Appleton (1993) reported that the emotions falling on the disgusted/angry scale and those on the worried/fearful scale were the two subsets of emotions the general duty nurses experienced the most intensely during the first few days and evenings following the critical event. It is not surprising that nurses experience negative intense emotional responses after a critical incident. Home care nurses would be expected to experience strong feelings of frustration and disappointment when involved in incidents categorized as organizational limitations of care because of their perceived helplessness or let down by a system they trusted. Disgust and anger are understandable in critical incidents associated with abuse because of the violation of trust that occurs. Likewise, feelings of worry, fear, and anxiety may all be strongly experienced with incidents involving threats to personal health, sexual inappropriateness, and urgent situations because of risk to nurse and clients. A plethora of intense negative emotions would have been experienced when home care nurses were involved in critical incidents connected to a client's death.

These findings are supported in a study of the effects of violence and aggression on home care nurses (Büssing & Höge, 2004). While the home care nurses in that study did not have significant levels of psychosomatic complaints, they did have statistically significant levels of measures such as irritation/strain, emotional exhaustion, and depersonalization. In addition, patient aggression was more likely to be correlated to these effects than were incidents of aggression from the relatives of these patients. The acute care nurses in the study by Wolf and Zuzelo (2006) were more likely to report feelings categorized as guilt and neglect.

The fact that some home care nurses did experience some positive emotions during the days and evenings following the critical incident is consistent with Lazarus and Folkman's (1984) theory and research (1985). In the latter, college students assessed at three stages of a midterm examination demonstrated similar principles of emotional appraisal as were experienced by home care nurses during critical incidents. The first is that during any point in an occurrence, people may feel opposing emotions (Folkman & Lazarus, 1985). The second important principle is that at any stage during a stressful situation, there are individual differences in emotion and this suggests distinct differences in appraisal (Folkman & Lazarus, 1985). Henceforth, as different as each home care nurse's cognitive appraisal is of a critical event, the intensity and emotions experienced are also individual.

Coping with critical incidents

Home care nurses coped with the events they appraised as critical incidents in a variety of ways. The general duty nurses that Appleton studied in 1993 had similar ways of coping with a critical incident. She reported that medical/surgical nurses used the same four coping scales most frequently, e.g., seeking social support, planful problem solving, self-controlling, and positive reappraisal. However, there was a slight difference between the two groups of nurses in the order of the coping scales. Both samples of nurses used seeking social support as their primary coping strategy. Appleton's medical/surgical nurses employed self-controlling as their second most frequently used coping scale. The third most utilized coping scale for the medical/surgical nurses was positive reappraisal. Planful problem solving was the fourth most popular coping scale for the medical/surgical nurses Appleton surveyed. Healy and McKay (2000) reported planful problem solving to

be the most frequent coping scale used by their sample of nurses. The second and third most frequently applied coping strategies were seeking social support and self-controlling.

The findings of this study and the findings of Appleton (1993), support a hypothesis that nurses seek social support as a primary method of coping in the first few days and evenings after a critical incident. This is supported in other literature related to how nurses cope with stress (Healy & McKay, 2000; Fagin et al., 1995; Payne, 2001; Stewart & Arklie, 1994). Seeking social support includes strategies such as “seeking professional help” or “talking to someone about feelings and the situation” (Folkman et al., 1986, p.109). The fact that the nurses wanted to discuss the critical event provides support for the suggestion that talking about the critical incident is extremely important.

Traditionally, critical incident stress debriefing has been incorporated as an aspect of a critical incident stress management program (J. T. Mitchell, 2004). Managing a critical incident involves crisis intervention, a term describing short-term support for individuals and groups experiencing an episode of extreme stress (J. T. Mitchell, 2004). The goals of crisis intervention include reducing the tension caused by the event, supporting the recovery process and reinstating normal functional abilities (Everly, 2000). Critical incident stress debriefing was designed as a crisis intervention tool for a group of people who had all experienced the same traumatic event.

According to the Fraser Health Authority, “a debriefing is a group process in which trained providers will assist in addressing and responding to the emotional and psychological consequences resulting from the critical incident. The process is based in crisis intervention and educational intervention theory” (Critical Incident Stress

Management Program pamphlet, 2002). If Appleton's (1993) hospital nurses used "seeking social support" as a coping strategy, then debriefings would provide a venue for them to talk about the situation and how they are feeling with a professional that is trained in critical incident stress management. Other literature written also supports the use of critical incident stress debriefing for groups of nurses (Caine & Ter-Bagdasarian, 2003; Hollister, 1996; Martin, 1993).

Critical incident stress debriefing usually involves a group discussion for only the people involved in the event a few days after the critical incident. The discussion is controlled by the people who experienced the traumatic event and a trained professional is present to guide the discussion. The trained professional uses seven phases to guide the debriefing (Caine & Ter-Bagdasarian, 2003). The introductory phase explains the purpose of the debriefing. The fact phase allows participants to share their perception of the facts and actions of the event. Encouraging participants to share their thoughts about the critical incident is the next phase of the debriefing and is referred to as the thought phase. The feeling phase permits participants to explore their emotional reactions to the critical incident. Assessment phase asks the people who experienced the traumatic event to identify the physical, cognitive, emotional, and behavioural signs and symptoms they are experiencing (Caine & Ter-Bagdasarian). The education phase teaches participants about stress reactions and suggestions on how to cope with them. The final phase, the reentry phase, summarizes the experience and provides additional resources for participants who may need more counseling. In essence, critical incident stress debriefing is a formal approach for nurses using social support as their coping strategy if they were a part of a group that experienced the same critical incident.

One limitation on the use of critical incident stress debriefing in the home care setting is related to the environment in which the nurses work. Critical incident stress debriefing was not designed as a tool to be used with individuals (J. T. Mitchell, 2004). When home care nurses experience a critical incident, they are generally isolated from their colleagues and other health care professionals at the time of the incident. The incident would normally take place in a patient's home. The lack of a "group" with which to debrief the incident may limit the effectiveness of this technique in the home care setting.

Recent literature cautions about the potential for traumatizing individuals who were not involved in the critical incident, but are involved in the debriefing (Lewis, 2002; Sacks & Fay-Hillier, 2001). It is possible for the individual home care nurse to experience the benefits of debriefing that include an opportunity for verbal expression, emotional support, and recognition and normalization of his/her reactions, without being involved in a group debriefing (Anatai-Otong, 2001). Lewis proposed structuring crisis interventions, depending on a person's association with the critical incident. For example, the primary group would consist of only those who experienced the critical incident firsthand. The secondary group would consist of the family members of those who experienced the critical incident. Workplace colleagues who may be impacted by the critical incident, but who were not directly involved, would be considered the tertiary group. Therefore, home care nurses could have individual discussions with trained personnel to explore their experience of a critical incident. This would validate a home care nurses appraisal of a critical incident and provide an opportunity to use "seeking social support" as a coping strategy.

The sample of home care nurses who participated in this study and the sample of medical/surgical nurses who participated in a similar study (Appleton, 1993), ranked the second, third, and fourth coping scales in a different order. There are several potential explanations for the difference in frequency of use between the populations. Age may be one explanation why the two different samples had a different order of coping scales. Overall, the medical/surgical nurses in Appleton's study were younger than the home care nurses in this sample. Eight percent of home care nurses in the sample population were under the age of 35, and 72% of medical/surgical nurses were under the age of 35. Although the timing of the incident varied significantly and may have happened earlier in the careers of both groups, the timing of the incident would still have occurred at an earlier average age based on the demographics of the home care nursing population and the average duration of time that had passed since the original incident. However, research has been performed on the correlation of age and coping strategies (Folkman & Lazarus, 1980; Chung, Werrett, Easthope, & Farmer, 2004), and no noted difference has been identified.

Home care nurses used planful problem solving as their second most frequent coping strategy, while medical/surgical nurses used self-controlling. Self-controlling involves items such as "keeping feelings to oneself", "keeping others from knowing how bad the situation was", and "keeping feelings from interfering with the situation" (Folkman et al., 1986). Planful problem solving involves "concentrating on the next step", "making an action plan and following it", and "doubling efforts to make things work" (Folkman et al., p 109).

If the research is inconclusive about age and coping with stress, then another plausible explanation for the medical/surgical nurses using self-controlling as a coping strategy more than home care nurses and home care nurses using planful problem solving more than medical/surgical nurses is the difference in the working conditions. General duty nurses who work in hospitals are surrounded by patients, families, and other health care professionals, including administration. Home care nurses generally visit patients independently and spend limited time in the office with other health care professionals. As a result of hospital medical/surgical nurses being surrounded by other people most of their working day, they may feel the need to be in control of their emotions, especially following critical incidents.

Researchers have recently begun to study the role of emotion regulation in organizational behaviour (Gross, 1998). One study on emotion regulation in the work place reported that employees display emotions they think are suitable to the work environment, regardless if that is the actual emotion they are feeling (Grandey, 2000). Grandey posited an employee may have an emotional response to an event at work and the natural reaction may not be appropriate to display at work. In these situations, the employee modifies behaviours, expressions, and feelings.

The medical/surgical nurses are surrounded by people including clients, families, colleagues, and other health professionals, in their work environment and may feel they have to regulate their emotional reaction to the traumatic event. Home care nurses do not spend as much of their day at work constantly surrounded by as many people and, therefore, may not feel they need to regulate their emotions as often. For example, home care nurses spend time each day traveling to client's premises. During that time they are

not in contact with others and can more easily express emotions without being viewed by others. Consequently, the medical/surgical nurses may use self-controlling as a coping strategy more frequently than home care nurses. In addition Appleton's (1993) study was conducted over a decade ago, when professionalism encompassed controlling emotions in the workplace.

The increased use of planful problem solving by home care nurses can also be attributed to the work environment. As home care nurses spend a significant portion of their working day in isolation from other medical professionals, there is increased responsibility for them in relation to a patient's health and increased accountability in relation to the perception a client and caregivers may expect from the nurse.

Medical/surgical nurses are only one of many members of a multidisciplinary health care team that interact with a patient and caregivers during a day. As a result, there is not always a clearly identifiable person that would be considered accountable for issues associated with a patient. As the nurse is expected to be in professional control of the home care environment, these factors increase the professional vulnerability of the home care nurse and increase the onus on the nurse to demonstrate competence in his or her knowledge, skills and judgment.

Home care nurses may be more likely to use planful problem solving because they act in isolation during the critical incident. They do not have a group of health care professionals in close proximity with which to share any undesirable outcome. They are also conscious that, because they work in isolation, they could encounter a similar situation in the future and be required to react again. They recognize, both at the time of the incident and in the period following the incident, they are the person who has

professional control of the situation. In order to avoid any undesirable negative impact on his or her professional reputation, the nurse must attempt to resolve the situation in question through the means available. This process results in planful problem solving being a significant coping strategy for home care nurses. Medical/surgical nurses would be presumed to use planful problem solving to a lesser extent due to their ability to rely on other members of the health care team, both at the time of the incident, and in the future if a similar incident occurred.

The difference in work environment is not the only hypothesis that explains why home care nurses use planful problem solving as a coping strategy more frequently than medical/surgical nurses (Appleton, 1993). The nurses' number of years of experience may also explain the difference in frequency of coping strategy utilization. Eighty percent of home care nurses in this sample had more than ten years experience; in Appleton's study, only 20% of medical/surgical nurses had more than ten years experience. Twenty percent of home care nurses had 4 to 9 years experience, but 66% of the general duty nurses had 1-6 years of experience. The cumulative years of experience is significantly higher for home care nurses than it was for the medical/surgical nurses.

While not identified as such, the acute care nurses in the study by Wolf and Zuzelo (2006) also used planful problem solving in the critical incidents they shared under their "never again" stories. They were able to identify from these critical incidents what they could do to prevent a similar incident from happening. Insights that nurses gained from their involvement in the critical incident were also critical in the sense that they learned from what had happened.

Home care nurses identified planful problem solving as their second favoured coping strategy; medical/surgical nurses ranked it as the fourth coping scale they used (Appleton, 1993). Some of the elements of that strategy include “drawing on past experiences after being in a similar situation”, and “coming up with different solutions to the problem” (Folkman et al., 1986, p.109). I believe that the lack of nursing experience of the medical/surgical nurses resulted in more limited experience to use in planful problem solving. The medical/surgical nurses may not have felt as confident in their abilities as the home care nurses did, because they had not been engaged in nursing practice as long. Instead, medical/surgical nurses used self-controlling as their second coping strategy that includes elements such as “thinking about how a person you admire would handle the situation and use that as a model”, or “going over in your head what you would say or do” (Folkman et al., 1986, p.109). Instead of the general duty nurses having the confidence in their knowledge, skills, and judgment to think of other solutions to the situation, they “imagined how someone they admire would handle the situation”. Self-doubt has been reported in nurses who have less than two years nursing experience (Humpel & Caputi, 2001).

The concept of nursing experience and knowledge in clinical practice is not a new one. Benner (1984) proposed in her situational model that nurses gain knowledge through nursing practice, and time is needed for a nurse to become an “expert” in the chosen area of nursing. The ability to incorporate both knowledge and critical thinking into practice moves through stages according to Benner. Stage one is novice when a nurse begins as a student. Stage two is advanced beginner when a nurse is a new graduate and starting a job. Stage three is competent, when a nurse has been nursing in the same setting for two

to three years and starts to have feelings of mastery and can cope with most of the expectations associated with clinical nursing. Stage four is the proficient nurse who has three to five years nursing experience. The proficient nurse has an understanding of the entire situation. The fifth and final stage is when a nurse has been practicing for at least five years and is now considered an expert. An expert nurse has an intuitive awareness of situations, based on a vast amount of experience in the clinical setting.

Therefore, Benner's model (1984) is helpful to support the explanation for home care nurses using planful problem solving more than the medical/surgical nurses (Appleton, 1993). As already stated, the home care nurses have more experience than the medical/surgical nurses. The majority of home care nurses, according to Benner's typology, would be considered expert nurses based on the years in their current position while the majority of medical/surgical nurses in Appleton's study would be classified as advanced beginners to competent nurses because they have not been practicing as long. Perhaps expert nurses use planful problem solving as a coping strategy as a result of their perceptual acuity in recognizing challenging situations. If expert nurses are able to intuitively know from their experiences that a traumatic event could have possibly been avoided, they may cope by focusing on actions plans and trying to make them work. The medical/surgical nurses, who have just begun to formulate principles and make plans as advanced beginner and competent nurses, may focus coping strategies on controlling their emotions after the traumatic event rather than planning solutions.

This hypothesis is further supported by the work of other authors. Folkman et al., (1986) identified problem-focused forms of coping as planful problem solving and confrontive coping. Distancing, escape-avoidance, accepting responsibility, self-

controlling, seeking social support, and positive reappraisal are identified as emotion-focused forms of coping. Problem-focused forms of coping have been identified as being used in situations whereby the situation was appraised as changeable and the emotion-focused forms of coping have been used when situations were appraised as unchangeable (Folkman & Lazarus, 1986). Given that home care nurses were more experienced, they may appraise critical incidents as changeable and, therefore, used the planful problem solving coping strategy more often than less experienced hospital staff nurses. The hospital staff nurses may have appraised the situation as unchangeable and, consequently, chose coping strategies that were more emotion-focused.

Impact of critical incidents

The respondents in the current study indicated that their relationship with their family and friends was negatively impacted more often (20%) than their relationship with their colleagues at work (16%). This finding stands in contrast to those of Appleton (1993) who indicated that the relationship with colleagues at work was negatively impacted more often (29%) than their relationship with their family and friends (18%). The difference in the impact on friends and family versus colleagues at work further supports that working conditions can affect the manner in which nurses address critical incidents. Due to the limited time home care nurses spend interacting with colleagues each day, many home care nurses may process critical incidents outside of their professional environment. This processing may have an impact on their personal lives in a negative way. Hospital medical/surgical nurses are, generally surrounded by colleagues at the time of their critical incident. As a result, the processing of their critical incident

and the invocation of coping strategies is more likely to impact relationships with colleagues than those of friends and family.

Stress can affect relationships with family and friends, as well as decreasing job satisfaction (Boswell, 1992; Healy & McKay, 1999), and increase burnout (Coffey, 1999; Payne, 2001). Stress associated with work and responsibilities at home has been associated with poor health in nurses (Walters, Evles, Lenton, French, & Beardwood, 1998). Therefore, nurses have a responsibility to be aware of circumstances that have a negative impact on their working life and what causes them additional stress. Perhaps more questions should have been included on the questionnaire to comprehend the extent of the negative impact that the critical incident had on the lives of the home care nurses.

A question that perhaps needs to be included on the survey is “do you recall the critical incident having a negative impact on your interpersonal relationship with your manager?” Some home care nurses indicated that a negative aspect of the critical incident was the lack of support from their manager. As 92% of the nurses participating in the study continued to work in the same position following the incident, it can be presumed that the lack of support had minimal impact on the nurse’s decision to remain in their position. However, as home care nurses have little direct involvement with their manager on a daily basis, it is unclear whether this is a significant consideration in their continuing employment with the organization. There was also some indication that home care nurses were not content with certain aspects of the organization for which they worked. Another appropriate question to include on the survey may have been “do you recall the critical incident having a negative impact on your perception of the organization you work for?”

In retrospect, the survey should have asked more specific questions to gain a better understanding of how the critical incidents affected the home care nurses' lives.

Chapter Six

Limitations, and Implications for Nursing Practice

This chapter summarizes the limitations of the research study and provides recommendations for nursing practice in the areas of education, administration, and research.

Limitations

Of the 165 questionnaires distributed, 25 responses met the criteria to be included in the study. Although, the incidence of critical incidents among home care nurses is unknown, this seems like a small number. The small number of reported critical incidents may be attributed to several factors. First, the questionnaires were distributed during the summer, a time when many home care nurses are on holidays and workloads may be heavier. Other home care nurses during the discussion period at the end of the presentations, stated they had experienced a critical incident as a home care nurse, nevertheless, could not recall the emotions and coping strategies they used in the days following the critical incident. Some nurses felt that the questionnaire should not have to be done during their own time but rather they should be allowed to do it during working hours.

The low response to the questionnaires may also be attributed to the absence of an important group of home care nurses; those on leave. Any home care nurse on leave may have experienced a critical incident, but would not have been at work to fill out the questionnaire during the study period. This may also include any home care nurse that may have been on medical leave as a result of experiencing a critical incident. In addition

perhaps some home care nurses found the critical incident too traumatic to relive by participating in the study.

There is the possibility that some of the home care nurses had not experienced a critical incident as a home care nurse. It is difficult to determine from the approach used in the study if the nurses did not participate because they believed they had not experienced a critical incident while practicing as a home care nurse or they simply chose not to respond. Five questionnaires returned described a critical incident in a different health care setting. One questionnaire described an accumulation of stressors rather than a critical event.

Generalizability of the findings to other home care nurses in different health authorities is not possible due to the use of a nonprobability convenience sample. The data used in this study may also be limited due to the participants' ability to recall the critical incident and how they reacted and coped with it.

Implications

The study is a beginning exploration of critical incidents among a group of nurses not previously studied; home care nurses. It further documents the effects they experienced as a result of the critical incident. Therefore, a number of implications for nursing education, administration, and research have been identified.

Nursing Education.

Nursing educators could better prepare future nurses by discussing the potential for critical incidents with nursing students, emphasizing that nurses can experience critical incidents regardless of their area of nursing practice or their number of years of experience as a nurse. Some nursing instructors have begun doing presentations about

preincident education information (S. Ringland, personal communication, June 1, 2005) to enhance a safe psychological environment for student nurses. If nurses are aware of the potential for critical incidents early in their nursing careers, they can identify the coping strategies needed to deal with this specific type of acute stress and seek out the appropriate resources to assist them. Ideally, the discussion about critical incidents in nursing will emphasize that each traumatic event is unique and different nurses will appraise and cope with critical incidents differently.

There is some literature to suggest that critical incidents are already being used in nursing education to promote reflective nursing practice and guide content curriculum. (Gould & Masters, 2004; Minghella & Benson, 1995). Nursing students are requested to present incidents from their practice that significantly challenged their beliefs or values. The critical incidents are then analysed using different teaching and learning activities. The purpose of the exercise is to reflect on their practice experiences.

Nurse educators working in the community also need to be aware that different home care nurses will appraise and cope with critical incidents differently. Home care nurse educators would ideally discuss the potential for critical incidents in the community with new employees during orientation, and outline the resources available to the home care nurses should they experience a traumatic event. Reinforcing resource availability could be followed up with experienced nurses on an annual basis. Workshops should be conducted by the organization to teach nurse educators how to recognize, support, and assist a home care nurse who has experienced a critical incident. Nurse educators have to be knowledgeable about the possible physical and emotional reactions of home care nurses in the first few days following the critical incident, as well as the possible coping

strategies. Nurse educators could be trained in crisis intervention or supportive listening, or know whom to contact that has the appropriate training.

Nursing Administration.

Workshops addressing critical incidents and coping could also be attended by nursing administrators so they may have a greater awareness of the scope of critical incidents and how their nursing staff may be affected. Nursing administrators need to realize that critical incidents are self-defined and how a home care nurse appraises, reacts, and copes with the event will differ for each individual. Nursing administrators also need to be supportive of some form of crisis intervention for their staff that has experienced a critical incident, given the strong reliance on seeking social support as a coping strategy.

It is important for nursing administrators to realize that although home care nurses deal with death and dying of their clients receiving palliative care on a regular basis, critical incidents can still occur within this context. Nursing administrators' awareness of possible physical and emotional reactions of home care nurses in the first few days is crucial following the critical incident. Familiarity with possible or lack of coping strategies would alert nursing managers to potentially self-destructive or team destructive behaviour.

Abuse must not be tolerated in any nursing practice setting, and nursing administrators can provide educational in-services to nurses that help them identify the types of abuse they may encounter and educate them on how to address situations that involve threatening behaviour, intimidation, and verbal or physical abuse. Acute care settings have trained teams that respond to patients that are displaying aggressive behaviours; home care nurses have little recourse when they are in situations where a

client's behaviour is escalating, other than to leave, if it is possible. Administrators who establish and demonstrate that nursing safety is the number one priority, share similar values with nurses who are committed to patient safety being their number one priority.

Nursing administrators need to provide clear, written policies about the tolerance of sexual harassment in the home care setting. Sexual harassment as a traumatic event in nursing practice is a vague and complex issue, open to much interpretation. There is a strong calling to clearly identify the procedures a home care nurse and administration should follow when a home care nurse has appraised an incident as sexual harassment. One home care nurse described feelings of frustration that discussion about the critical incident only occurred when the client was accepted again for home care nursing service. This nurse felt that administration had "just swept it under the table!"

Guidelines and protocols need to be established by nursing administration insofar as potential threats to a nurse's personal health are concerned. Some nurses expressed frustration at having to go to the emergency department and then being questioned by the emergency staff about the purpose of their visit. All health care workers are expected to know the policy and procedure to follow if they have had a threat to their personal health. The health care workers providing the care to those who have had exposure to blood borne pathogens could receive sensitivity training to understand the reactions of a person who has experienced a critical incident of this nature.

Lastly, nursing administration should communicate with the health care organization to ensure that policies and procedures are clearly outlined for discharge of a patient from the acute care setting to the community. Nursing administrators can also be involved in discussions regarding when a client is eligible for certain procedures or

equipment and when they are not. Open and direct dialogue between administrators in the acute setting and in the community setting is essential for continuity of care for clients. Providing continuity between acute care and community care will reduce anxiety in clients and families, thereby decreasing stress for home care nurses and not putting them at risk for critical incidents that result from organization limitations of care.

Nursing Research.

The sample size used in this study was relatively small. It may be worth repeating the study at a time when data can be collected from more home care nurses. The timing of the study should anticipate workloads and holidays during various periods of the year. The study could also be repeated using home care nurses from multiple cities and working for a variety of health authorities to increase the generalizability of the findings. This would be beneficial in exploring critical incidents that home care nurses' experience when they work in more rural settings. Critical incidents in smaller populated areas are often complicated by the close relationships within the community (Jimmerson, 1988).

It may also be beneficial to study the prevalence of critical incidents among home care nurses using a different methodology than the one employed to establish how many home care nurses have experienced one or more critical incidents in their practice. A survey on whether or not a nurse has experienced a critical incident would help in this respect. Other aspects of prevalence could help with program planning. During the question period after the presentation, one home care nurse asked if there was any way to distinguish in which area of the city the critical incidents had occurred to determine if there were areas of the city that home care nurses visited that were at higher risk for appraising more events as critical. This may warrant further investigation as home care

nurses who work with more marginalized clients may experience more critical incidents than those who work in areas with a higher socioeconomic status.

There are some areas not addressed in this study in terms of home care nurses and how they coped with critical incidents. Research designed to evaluate the effectiveness of different coping strategies for the nurses involved would add to our understanding of managing the intense emotional reactions and surviving the stress associated with critical incidents. Longitudinal designed studies may assist nursing researchers in exploring the long-term impact critical incidents have on home care nurses. Studies can also be proposed that investigate the effectiveness of preincident planning and critical incident stress debriefing as components of a critical incident stress management program.

It is also important to broaden nursing knowledge by exploring how critical incidents affect the home care nurse's practice. Qualitative studies could be used to explore if the home care nurse changed the way he/she practiced after experiencing the critical incident. It would also be extremely valuable to interview home care nurses who stopped practicing in home care because they experienced a critical incident in order to understand what incidents these former home care nurses appraised as critical and how they reacted and coped with the event.

Conclusion

This descriptive study explored how home care nurses appraised, reacted and coped with the critical incidents they experienced. Critical incidents are very traumatic and stressful events for home care nurses in their daily practice. Personal meaning is pivotal in home care nurses' appraisal, reaction, and coping strategies in a critical incident. Home care nurses experienced critical incidents in the categories of patient

death, abuse, sexual harassment, urgent situations, organization limitations of care, and potential threat to personal health. Within the critical incident categories, there were a variety of events unique to the home care setting. The events were unique because home care nurses work in isolation with significant vulnerability, have considerable autonomy in their practice, and have personal expectations of being in control.

During the first few days or evenings after the critical incidents, home care nurses experienced physical reactions of fatigue and nausea and emotional reactions of harm/loss and threat (Lazarus & Folkman, 1984). The top four types of coping strategies that home care nurses used to deal with critical incidents were seeking social support, planful problem-solving, self-controlling, and positive reappraisal. Critical incidents can have a negative impact on the professional or personal life of a home care nurse.

The research has focused on how home care nurses appraise, react and cope with a critical incident. Exploring what a home care nurse appraises as a critical incident is an important aspect in learning what type of traumatic events might be preventable. Acknowledging and understanding the home care nurses' individual reactions and coping strategies after they experience the critical incident is crucial to support them in dealing with the traumatic event.

References

- Antai-Otong, D. (2001). Critical incident stress debriefing: A health promotion model for workplace violence. *Perspectives in Psychiatric Care*, 37, 125- 139.
- Appleton, L. (1994). What's a critical incident? *The Canadian Nurse*, 90(8), 23-26.
- Appleton, L. A. (1993). *Staff nurses' appraisals and coping strategies in a critical incident*, Unpublished master's thesis, University of British Columbia, British Columbia, Canada.
- Appleton, L. A. (1992a). *Critical incident information form*. Unpublished manuscript.
- Appleton, L. A. (1992b) *Participant information sheet*. Unpublished manuscript.
- Arnetz, J. E., Arnetz, B. B., Peterson, I. L. (1996). Violence in the nursing profession: Occupational and lifestyle risk factors in a Swedish nurses. *Work & Stress*, 10, 119-127.
- Back, K. J. (1992) Critical incident stress management for care providers in the pediatric emergency department. *Critical Care Nursing*, 12(1), 78-83.
- Bell, N. (1991). Critical incident stress debriefing: Smoothing out the edges of rough calls. *Emergency*, 23(9), 31-35.
- Benner, P. (1984). *From novice to expert: Excellence and power in clinical practice*. Don Mills, Ontario: Addison-Wesley.
- Bergen, E., & Fisher, P. (2003). When working hurts: Stress, burnout, and trauma in health care. *Nursing BC*, 35(5), 12-15.
- Boswell, C. A. (1992). Work stress and job satisfaction for the community health nurse. *Journal of Community Health Nursing*, 9, 221-227.
- British Columbia Nurses Union. (2006). *Occupational health and safety manual: Keeping*

nurses safe (needlestick injuries). Retrieved October 26, 2006 from:

http://www.bcnu.org/health_and_safety/keeping_nurses_safe/needlestick_injuries.htm

Burnard, P., Edwards, D., Fothergill, A., Hannigan, B., & Coyle, D. (2000). Community mental health nurses in Wales: self-reported stressors and coping strategies.

Journal of Psychiatric and Mental Health Nursing, 7, 523-528.

Burns, C. & Harm, N. J. (1993). Emergency nurses' perceptions of critical incidents and stress debriefing. *Journal of Emergency Nursing*, 19, 431-436.

Burns, C. & Rosenberg, L. (2001). Redefining critical incidents: A preliminary report.

International Journal of Emergency Medicine, 3(1), 17-24

Büssing, A., & Höge, T. (2004). Aggression and violence against home care workers.

Journal of Occupational Health Psychology, 9, 206-219.

Butterworth, T., Carson, J., Jeacock, J., White, E., & Clements, A. (1999). Stress, coping, burnout and job satisfaction in British nurses: Findings from the clinical supervision evaluation project. *Stress Medicine*, 15, 27-33.

Caine, R. M., & Ter-Bagdasarian, L. (2003). Early identification and management of critical incident stress. *Critical Care Nurse*, 23(1), 59-65.

Canadian Institute for Health Information. (2006, October 17). *Workforce Trends of*

Registered Nurses in Canada, 2005. Retrieved October 24, 2006 from

http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=download_form_e&cw_sku=SDRN2005PDF&cw_ctt=1&cw_dform=N

- Canadian Nurses Association. (2003, October). *Ethical distress in health care environments*. Retrieved December 26, 2006 from http://www.cna-nurses.ca/CNA/practice/ethics/code/default_e.aspx
- Canadian Nurses Association. (2002, March). *Position Statement on Violence*. Retrieved October 25, 2006 from http://www.can-nurses.ca/CNA/issues/position/practice/default_e.aspx
- Chung, M. C., Werrett, J., Easthope, Y., & Farmer, S. (2004). Coping with post-traumatic stress: Young, middle-aged and elderly comparisons. *International Journal of Geriatric Psychiatry, 19*, 333-343.
- Coffey, M. (1999). Stress and burnout in forensic community mental health nurses: An investigation of its causes and effects. *Journal of Psychiatric and Mental Health Nursing, 6*, 433-443.
- Duxbury, J. (1999). An exploratory account of registered nurses' experience of patient aggression in both mental health and general nursing settings. *Journal of Psychiatric and Mental Health Nursing, 6*, 107-114.
- Edwards, D., Burnard, P., Coyle, D., Fothergill, A., & Hannigan, B. (2000). Stressors, moderators and stress outcomes: findings from the All-Wales Community Mental Health Study. *Journal of Psychiatric and Mental Health Nursing, 7*, 529-537.
- Evans, L. (2002). An exploration of district nurses' perception of occupational stress. *British Journal of Nursing, 11*, 576-585.

- Everly, G. S. (2000). Five principles of crisis intervention: Reducing the risk of premature crisis intervention. *International Journal of Emergency mental Health, 2*, 1-4.
Retrieved January 16, 2007 from <http://www.icisf.org/articles/>
- Fagan, N., & Freme, K. (2004). Confronting posttraumatic stress disorder. *Nursing2004, 34*, (2), 52-53.
- Fagin, L., Brown, D., Barlett, H., Leary, J., & Carson, J. (1995). The Claybury community psychiatric nurse stress study: is it more stressful to work in hospital or community? *Journal of Advanced Nursing, 22*, 347-358.
- Fiedler, A., & Hamby, E. (2000). Sexual harassment in the workplace. *Journal of Nursing Administration, 30*, 497-503.
- Folkman, S., & Lazarus, R. S. (1985). If it changes it must be a process: Study of emotion and coping during three stages of a college examination. *Journal of Personality and Social Psychology, 48*, 150-170.
- Folkman, S., & Lazarus, R. S. (1986). Stress processes and depressive symptomatology. *Journal of Abnormal Psychology, 95*, 107-113.
- Folkman, S., & Lazarus, R. S. (1980). An analysis of coping in a middle-aged community sample. *Journal of Health and Social Behavior, 21*, 219-239.
- Folkman, S., Lazarus, R. S., Dunkel-Schetter, C., DeLongis, A., & Gruen, R. (1986). Dynamics of a stressful encounter: Cognitive appraisal, coping, and encounter outcomes. *Journal of Personality and Social Psychology, 50*, 992-1003.

- Foxall, M. J., Zimmerman, L., Standley, R., & Bene, B. (1990). A comparison of frequency and sources of nursing job stress perceived by intensive care, hospice and medical-surgical nurses. *Journal of Advanced Nursing, 15*, 577-584.
- Fraser Health Authority. (2002). *Critical incident stress management*. Retrieved September 21, 2005 from <http://fhaweb/HR+Online/Critical+Incident+Stress+Management/Recognizing.htm>
- Freehill, K. (1992). Critical incident stress debriefing in health care. *Critical Care Clinics, 8*, 491-500.
- Gotay, C. C., Crockett, S., & West, C. (1985). Palliative home care nursing: Nurses' perceptions of roles and stress. *Canada's Mental Health, 33*(2), 6-9.
- Grandey, A. A. (2000). Emotion Regulation in the workplace: A new way to conceptualize emotional labour. *Journal of Occupational Health Psychology, 5*, 95-110.
- Gross, J. J. (1998). The emerging field of emotion regulation: An integrative review. *Review of General Psychology, 2*, 271-299.
- Gould, B., & Masters, H. (2004). Learning to make sense: The use of critical incident analysis in facilitated groups of mental health student nurses. *Learning in Health and Social Care, 3*, 53-63.
- Healy, C., & McKay, M. (1999). Identifying sources of stress and job satisfaction in the nursing environment. *Australian Journal of Advanced Nursing, 17*(2), 30-35.

- Healy, C. M., & McKay, M. F. (2000). Nursing stress: the effects of coping strategies and job satisfaction in a sample of Australian nurses. *Journal of Advanced Nursing*, 31, 681-688.
- Hollister, R. (1996). Critical incident stress debriefing and the community health nurse. *Journal of Community Health Nursing*, 13, 43-49.
- Humpel, N., & Caputi, P. (2001). Exploring the relationship between work stress, years of experience and emotional competency using a sample of Australian mental health nurses. *Journal of Psychiatric and Mental Health Nursing*, 8, 399-403.
- International Critical Incident Stress Foundation, Inc. (2001). *Handout: Critical Stress Information Sheet*. Retrieved December 19, 2006 from <http://www.icisf.org/articles/>
- Jackson, D., Clare, J., & Mannix, J. (2002). Who would want to be a nurse? Violence in the workplace- a factor in recruitment and retention. *Journal of Nursing Management*, 10, 13-20.
- Jimmerson, C. (1988). Critical incident stress debriefing. *Journal of Emergency Nursing*, 14(5), 43a-45a.
- Laws, T., & Hawkins, C. (1995). Critical incident stress. *Australian Nursing Journal*, 2(7), 32-36.
- Lewis, G. (2002). Post-crisis stress debriefings: More harm than good? *Behavioral Health Management*, 22(4), 22-25.
- Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, coping*. New York: Springer.
- Madison, J., & Minichiello, V. (2001) *Sexual harassment in healthcare: Classification of harassers and rationalizations of sex-based harassment behaviour*, 31, 534-543.

- Martin, K. R. (1993). Critical incidents: Pulling together to cope with the stress. *Nursing93*, 23(5), 38-41.
- McVicar, A. (2003) Workplace stress in nursing: a literature review. *Journal of Advanced Nursing*, 44, 633-642.
- Minghella, E., & Benson, A. (1995). Developing reflective practice in mental health nursing through critical incident analysis. *Journal of Advanced Nursing*, 21, 205-213.
- Mitchell, G. J. (2001). A qualitative study exploring how qualified mental health nurses deal with incidents that conflict with their accountability. *Journal of Psychiatric and Mental Health Nursing*, 8, 241-248.
- Mitchell, J. T. (January 9, 2004). Crisis intervention and critical incident stress management: A defense of the field. Retrieved January 16, 2007 from <http://www.icisf.org/articles/>
- Nabb, D. (2000). Visitors' violence: The serious effects of aggression on nurses and others. *Nursing Standard*, 23(14), 36-38.
- NHS Careers. (2006, September) *District nursing: Role of a district nurse*. Retrieved January 12, 2007, from <http://www.nhscareers.nhs.uk/details/Default.aspx?Id=916>
- O'Connell, B., Young, J., Brooks, J., Hutchings, J., & Lofthouse, J. (2000). Nurses' perception of the nature and frequency of aggression in general ward settings and high dependency areas. *Journal of Clinical Nursing*, 9, 602-610.
- O'Connor, J., & Jeavons, S. (2003). Nurses' perceptions of critical incidents. *Journal of Advanced Nursing*, 41, 53-62.
- Payne, N. (2001). Occupational stressors and coping as determinants of burnout in female

- hospice nurses. *Journal of Advanced Nursing*, 33, 396-405.
- Perry, L. (1997). Critical incidents, crucial issues: Insights into the working lives of registered nurses. *Journal of Clinical Nursing*, 6, 131-137.
- Rippon, T. J. (2000). Aggression and violence in health care professions. *Journal of Advanced Nursing*, 31, 452-460.
- Robbins, I., Bender, M. P., & Finnis, S. J. (1997). Sexual harassment in nursing. *Journal of Advanced Nursing*, 25, 163-169.
- Rout, U. A. (2000). Stress amongst district nurses: A preliminary investigation. *Journal of Clinical Nursing*, 9, 303-309.
- Sacks, S. B., & Fay-Hillier, T. (2001). Care after chaos: Use of critical incident stress debriefing after traumatic workplace events. *Perspectives in Psychiatric Care*, 37, 133-136.
- Salmond, S., & Ropis, P. E. (2005). Job stress and general well-being: A comparative study of medical-surgical and home care nurses. *MEDSURG Nursing*, 14, 301-309.
- Shannon, P. A. (1991). The crisis of the caregivers. *Critical Care Nursing Clinics of North America*, 3, 353-359.
- Snelgrove, S. R. (1998). Occupational stress and job satisfaction: a comparative study of health visitors, district nurses and community psychiatric nurses. *Journal of Nursing Management*, 6, 97-104.
- Speziale, H. J. S., & Carpenter, D.R. (2003). *Qualitative research in Nursing: Advancing the humanistic imperative*. Philadelphia: Lippincott Williams & Wilkins.
- Stewart, M. J., & Arklie, M. (1994). Work satisfaction, stressors and support experienced

- by community health nurses. *Canadian Journal of Public Health*, 85, 180-184.
- Valente, S., & Bullough, V. (2004). Sexual harassment of nurses in the workplace. *Journal of Nursing Care Quality*, 19, 234-241.
- Vancouver Coastal Health. (2006). *A guide for the person on home oxygen. [Brochure]*.
- Walcott-McQuigg, J. A., & Ervin, N. E. (1992). Stressors in the workplace: Community health nurses. *Public Health Nursing*, 9, 65-71.
- Walker, G. (1990). Crisis-care in critical incident stress debriefing. *Death Studies*, 14, 121-133.
- Walters, V., Evles, J., Lenton, R., French, S., & Beardwood, B. (1998). Work and health: A study of the occupational and domestic roles of women registered nurses and registered practice nurses in Ontario, Canada. *Gender, Work and Organization*, 5, 230-245.
- Wilkes, L. M., & Beale, B. (2001). Palliative care at home: Stress for nurses in urban and rural New South Wales, Australia. *International Journal of Nursing Practice*, 7, 306-313.
- Wilkes, L., Beale, B., Hall, E., Rees, E., Watts, B., & Denne, C. (1998). Community nurses' descriptions of stress when caring in the home. *International Journal of Palliative Nursing*, 4(1), 14-20.
- Wolf, Z. R., & Zuzelo, P. R. (2006). "Never again" stories of nurses: Dilemmas in nursing practice. *Qualitative Health research*, 16, 1191-1206.

WorkSafeBC (2006, February). Registered nurses in health care and social assistance in BC provincial overview. Retrieved October 25, 2006 from

http://www2.worksafebc.com/PDFs/Healthcare/RN_FactSheet_Feb06.pdf

World Health Organization (2006). *Palliative Care*. Retrieved June 14, 2006 from

<http://www.who.int/hiv/topics/palliative/care/en/>

Appendix B

Script for Presentation to Home Care Nurses

Good afternoon. Thank you for allowing me to come and speak with you today. My name is Lisa Bower and I am one of the float home care nurses between South and Evergreen. I am also a student enrolled in the Master of Nursing program at Memorial University of Newfoundland. As part of my master's program, I am writing a thesis on home care nurses' appraisals, reactions and coping strategies in a critical incident.

In 1994, Leanne Appleton published an article titled *What's A Critical Incident* in the Canadian Nurse Magazine. Appleton acknowledged that most studies on critical incidents were associated with first responders such as firefighters and paramedics and very few studies involved nurses and critical incidents. Appleton states that critical incidents are self-defined but there was no literature suggesting what nurses consider to be critical incidents. Appleton then studied 50 medical/surgical nurses that worked in hospitals. She asked the nurses to describe a traumatic event in their nursing career to understand what general duty nurses define as a critical incident. She also asked them how the incident made them feel and how they coped.

What defines a critical incident? According to Appleton, a critical incident is a traumatic event that causes a strong emotional and/or physical response and the person's usual coping skills are ineffective. This results in critical incident stress that can be immediate or delayed. Emotional, physical, cognitive and behavioural reactions can all have a negative impact on your personal and professional life. The traumatic events that Appleton's 50 nurses appraised as critical incidents were categorized into moral distress, lack of responsiveness by a health care professional, violence towards a nurse, emergency situations, patient death and actual or potential contact with infectious body fluids.

To date, there is no research into what nurses appraise as a critical incident in the home care setting. This study will explore what we as home care nurses define as a critical incident and how we react and cope with those incidents.

I am here today to ask for your participation in my study. I will be distributing packages that ask you to describe a critical incident and how you reacted and coped with that incident. The total package will take approximately 30 to 45 minutes to complete that will have to be done on your own time. Participation in this study is entirely voluntary and your employment with Vancouver Coastal Health will not be affected if you choose not to participate. All responses will be anonymous so no one will know who takes part in the study.

I know that you are all very busy and half an hour out of your day may seem a lot to ask. I am asking you to participate in this study so home care nurses' stories of critical incidents and how you reacted and coped, can be documented. Some of you may not have experienced a critical incident as a home care nurse but perhaps your colleague has and I encourage you to support them in filling out the questionnaire. Our clients are coming home more complex and acute and resulting in a greater potential for critical incidents. Perhaps if we have a better understanding of critical incidents in home care nurses, we will be more proficient in dealing with them.

Are there any questions or comments?

Appendix C

PARTICIPANT INFORMATION SHEET (Appleton 1992, Revised with permission)

AGE:

20-23 ___
24-27 ___
28-31 ___
32-35 ___
36-39 ___
40-43 ___
44-47 ___
48-50 ___
51-54 ___
55-58 ___
59-62 ___
> 62 ___

GENDER: Female ___
Male ___

YEARS OF EXPERIENCE AS A R.N.:

< 1 Year ___
1-3 ___
4-6 ___
7-9 ___
> 10 ___

YEARS IN PRESENT POSITION:

<1 Year ___
1-3 ___
4-6 ___
7-9 ___
> 10 ___

EMPLOYMENT STATUS

Permanent full-time ___
Permanent part-time ___
Casual full-time ___
Casual part-time ___

Appendix D

CRITICAL INCIDENT INFORMATION FORM (Appleton 1992, Revised with permission)

A critical incident is an event or situation that you consider as being traumatic and causes you to have unusually strong emotional responses, and may also make your usual coping skills ineffective.

1. Describe in 50-75 words a critical incident that you have experienced (Please include in this description who was involved, a brief description of what happened and what role you played in the situation).

2. How long ago did this incident occur?

3. When did this critical incident occur? (circle one)

a) Weekday day shift (0815-1700)

b) Weekday evening shift (1245 - 2130)

c) Weekend day shift (0815-1700)

d) Weekday evening shift (1245 - 2130)

e) On- call shift (2130-0815)

4. What was the worst part of this critical incident?

5. Do you recall this incident as challenging your personal beliefs? ___yes___no
Elaborate if you wish.

6. Do you recall this situation occurring suddenly (without warning)?
a) yes _____ b) no _____

7. Do you recall having any other stresses in your life at the same time as this critical incident? a) yes _____ b) no _____

If yes, please specify:

- a) personal stress _____
- b) professional stress _____
- c) other _____

8. Did this incident involve dealing with something new?
a) yes _____ b) no _____

If yes please explain:

9. Do you recall that there was an element of uncertainty with this incident?
a) yes _____ b) no _____

If yes please explain:

10. Were you comfortable with the decisions that you made during the incident?
a) yes _____ b) no _____

Elaborate if you wish:

11. After the critical incident (within the first few days and evenings following this event) do you recall experiencing any of the following physical reactions?

- a) nausea
- b) diarrhea
- c) headache
- d) fatigue
- e) insomnia
- f) of others, please specify:

12. Do you recall the critical incident having a negative impact on your interpersonal relationships with your colleagues at work?

a) yes _____ b) no _____

with your friends and/or family?

a) yes _____ b) _____

13. Did this incident occur while you were working at your present position?
a) yes _____ b) no _____
14. Did you consider leaving your position because of this incident?
a) yes _____ b) no _____
15. Have you considered leaving your present position because of this incident?
a) yes _____ b) no _____

16. Please read the following (prior to answering this question):
Debriefing is defined as a formal psychological and educational group process aimed at softening the impact of stress as a result of experiencing a critical incident through "talking it out." This is different than informal talking to a colleague about the event.

Did you participate in a debriefing session following the critical incident that you have just described?
a) yes _____ b) no _____

If you answered yes, go to question 18. If you answered no, go to question 17.

17. Would you have liked a debriefing session following your critical incident?
a) yes _____ b) no _____

18. If there is anything you wish to add regarding this critical incident, please do so in the space provided:

Appendix E

Emotional Appraisal Scale (Folkman & Lazarus, 1986)

As best you can, describe how you felt after experiencing this critical incident (within the first few days and evenings following this event). To do this, it is important that for each item you circle the number that best describes the extent of that feeling.

	Not at all	A little	Some- what	Quite a bit	A great deal
a. angry	0	1	2	3	4
b. worried	0	1	2	3	4
c. exhilarated	0	1	2	3	4
d. disappointed	0	1	2	3	4
e. secure	0	1	2	3	4
f. confident	0	1	2	3	4
g. in control	0	1	2	3	4
h. fearful	0	1	2	3	4
i. pleased	0	1	2	3	4
j. hopeful	0	1	2	3	4
k. disgusted	0	1	2	3	4
l. eager	0	1	2	3	4
m. frustrated	0	1	2	3	4
n. anxious	0	1	2	3	4
o. happy	0	1	2	3	4
p. relieved	0	1	2	3	4
q. other (please specify):	0	1	2	3	4

Appendix F

Ways of Coping (Revised) (Folkman et al., 1986)

Please read each item below and indicate, by circling the appropriate category, to what extent you used it after experiencing the critical incident (the first few days, and evenings following the event). Simply circle the "not used" column if an item is not applicable.

	Not Used	Used some- what	Used quite a bit	Used a great deal
1. Just concentrate on what I had to do next- -the next step.	0	1	2	3
2. I tried to analyzed the problem in order to understand it better.	0	1	2	3
3. Turned to work or substitute activity to take my mind off things.	0	1	2	3
4. I felt that time would make a difference- the only thing to do was wait.	0	1	2	3
5. Bargained or compromised to get something positive from the situation.	0	1	2	3
6. I did something which I didn't think would work, but at least I was doing something.	0	1	2	3
7. Tried to get the person responsible to change his or her mind.	0	1	2	3
8. Talked to someone to find out more about the situation.	0	1	2	3
9. Criticized or lectured myself.	0	1	2	3
10. Tried not to burn my bridges, but leave things open somewhat.	0	1	2	3
11. Hoped a miracle would happen.	0	1	2	3
12. Went along with fate; sometimes I just had bad luck.	0	1	2	3
13. Went on as if nothing had happened.	0	1	2	3
14. I tried to keep my feelings to myself.	0	1	2	3
15. Looked for the silver lining, so to speak; tried to look on the bright side of things.	0	1	2	3
16. Slept more than usual.	0	1	2	3
17. I expressed anger to the person(s) who caused the problem.	0	1	2	3
18. Accepted sympathy and understanding from someone.	0	1	2	3
19. I told myself things that helped me to feel better.	0	1	2	3

20. I was inspired to do something creative.	0	1	2	3
21. Tried to forget the whole thing.	0	1	2	3
22. I got professional help.	0	1	2	3
23. Changed or grew as a person in a good way.	0	1	2	3
24. I waited to see what would happen before doing anything.	0	1	2	3
25. I apologized or did something to make up.	0	1	2	3
26. I made a plan of action and followed it.	0	1	2	3
27. I accepted the next best thing to what I wanted.	0	1	2	3
28. I let my feelings out somehow.	0	1	2	3
29. Realized I brought the problem on myself.	0	1	2	3
30. I came out of the experience better than when I went in.	0	1	2	3
31. Talked to someone who could do something concrete about the problem.	0	1	2	3
32. Got away from it for a while: tried to rest or take a vacation.	0	1	2	3
33. Tried to make myself feel better by eating, drinking, smoking, using drugs or medication, etc.	0	1	2	3
34. Took a big chance or did something very risky.	0	1	2	3
35. I tried not to act too hastily or follow my first hunch.	0	1	2	3
36. Found new faith.	0	1	2	3
37. Maintained my pride and kept a stiff upper lip.	0	1	2	3
38. Rediscovered what is important in life.	0	1	2	3
39. Changed something so things would turn out all right.	0	1	2	3
40. Avoided being with people in general.	0	1	2	3
41. Didn't let it get to me; refused to think about it too much.	0	1	2	3
42. I asked a relative or friend I respected for advice.	0	1	2	3
43. Kept others from knowing how bad things were.	0	1	2	3
44. Made light of the situation; refused to get too serious about it.	0	1	2	3
45. Talked to someone about how I was feeling.	0	1	2	3
46. Stood my ground and fought for what I wanted.	0	1	2	3
47. Took it out on other people.	0	1	2	3
48. Drew on my past experiences; I was in a similar situation before.	0	1	2	3
49. I knew what had to be done, so I doubled my efforts to make things work.	0	1	2	3
50. Refused to believe that it had happened.	0	1	2	3
51. I made a promise to myself that things would be different next time.	0	1	2	3
52. Came up with a couple of different solutions to the problem.	0	1	2	3
53. Accepted it, since nothing could be done.	0	1	2	3

54. I tried to keep my feelings from interfering with other things too much.	0	1	2	3
55. Wished that I could change what had happened or how I felt.	0	1	2	3
56. I changed something about myself.	0	1	2	3
57. I daydreamed or imagined a better time or place than the one I was in.	0	1	2	3
58. Wished that the situation would go away or somehow be over with.	0	1	2	3
59. Had fantasies or wishes about how things might turn out.	0	1	2	3
60. I prayed.	0	1	2	3
61. I prepared myself for the worst.	0	1	2	3
62. I went over in my mind what I would say or do.	0	1	2	3
63. I thought about how a person I admire would handle this situation and used that as a model.	0	1	2	3
64. I tried to see things from the other person's point of view.	0	1	2	3
65. I reminded myself how much worse things could have been.	0	1	2	3
66. I jogged or exercised.	0	1	2	3



