Quality of Working Life in the Emergency Department: Physicians' and Nurses' Perspective

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Abstract

This descriptive phenomenological qualitative case study aimed to examine the perceptions of emergency department (ED) workers regarding quality of working life (QWL). Nine QWL dimensions were investigated. Two rounds of individual semi-structured face-to-face in-depth interviews were held with 5 physicians and 11 nurses. Data were analyzed using Colaizzi's process. The findings indicate that most negative QWL issues centered on high workload and poor salary. EDs should deploy additional resources to improve the QWL of ED workers.

Keywords: QWL, ED, physicians, nurses, public hospital, Jordan

1. Introduction

For many years, economists and psychologists have argued for the importance of quality of working life (QWL), citing its critical effect on workplace success, development, and staff retention. QWL rests on the principle that people are the most important assets in any organization, and should be treated with dignity and care (Pablos & Tennyson, 2014); QWL is receiving an increasing amount of interest globally (Jayakumar & Kalaisevi, 2012), and is guaranteed by law in America and Europe (McWay, 2008; Beinum, 2012); it refers to the relationship between workers and their working environment. Interventions promoting QWL aim to improve the quality of working conditions (Cummings & Worley, 2013).

Adequate QWL is a critical need for hundreds of millions of workers worldwide (Johnston & Marshall, 2013), and improves organizational productivity, competitiveness, and worker commitment; QWL levels also affect community development (World Health Organization, 2010). Poor QWL negatively affects performance (Lanctot, Durand, & Corbiere, 2012) and worker and customer satisfaction, as well as organizations' reputation, productivity, and survival (Topchik, 2001; Anita, 2014).

The Jordan Ministry of Health (MoH) is constantly seeking new ways to conduct business in healthy workplaces in order to meet health challenges and workers and patients' needs and expectations. Presently, QWL is important to hospital management and critically affects hospitals' performance (Sharma & Goyal, 2013). Emergency departments (EDs) are vital sites in hospitals, and are distinguished by unplanned patient attendance, and by their preparedness to manage a wide variety of illnesses, life threatening conditions, and injuries that require immediate attention. In Jordan, the MoH's central concern from 2002 until the present has been to improve working conditions, performance, and outcomes in EDs in public hospitals (United States Agency for International Development, 2015). EDs commonly experience problems such as worker dissatisfaction, workplace violence, and stress (Hayajneh, AbuAlRub, Athamneh, & Almakhzoomy, 2009; Saleh & Saif, 2014). While many studies have examined QWL worldwide (Royuela, Tamayo, & Suriñach, 2007; Rai & Tripathi, 2015), QWL has received more limited attention in Jordan; hence, examining QWL in a Jordanian context may enhance Jordanian healthcare organizations' performance.

2. Study Goals

QWL is complex: it interacts with many aspects of workers' professional and personal lives. This complexity can impede analysis addressing all aspects of QWL. This study therefore aimed to examine the experiences and perceptions of physicians and nurses regarding QWL in EDs. Clarifying this topic will assist senior managers and policymakers in improving QWL in EDs, improving department conditions, performance, and outcomes.

3. Literature Review

3.1 Bashir Hospital's ED

Initially, Jordan focused on developing a strategy to improve healthcare facilities. Bashir hospital, which is among the most important public hospitals in Jordan and provides around 31% of Jordan's health services, adopted this strategy. Due to Bashir hospital's size, and its crucial role in providing healthcare and educational services to a large number of patients and trainees, all of Bashir hospital's facilities are currently being renovated or rebuilt in order to comply with quality and accreditation standards. Among Bashir hospital's departments, its ED was of the highest priority regarding improvement of care (United States Agency for International Development, 2015).

Bashir hospital's ED is located near the hospital's main entrance, and provides comprehensive emergency medical services to a wide range of patients. The ED includes a triage area, and orthopedic, medical, surgical, pediatric, and trauma rooms, alongside a laboratory and radiology and minor operations rooms. Other facilities include a pharmacy and administration, accounting, and security rooms. The ED is staffed by a mixture of specialized, generalist, emergency, and trainee physicians, as well as nurses and support workers, and receives around 1,300 patients per day; this creates a great need to improve working conditions in this department (Ministry of Health, 2014).

3.2 Quality of Working Life

QWL began to attract attention during the 1960s (Arora, 2000), and appeared in research journals from the 1970s (Gaurav, 2012); initial research focused on identifying working conditions that contribute to QWL, in order to develop interventions improving working conditions and organizations' productivity. QWL has been defined as a feeling resulting from positive interaction between individuals and a working environment that meets their requirements, and is positively related to performance (Griffin & Moorhead, 2014; Inda, 2013; Anupreeti & Prabha, 2013). QWL addresses employees' satisfaction with their working life; QWL levels are affected by employees' experiences their workplace, as well as factors affecting those experiences (Easton & Laar, 2013). Adequate QWL is essential to organizations' efficient growth and development (Vasita & Prajapati, 2014), and to worker health, happiness, and productivity (Tabassuma, Rahmanb, & Kursia, 2011).

A review of a part of the literature on QWL from 1980 to 2015 indicated to the author that it is practically difficult to encompass all of QWL's dimensions. A broad spectrum of QWL dimensions exists, and parts of it may be addressed depending on researcher interest and organizational characteristics. Nonetheless, the majority of extant research has addressed the following dimensions of QWL:

3.2.1 Job Autonomy

This refers to workers' independence and scope for exercising judgment and control in deciding how to carry out their duties (Goodman, 1980; Anupreeti & Prabha, 2013). Job autonomy is positively related to workers' perception that work outcomes are the results of their own efforts (Madanagopal & Thenmozhi, 2015).

3.2.2 Compensation

This refers to monetary and nonmonetary returns the worker accrues due to work done, which are sufficient to meet the basic requirements of the worker and his family (Goodman, 1980; Tinuke, 2013).

3.2.3 Cooperation and relation

Cooperation and positive relations between workers critically promote QWL (Muftah & Lafi, 2011; Jayakumar & Kalaisevi, 2012).

3.2.4 Standardization

This refers to the presence of clear policies and guidelines that ensure all workers understand their duties and how to discharge them (Anupreeti & Prabha, 2013; Gayathiri & Ramakrishnan, 2013).

3.2.5 Organizational Support

This refers to senior management support and communication, supervisor support, attention to worker satisfaction, and provision of facilities providing appropriate services (Steenkamp & Schoor, 2008; Sinha, 2012).

3.2.6 Safety and Security

This refers to job security, organizational compliance with accreditation codes and safety regulations (Marcozzi, 2011), presence of safe and healthy working conditions, and prompt intervention to protect workers when necessary (World Health Organization and Pan American Health Organization, 2015; Walton, 1985; Jayakumar

& Kalaisevi, 2012).

3.2.7 Training and Career Growth

This refers to organizations' conviction that their workers are their most valuable resource, and to organizations' promotion of training and career growth. Factors of training and career growth include availability of training and orientation programs, provision of materials and equipment needed for training, and ongoing in-service training (Cooney & Stuart, 2013; Jayakumar & Kalaisevi, 2012; Gayathiri & Ramakrishnan, 2013).

3.2.8 Working Issues

This refers to workload suitability, flexibility of working arrangements and hours, availability of break time during work, and sufficiency of worker numbers (Tabassuma, Rahmanb, & Kursia, 2011; Jayakumar & Kalaisevi, 2012; Sinha, 2012; Tinuke, 2013).

4. Method

This research used a descriptive phenomenological qualitative case study design; research was conducted in Bashir public hospital in Jordan and aimed to clarify the perceptions and experiences of ED workers regarding key dimensions of QWL. The target population was 96 permanent physicians and nurses listed in the ED. The sample consisted of 16 participants (5 physicians, 11 nurses); this sample size is acceptable for the present research (Remenyi, 2013). The sample was selected to ensure participants represented all medical health worker disciplines in the ED; personnel who had been employed at least five years were included in order to ensure that participants were adequately experienced in the ED. Trainees and temporary workers were excluded. All participation was voluntary. Interviews were conducted in a comfortable room; the first round of interviews lasted for 60-70 minutes; the second lasted 15-20 minutes. Semi-structured face-to-face in-depth interviews were used to collect data; this methodology helped participants to convey experiences, anecdotes, and rich meaning, which critically facilitated achievement of the research objectives. The author adhered to all ethical regulations set out by Bashir hospital and the MoH, and maintained the confidentiality of all collected data.

Regarding data collection, each participant participated in two interviews conducted in Arabic in 2015. The first round of interviews aimed to collect data related to the research objectives; the second round aimed to ensure that the obtained results reflected participants' experience, as well as permitting addition, modification, and elimination of data. Prior to the interviews, the author visited the ED in order to become familiar with it.

At the beginning of each interview, the author explained the research objectives, and presented participants with the hospital's consent for the research to be conducted. All participants received an explanation that participation was voluntary, that they had the right to withdraw at any time, that interviews would be audio-recorded, and that their responses would be kept confidential; consent was indicated by signature. Participants responded to the following questions, developed by the author: "Can you tell me about your personal feelings about or perception of QWL in the ED," and "can you describe factors positively and negatively related to your experience of QWL in the ED, regarding [each of the factors of QWL mentioned in the Introduction]?" During interviews, the author would ask additional questions such as "What do you mean by that," and "can you give me an example of that" in order to collect rich information.

The author adopted Colaizzi's process for data analysis, which has been used in similar studies (Shosha, 2012; Lanctot, Durand, & Corbiere, 2012), and consists of seven steps: 1) reading each transcription in depth in order to grasp the general meaning of the content; 2) extracting significant statements; 3) clear reformulation to identify significant meanings; 4) sorting formulated meanings into categories; 5) integrating findings into a comprehensive picture; 6) description of the phenomenon's basic structure; 7) validation of findings by return to participants (Pitney & Parker, 2009).

5. Results

Thirty-two interviews were completed; 11 nurses and 5 physicians participated; each had over eight years of experience working in the ED; the majority of participants were female (11 of 16, 69%). Participants' views of the analyzed QWL dimensions are as follows:

5.1 Job Autonomy

Thirteen participants (81%) stated that they felt able to control and arrange their work, scheduling, and regulation. One physician stated that the lack of strict hospital policies and rules supported workers' autonomy. Two nurses stated that any strict rules and instructions were usually related to financial matters. Eight participants (50%) stated that they felt ownership of their work.

5.2 Compensation

Ten participants (63%) stated that working in the ED did not adversely affect their ability to meet their family's requirements, including family emergencies, and that workers were able to manage religious requirements. Seven participants (44%) stated that working in the ED promoted their self-esteem. 14 participants (88%) stated that the principal benefits they received from working in the ED were their salaries and health insurance for themselves, their parents, and their families.

Fifteen participants (94%) stated that they received inadequate salary and benefits. One physician stated that poor salaries were the cause of the shortage of expert medical staff, especially regarding physicians. Participants stated that no incentives for good performance or systems to reward innovation were in place, and noted that salaries in the MoH are the lowest among the health sectors. One physician stated, "I don't get paid enough money; I'm working in the MoH for a few years to get the experience, then I will go to one of the Arab Gulf states where salaries are higher than in Jordan." Another physician said: "I've accepted this low salary because I want to get enough experience; then I will look for other opportunities."

5.3 Cooperation

Fifteen participants (94%) stated that good relations and cooperation existed among workers in the ED. One physician stated, "The absence of cultural differences between the workers themselves limits differences and increases cooperation, and appropriate channels of communication exist between workers and support staff. Emotional and professional assistance are available on request." A nurse stated, "The only positive thing in the ED is the good relationship between its workers; I can always find someone who will assist and support me, and who will agree to replace me when I need it."

5.4 Standardization

Fourteen participants (88%) stated that clear policies, procedures or plans for organizing work in the ED were not present, nor were protocols for assessment and treatment of patients or plans for managing unusual situations. One nurse said, "Bashir hospital has been involved in the hospital accreditation program for years, which means it must have policies and plans to improve work quality, but these haven't been implemented so far." One physician stated, "Hospitals should provide plans for managing disasters and mass casualties and train us accordingly, to get rid of the constant state of anxiety concerning such events." One physician said, "The problem in Jordanian public hospitals is that those who have attained higher-level management positions do not have any qualifications in health care management; they are specialized doctors who have worked for long periods in hospitals and who have good relations with decision-makers in the Ministry of Health."

5.5 Organizational Support

Twelve participants (75%) stated that they had adequate supervisor support in the workplace, adequate medical equipment, materials, and drugs available, and a sufficient number of medical, supportive, and security staff. Twelve participants (75%) stated that communication was weak between workers and senior management, and that senior management decisions did not account for ED workers' needs or allow for feedback. Ten participants (63%) agreed that no clear communication system was in place between the hospital director and hospital workers. One nurse said, "We see the hospital directors during their inspection rounds." Another nurse said, "No one considers our participation in decisions about conditions in the ED important. A physician said, "Worker satisfaction is the last priority for the hospital's top management. There is a real problem with accessing relevant information to solve job issues. There are no information or medical records systems to help manage patients, no organized break times, and no appropriate area for resting."

Fourteen participants (88%) stated that the ED's design provided adequate space to treat patients, although there were no adequate patient and escort waiting areas and no register of attending patients. One nurse said, "The waiting area is unable to cope with attendance at peak times."

5.6 Safety and Security

Thirteen participants (81%) stated that MoH workers do not come under pressure from the probability of job loss, and that job loss occurs only when workers reach the age of retirement (60 years). Regarding workplace safety, 15 participants (93%) strongly agreed that they were personally unsafe in the ED. They agreed that they were exposed to two types of risk in ED, the more important being that of patient or escort violence, and the less important being that of infection. One physician said, "We are exposed to violence at all times." Another physician said, "We experience many cases of attacks on workers and the destruction of assets and devices." Another physician added that the most common perpetrators of violence were patients' escorts, particularly in the event of delayed treatment or patient death. Eight participants (50%) stated that hospital policies managed the

identification and management of occupational hazards, but that these policies were not implemented. One nurse said, "The hospital needs to continually monitor accident rates." Another nurse said: "The Civil Defense Directorate assesses the hospital's safety and presents a detailed report annually, but there is no follow-up or obligation to implement these reports' recommendations."

5.7 Training & Career Growth

Five physicians (100% of participating physicians) stated that training programs were limited to discussion of unusual medical cases. No planned and announced ongoing training programs were implemented in the ED. One physician said, "Because of excessive workloads and work- related requirements, there is little time for training." Nine nurses (81% of participating nurses) stated that ongoing training programs for nursing staff were in place, but that these programs were not designed according to nurses' specific needs or situations affecting nurses in the ED, and instead were comprised of an annual set of theory-focused lectures. Regarding medical workers, three physicians (60% of participating physicians)   agreed that opportunities for career advancement existed due to the wide range of patients and cases addressed in the ED, and that they were able to develop new skills through their work in the ED. One physician said, "We have the opportunity to engage in the full scope of medical practice."

5.8 Work Issues

Fourteen participants (87%) stated that clear and fair work schedules existed; however, all participants stated that information provided to workers regarding planned changes to the ED was lacking. All participants agreed that the ED was a disorganized, stressful, and crowded working environment, particularly during evening shifts. No air conditioning, canteen, or drinking water facilities were provided. Sixteen participants (100%) stated that the ED operated 24 hours a day, seven days a week, unlike other MoH centers, which operate from 8 am until 3 pm from Sunday to Thursday, and that this difference led to large patient numbers in the evenings, resulting in weaknesses in the process of distinguishing between urgent and non-urgent patients (i.e. triage). One physician said, "I am commonly required to address non-urgent cases while urgent cases wait; this causes problems with patients and escorts." Another physician said: "The majority of cases we handle are not urgent and should be managed by primary care centers." Another physician said, "I am not satisfied with the service we provide to patients in the evening shift."

6. Discussion

This study's results indicate that job autonomy (a QWL dimension) is readily available in the ED; however, autonomous workers must perform their jobs skillfully and in accordance with agreed standards (Weston, 2010).

Regarding compensation, ED workers indicated that little conflict existed between their work and non-work commitments such as family and religious requirements. Research in a Saudi Arabian context indicates that this supports workers' QWL (Almalki, FitzGerald, & Clark, 2012). Nonetheless, participants clearly indicated that the rewards they received for their work were inadequate, particularly regarding their salary. Poor remuneration was observed to lead to dissatisfaction and weak commitment, willingness to leave work, and a shortage of expert medical staff, indicating that participants' QWL was impaired by poor compensation. This reflects extant research whose results indicate that compensation (particularly remuneration) is the most consequential factor affecting QWL (Dargahi, Gharib, & Goodarzi, 2007; Permarupan, Al-Mamun, & Saufi, 2013; Swamy, 2013; Timossi, Pedroso, Francisco, & Pilatti, 2008).

This study's results further indicate that the levels of cooperation and quality of relation between ED workers were high, promoting workers' QWL (Voos, 1989; Senasu & Virakul, 2014). In contrast, participants described critical failings regarding adherence to policies, standards of accreditation, and guidelines for initial patient evaluation, and regarding creation and implementation of plans facilitating worker performance. Standards informing workers of their duties and of how to discharge them reduce workplace tension and improve workers' QWL (Ministry of Health, 2011; Rozaini, Norailis, & Aida, 2015); hence, these failings likely diminished the participants' QWL.

Organizational support is widely regarded as importantly promoting QWL; further, among types of support, provision of sufficient resources importantly promotes QWL (Swamy, 2013). The ED thus promoted its workers' QWL by providing the resources necessary to patient management (i.e. human resources, equipment, patient treatment areas, and supervisor support). Nonetheless, support from senior management also critically affects QWL (Laschinger & Leiter, 2006), and participants identified failings in the ED regarding arrangements for clear and adequate communication between senior management and workers, negatively affecting workers' perception of managerial regard for workers and diminishing worker satisfaction with the decision-making process.

Additionally, participants stated that the ED did not possess adequate information systems assisting workers in satisfactorily performing their duties, and did not routinely collect detailed information regarding patient outcomes. Further, participants indicated that the ED's physical layout was flawed as it did not provide adequate waiting areas for patients and their escorts, or break rooms for workers. This latter observation's significance is supported by Garima (2014), who argued for the importance of proper site design in improving QWL.

Workers have the right to work in a safe environment, and require their working environment to provide security (Finney, 2008); working in an unsafe environment thus diminishes QWL (Ismail, Asumeng, & Nyarko, 2014). This study's participants indicated that the ED was unable to protect their right to safety, especially regarding protecting workers from violence and ensuring the systematic evaluation and management of occupational hazards; this diminished their QWL.

Keeping track of the rapid development of medical knowledge and new technical procedural skills in medical practice is vital to medical workers' QWL (Widyastuti & Parimita, 2013). ED workers were able to practice a wide range of skills, and received supervision and counseling to further their abilities; however, participants indicated that the ED did not provide organized and ongoing training programs that promoted their continuing development. As working in sensitive areas such as the ED requires orientation programs, ongoing training requires initial worker evaluation, reevaluation programs, skill identification, and knowledge and experience specific to each role in the ED.

Participants in the present study indicated that work-related issues were the most important among those affecting their QWL, and required the most urgent resolution, corroborating Mensah and Tawiah (2014). Participants identified several positive points regarding the ED, particularly the availability of sufficient resources and clinical materials. Clear, fair, flexible, and defined work schedules were in place. In contrast, several issues significantly impaired worker QWL in the ED, including overcrowding, lack of organization in the working environment, and a majority of non-urgent patients especially during the evening and night shifts. These working conditions impaired workers' QWL by diminishing commitment and increasing desire to leave work, corroborating Afsar (2014).

This research is limited by its dependence on a case study and on qualitative methodology; hence, its results should not be generalized to other Jordanian public hospitals. Additionally, the sample was confined to permanent employees in the ED; large numbers of trainee workers were therefore excluded. Future research should quantitatively examine the perceptions and needs of larger numbers of various types of medical workers in diverse geographic areas.

7. Conclusions

Regarding dimensions of QWL, Bashir hospital's emergency department successfully provided worker autonomy, job security, and adequate resources to ED workers, generated cooperation and positive relations between workers, and prevented workers' duties conflicting with workers' non-work commitments. In contrast, the ED did not provide or implement sufficient salaries, standards for improving service quality, plans and guidelines for patient management, communication with senior management, an effective physical layout, safe and comfortable working conditions, or ongoing training programs.

These findings suggest that QWL in the Bashir hospital ED may be improved by implementing the following recommendations: Following comparison of public health sector employee salaries with those of employees in other health sectors, rewards and benefits provided to workers in sensitive areas such as the ED should be suitably increased. Standards and guidelines concerning health service quality should be enforced. A mechanism ensuring clear communication between senior management and workers, and which focuses on staff satisfaction, should be implemented. A suitable waiting area should be provided to meet the needs of patients and their escorts. Broad data collection processes should be implemented; accurate computerized information necessary to worker performance should be made available. Access to the ED should be controlled; patient entry should be regulated, and large numbers of escorts should not be permitted entry. Incidents of violence should be prevented by clarifying and organizing the duties of security personnel and installing alarms in high-risk areas. Ongoing training programs for ED workers should be developed and implemented. A safe rest area with refreshment facilities should be provided to ED workers. The triage system should be applied on a scientific basis, in order to regulate patient management and prioritize urgent cases.

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