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Nursing PhD Program

REPORT OF FINAL EXAMINATION
NURSING PhD

Date: 03/11/2024

We, the undersigned, as the Supervisory Committee in charge of the work of

Judson LaGrone, for the Doctor of Philosophy in Nursing Degree, report that we have examined this student on his/her dissertation, the general field of the dissertation, and the following other parts of his/her program.

The student named above has:

1. completed the work assigned by the Committee.
   ✔ Yes ____ No
2. passed all examinations required by the program, including the final oral defense of the dissertation.
   ✔ Yes ____ No
3. selected option 1: ✔ a traditional dissertation
   OR
4. selected option 2: _____ 3 manuscript(s) suitable for publication in peer-reviewed journals which meet the approval of the Committee.
5. completed either dissertation option 1 or 2 satisfactorily, which gives evidence of ability to do independent investigation in the major field, and itself constitutes a contribution to knowledge.
   ✔ Yes ____ No
6. The student's dissertation is accepted by the committee
   As Is ✔ With minor revisions Not Accepted

We recommend that this student be granted the Doctor of Philosophy in Nursing Degree.

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Normalizing the Abnormal: Self-Identified Traumatic Events and Critical Care Nurses, A Focused Ethnography

by

Judson Paul LaGrone, MSN, RN, CVRN-BC

Dissertation

Presented to the Faculty of the School of Nursing of

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Dedication

To the brave nurses who have endured and continue to endure traumatic experiences that cause distress in the clinical setting and face unfavorable working conditions for the mere sake of the patient: I appreciate your willingness to share your stories during some of your most vulnerable moments as a nurse. May your experiences and dedication to the nursing profession be a testament to your unwavering determination to provide care to others and lead to positive change in the work culture for the betterment of the profession. May you always know that your voice and lived experiences matter. Never be afraid to advocate for yourself and your fellow man.

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Normalizing the Abnormal: Self-Identified Traumatic Events and Critical Care Nurses, A Focused Ethnography

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According to The National Institute for Occupational Safety and Health (2022), 20 million healthcare workers in the United States (U.S.) are at risk for symptoms of mental unhealthiness directly related to their work environment and experiences. Despite nurses reporting higher levels of burnout and other adverse effects within their work environment, approximately two-thirds of nurses indicate they are not receiving supportive resources for mental health, which is known to impact physical health (Berlin et al., 2023). The pandemic has shed light on pre-existing conditions for nurses, such as the workplace culture and understaffing, leading to unmanageable patient loads, which all minimize nurses' mental health (Bowie, 2022). Critical care nurses (CCNs) encounter singular and often repetitive traumatic events (TEs) within the work environment, which lead to adverse effects such as anxiety, depression, post-traumatic stress disorder, secondary traumatic stress disorder, burnout, compassion fatigue, moral distress, substance use, and suicidal behaviors. A TE is described as an extreme event causing an individual's ability to cope to be threatened, resulting in unusual and strong cognitive, emotional, or behavioral reactions (Kleim et al., 2015).

A limited number of studies have directly addressed the experiences of self-identified TEs among CCNs in the clinical work environment. This study aims to describe the CCN's TE, explore potential psychological impacts on the CCN, explore work culture impacts on the CCN's response, and examine resources offered to the CCN. A focused ethnography (Roper and Shapira, 2000) methodology was used for the study and was guided by the research question, "What are CCNs' experiences and responses to a self-identified traumatic event(s) in the emergency department or intensive-care unit settings that caused them distress?"

Purposive and snowball sampling was used for recruitment. CCNs (n=11) representing various regions in the U.S. participated in semi-structured interviews. Study data included

demographic data, transcribed interviews, field notes, and methodological journals. Collected data was analyzed using the constant comparative method (Glaser, 1998; Glaser and Strauss, 1967) until redundancy and data saturation occurred. The study utilized Beck's (1993) criteria to demonstrate scientific rigor. Data analysis revealed four themes of *normalizing the abnormal*, *suffering in silence*, *badge of honor*, and *resilience: we are CCNs*.

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List of Abbreviations

AACN	American Association of Colleges of Nursing
ADN	Associate Degree in Nursing
ANA	American Nurses Association
ANF	American Nurses Foundation
BSN	Bachelor of Science in Nursing
CCM	Constant Comparative Method
CCN	Critical Care Nurse
CPR	Cardiopulmonary Resuscitation
DNP	Doctor of Nursing Practice
ECMO	Extracorporeal Membrane Oxygenation
ED	Emergency Department
FE	Focused Ethnography
HIPAA	Health Insurance Portability and Accountability Act
ICU	Intensive Care Unit
IRB	Internal Review Board
MSN	Master of Science in Nursing
NIOSH	National Institute of Occupational Safety and Health
PhD	Doctor of Philosophy in Nursing
PRN	Pro Re Nata “as necessary”
POW	Prisoner of War
Pulse Survey	American Nurses Foundation, Pulse on the Nation’s Nurses Survey Series: Mental Health and Wellness Survey

PTSD	Post-traumatic Stress Disorder
RN	Registered Nurse
TE	Traumatic Event
U.S.	United States
U.S. BLS	U.S. Bureau of Labor and Statistics
UTMB	University of Texas Medical Branch

CHAPTER 1: INTRODUCTION

This qualitative focused ethnographic dissertation explored self-identified traumatic events from the perspectives of critical care nurses (CCNs) who work in the emergency department or intensive care specialty units, and how the work culture influences the CCN's response. Chapter One provides the study's introduction and includes the goal, significance, and research questions guided by the study's aims. Furthermore, a discussion of the study methodology and research design is provided in Chapter One. Chapter One concludes with a brief preview of the remaining four chapters of this dissertation.

SIGNIFICANCE AND AIM OF THE STUDY

According to The National Institute for Occupational Safety and Health (NIOSH) (2022), 20 million healthcare workers in the United States (U.S.) are at risk for symptoms of mental health issues directly related to their work environment and experiences. The COVID-19 pandemic has shed light on pre-existing conditions for nurses, such as the workplace culture and understaffing, leading to unmanageable patient loads, which all minimize nurses' mental health (Bowie, 2022). CCNs encounter singular and often repetitive, traumatic events within the work environment, which lead to adverse effects such as anxiety, depression, post-traumatic stress disorder, secondary traumatic stress disorder, burnout, compassion fatigue, moral distress, substance use, and suicidal behaviors. Kleim et al. (2015) described the term traumatic event as an extreme event causing an individual’s ability to cope to be threatened, resulting in unusual and strong cognitive, emotional, or behavioral reactions.

The American Nurses Foundation (ANF) and McKinsey conducted a four-phase survey titled American Nurses Foundation, Pulse on the Nation's Nurses Survey Series: Mental Health and Wellness Survey (“Pulse Survey”) beginning in 2020. It is important to note that the third phase of the Pulse Survey in September 2021 (n = 9,572), included an added focus on collecting data surrounding the emotional health status of nurses. These results showed substantially higher numbers of intensive care unit (ICU) (52%) and the emergency department (ED) (46%) nurses who participated in the survey were "not or not at all emotionally healthy" (ANF, 2021). The fourth phase (n = 7,419), conducted in May 2023, shows that although nursing turnover slightly decreased from its highest report in 2021, nurse turnover continues to surpass pre-pandemic numbers (Berlin et al., 2023). The results of the fourth phase show that more than half of the nurses who responded to the survey suffer from burnout (ANF, 2023) related to emotional exhaustion (56%) and a feeling of "a great deal of stress" (64%) related to their job (Berlin et al., 2023). Despite nurses reporting higher levels of burnout and other adverse effects within their work environment, approximately two-thirds of nurses indicate they are not receiving supportive resources for mental health which is known to impact physical health, with 56% believing it is related to a present stigma (Berlin et al., 2023).

There is a scarcity of literature examining the CCN's perceptions and experiences of self-identified traumatic events leading to distress in the clinical working environment. Literary searches yielded no Focused Ethnographic (FE) studies that specifically examine the CCN’s individualistic and unique self-identified traumatic event; the CCN workplace culture’s influence on the CCN’s response to and coping of traumatic events; or the availability of supportive resources offered to the CCN in the immediate aftermath of the

traumatic event. Despite the presence of quantitative studies focusing on adverse effects from traumatic events, there is a dearth of knowledge telling the story of the nurse and illuminating the root cause of the experienced trauma, ultimately leading to the untimely exodus from the nursing profession, potential harm during the delivery of patient care, and overall long-term effects that are detrimental to the nurse's health.

Research Question and Aim of the Study

This ethnographic study was conducted and guided by the research question, "What are critical care nurses' experiences and responses to a self-identified traumatic event(s) in the emergency department or intensive-care unit settings that caused them distress?" The study identified specific traumatic events in the CCN's work environment and examined ways the CCN culture influences the nurse's ability to cope with and manage self-identified traumatic events.

The goal of this ethnographic study was to examine self-identified traumatic events reported by CCNs in the clinical setting and how their work-place culture impacts the response. The rationale for addressing a specific self-identified traumatic event by the CCN compared to previously identified traumatic events within the clinical setting is to explore individualistically unique and categorical experiences causing distress and/or mental health symptom(s). The aims of this study included (1) a description of the CCN's self-identified traumatic event, (2) exploration of potential psychological impacts on the CCN, (3) exploration of work culture impacts on the CCN's response, and (4) examination of resources offered to the CCN.

Overview of the Methodology and Study Design

The research study utilized Roper and Shapira's (2000) qualitative focused ethnographic method, described for nursing research in particular, which draws on the seminal work of Fetterman (2020), to investigate the experiences and responses of CCNs after a self-identified traumatic event. Ethnographic studies are used to examine practices within a diverse culture or subculture group, but also to discover and focus on the practice of nursing as a phenomenon (Roper & Shapira, 2000). Roper and Shapira state that comparing healthcare environments (ED & ICU) as part of ethnographic nursing research will provide a better understanding of complexities among "common situations" (pg. 9), such as experiencing self-identified traumatic events causing distress among CCNs.

The process of conducting an ethnographic study begins with selecting a problem of interest. This is followed by developing a research question examining what is occurring in a given cultural group related to the phenomenon of interest from the emic, or insider's viewpoint (Fetterman, 2020). Through observations and interviews, ethnography collects shared patterns, perceptions, and behaviors within a specified cultural group (CCNs) (Creswell & Poth, 2018; Fetterman, 2020; Roper & Shapira, 2000).

The study proposal was submitted to and approved by the University of Texas Medical Branch (UTMB) Institutional Review Board (IRB). The study recruited participants through purposive and snowball sampling. Eleven registered nurses from the U.S. provided verbal consent and participated in the study. Each participant had at least one year of critical care nursing experience in the ED or a specialty unit within an ICU

and experienced a self-identified traumatic event in the ED or ICU clinical setting, causing them distress. The participant and researcher participated in a digitally recorded interview utilizing the Zoom Video Conferencing platform. Transcription of the recordings was accomplished through the secure artificial intelligence technology of Otter.ai™.

CONCLUSION AND ORGANIZATION OF THE CHAPTERS

This dissertation is organized into five chapters with the addition of appendices, tables, figures, and a reference list. In its entirety, this dissertation presents an ethnographic study of the perspectives and experiences of CCNs in the critical care clinical working environment who have self-identified a traumatic event that caused them distress. Chapter One has introduced the study's significance while providing an overview of the aims, research question, methodology, and research design. Chapter Two will review the literature regarding the crisis within the nursing profession and its current state, trauma, the workplace environment, and culture of the CCN, and supportive interventions. Chapter Three will explain the study design through focused ethnography to explore the culture of CCNs and their perspectives and experiences with self-identified traumatic events in the clinical work environment. Chapter Four will present and discuss the ethnographic study's findings, including major themes of *normalizing the abnormal*, *suffering in silence*, *badge of honor*, and *resilience: we are CCN's*. Lastly, Chapter Five will offer a discussion of the study's findings, compare the study findings with the extant literature, and present the implications of the study as well as suggestions for future research focused on CCNs and self-identified traumatic events.

CHAPTER 2: REVIEW OF LITERATURE

INTRODUCTION

Chapter Two of this dissertation provides a review of the current literature relevant to traumatic events experienced by CCNs in the U.S. that caused them distress in the clinical work environment. Although there is a vast amount of quantifiable data in the existing literature focused on the types of adverse effects on nurses in the work environment, this literature review focuses on the current state of nurses in the U.S. and experienced trauma. Chapter Two will begin with a discussion of the literature surrounding the conceptualization of trauma, the impact of trauma, and sentinel events leading to distress in the workplace. This Chapter continues with a discussion of relevant literature addressing previous exploration of the general CCN workplace culture, potential supportive resources to mitigate adverse effects from trauma, and the obligation of the healthcare organization to the nurse who has experienced trauma. Chapter Two also discusses the gaps in the current literature and provides a rationale for this study. This Chapter concludes with a summary of the Chapter and the plan for future dissertation chapters.

SIGNIFICANCE

According to the NIOSH (2022), an estimated 20 million healthcare workers in the U.S. are at risk for symptoms of mental health disorders directly related to their work environment and experiences. The mental health of those who work in the nursing profession is under attack and has been for many years, despite the recent adverse effects

of the COVID-19 pandemic. The pandemic has shed light on pre-existing conditions for nurses, such as the overall workplace culture to understaffing leading to unmanageable patient loads, all minimizing nurses' mental health (Bowie, 2022). Symptoms of mental health disorders experienced by healthcare workers include anxiety, depression, multiple types of stress, burnout, disorders of substance use, and suicidal behaviors (NOISH, 2022). International and U.S. studies before the COVID-19 pandemic linked increased rates of anxiety and depression among nurses related to the overall stress of the occupation (Wang et al., 2015; Gu et al., 2019; Melnyk et al., 2018). Hu et al. (2020) reported that adverse effects on the psyche of nurses will continue to rise from the experiences of the COVID-19 pandemic.

In 2022, the U.S. Bureau of Labor and Statistics (U.S. BLS) reported that the nursing profession is the largest among healthcare workers in the U.S., with a census of 3.1 million nurses actively practicing as of 2021. According to the American Nurse Association (ANA, 2021), in 2020 the ANF and McKinsey conducted a two-part American Nurses Foundation, Pulse on the Nation's Nurses Survey Series: Mental Health and Wellness Survey ("Pulse Survey"). In June 2020 (n = 10,997), an initial percentage of nearly 30% of nurses experienced depression as a result of working in the COVID-19 environment. In December 2020 (n = 12,881), the second phase of the Pulse Survey showed a significant increase to reflect 40% of nurses reported some level of depression. More importantly, the third phase of the Pulse Survey in September 2021 (n = 9,572), included an added focus on determining the emotional health status of nurses. These results showed substantially higher numbers of ICU (52%) and ED (46%) nurses who participated were "not or not at all emotionally healthy" (ANF, 2021). Additionally, the

study revealed that a staggering 68% of ICU and 62% of ED nurses had experienced an "extremely stressful, disturbing, or traumatic event" related to the COVID-19 pandemic in the clinical setting (ANF, 2021, para. 5).

Most recently, the ANF (2023) published the results of the fourth phase of the Pulse Survey (n = 7,419) conducted in May 2023. The fourth phase showed that although nursing turnover slightly decreased from the highest report in 2021, nurse turnover continues to surpass pre-pandemic numbers (Berlin et al., 2023) and that more than half of the nurses in the U.S. suffer from burnout (ANF, 2023). Areas of concern as contributing factors for nurse burnout include emotional exhaustion (56%) and a feeling of "a great deal of stress" (64%) directly related to their job (Berlin et al., 2023). The fourth phase of the Pulse Survey also indicated that another vital finding that may indicate the health and wellness of the nurse may be directly related to their experience level (Berlin et al., 2023). Nurses with less experience were noted to have higher rates of dissatisfaction as nurses, higher rates of potentially leaving their jobs, and higher rates of burnout (Berlin et al., 2023). The most astounding finding of the fourth phase is that despite nurses reporting higher levels of burnout and other adverse effects within their work environment, approximately two-thirds of nurses indicate they are not receiving resources for mental health support, with 56% believing it is related to a present stigma (Berlin et al., 2023). Other barriers for nurses to seek professional mental health support included lack of time (29%), ability to handle mental health on their own (23%), and cost or lack of financial resources (10%) (Berlin et al., 2023). It is important to note that although there is quantifiable data on the "pulse" of the current state for nurses in the

U.S., the long-term effects on the nurses' delivery of safe patient care and the root causes are not well known.

The U.S. BLS projected an overall registered nursing shortage to reach 1.1 million by the end of 2022 (ANA, 2021; Samuel & Oliver, 2021). In March 2022, a COVID-19 Impact Assessment Survey was conducted by the ANF and the ANA with alarming results: 52% of nurses having thoughts of leaving their job primarily due to workplace adverse effects on personal health and well-being, inability to provide quality patient care, and understaffing (AACN, 2022). Seventy-five percent of the CCNs who participated in the survey reported frustration, stress, and exhaustion in the clinical setting (AACN, 2022). According to the American Association of Colleges of Nursing (AACN, 2022), an American Association of Critical-Care Nurses survey in September 2021 showed 66% of CCNs have considered leaving the profession due to their experiences during the COVID-19 pandemic alone. McMeekin et al. (2017) found that long- and short-term effects on the CCN's ability to cope with repetitive psychological trauma, such as failed attempts at lifesaving measures and tolerating stress, are uncertain. To aid in mitigating mental health symptoms among CCNs, understanding the experiences and development of the symptom(s) must be known to improve the nurse's well-being and decrease untimely departure from the nursing profession (McMeekin et al., 2017).

The CCN, as defined for this study, includes nurses working in the ED and ICU who experience a variety of distressing and traumatic situations such as witnessing failed resuscitations, caring for patients at the end of life, deaths of young children, traumatic injuries, and treatment errors. According to Kleim et al. (2015), a traumatic event is any extreme event causing one's ability to cope to be threatened, resulting in unusual and

strong cognitive, emotional, or behavioral reactions. Dodek et al. (2019) state that distress, such as moral distress, negatively impacts nurses with significant emotional consequences, leading to distraction during patient care and resulting in dangerous or fatal errors. Other studies reflect that most workplace violence is directed at nurses and physicians and represents a "silent epidemic" (Nelson, 2019; Stephens, 2019). Kleim et al. (2015) mention that nurses may recall such experiences and incidents as intrusive memories. These moments appear as "frozen moments" and can consist of smells, tastes, sounds, and thoughts (Kleim et al., 2015, Introduction, para. 1). McMeekin et al. (2017) say that long- and short-term effects on the CCN's ability to cope and tolerate stress are uncertain.

Nurses in the Face of Historical Trauma

Nurses have been faced with traumatic events on and off the “battlefield” in the clinical setting, often driving many to leave the profession. In February 1945, 12 U.S. Navy nurses were imprisoned with other civilians and Prisoners of War (POW) in the Philippines (Lucchesi, 2021). While caring for the malnourished inmates and faced with a significant lack of resources, the nurses watched guns being set up around them in a circle. The ends of the barrels pointed directly at them with rumors of a potential massacre plot within the camp (Lucchesi, 2021). One nurse, a POW for more than three years, recalls these vivid experiences many years later that have haunted her for the rest of her life (Lucchesi, 2021).

September 11, 2001, was the U.S.’s most brutal and devastating terrorist attack. Nurses in and around New York City began preparing hospitals and triage units

according to disaster plans and waited for the unknown. No survivors remained to seek care from the prepared hospitals and triage areas. A nurse noted the realization of the extent of devastation while waiting for several hours for victims who never arrived at a triage area, "… well, they haven't gotten to them yet. That's why we haven't gotten them. They'll get to them, and when they do, we'll be busy" (Dickerson et al., 2002, "Theme two" section). Nurses noted that they were prepared and ready for the arrival of patients, but there was not anyone to treat because they were all dead (Dickerson et al., 2002). Dickerson et al. (2002) identified a new phenomenon from the traumatic event as a "disaster without patients" ("Theme two" section).

Nurses are called to action on many battlefronts in the clinical setting while attempting to remain ethical in all aspects of care for the patient. In 2013, the Boston Marathon was hit by an unexpected blast. The nurses expecting to care for dehydration, cramps, sprains, and electrolyte imbalances were now treating runners and bystanders covered in blood and with injuries caused by shrapnel from bomb explosions (Giroux, 2013). A nurse recalled, "My job had changed from treating dehydration and sore feet to coping with a disaster none of us could have anticipated." The simple first-aid tent became a makeshift warzone hospital (Giroux, 2013, para. 6).

CONCEPTUALIZING TRAUMA

> The American Psychiatric Association (2000) conceptualizes the term trauma as, direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or

> learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate. (Criterion A2, p. 463)

Hoon (2012) defines psychological trauma as an abrupt, intense rush of anxiety secondary to an external event that overloads an individual's ability to defend against and survive with in spite of the traumatic effects. The American Psychological Association (2018) defines trauma as "any disturbing experience that results in significant fear, helplessness, dissociation, confusion, or other disruptive feelings intense enough to have a long-lasting negative effect on a person's attitudes, behavior, and other aspects of functioning" (trauma, para. 1). Traumatic events can be caused by human behaviors or nature, challenging the victim's interpretation of the world around them as a "just, safe, and predictable place" (American Psychological Association, 2018, trauma, para. 1). The single term trauma is often complex to define due to its subjective nature related to the individual victim (Hoon, 2012).

Effects of Traumatic Experiences

Trauma can negatively affect the victim's emotional, mental, and physical health. Hoon (2012) states that traumatic experiences, although offering an extensive range of symptoms, can impair the victim's occupational, social, and other areas of daily living related to the significant distress. Traumatic experiences can significantly decrease the individual's brain functioning and even cause atrophy, especially in the prefrontal cortex and amygdala (Hoon, 2012). When an individual experiences a traumatic event, the brain initiates survival mode and responds involuntarily (NICABM, n.d.). However, the brain's

natural defense mechanism to keep one safe can hold the individual hostage through a forced cycle of memories from a traumatic event(s) (NICABM, n.d.). As an individual experiences stress, stress hormones (such as cortisol) are released in the brain, which can interfere with the brain's ability to regulate emotions, executive management, and impulse control. Exposure to repetitive traumatic events can cause the amygdala to be overstimulated, leading to hyperarousal or dissociative responses (Shonkoff & Garner, 2012). Dorland (2007) states that hyperarousal of the amygdala is the state in which there is increased psychological and physiological tension with effects of anxiety, insomnia, fatigue, emphasis on personality traits, exaggeration of startle response, and decreased pain tolerance. Dissociation in relation to the amygdala relates to the disconnect between emotions, memories, sensations, and thoughts (Dorland, 2007). Repetitive exposure to increased cortisol levels can cause damage and atrophy to the hippocampus, which is responsible for forming new memories, storing and recalling long-term memory, navigating the body through space, and forming emotions and learning (Shonkoff & Garner, 2012).

Effects of Trauma on Nurses

Nurses are at risk for experiencing frequent exposure to psychologically traumatic events related to their responsibilities in the clinical setting (Adriaenssens et al., 2012; Stelnicki et al., 2020). Exposure to traumatic events can lead to post-traumatic stress, post-traumatic stress disorder (PTSD), and secondary traumatic stress due to unmanaged stress. Medication errors, reduced concentration, and reduced cognition are all symptoms experienced by a nurse who suffers from PTSD, leading to potentially

significant events that can cause a patient injury or death (Park & Kim, 2013). PTSD has been identified as a detrimental condition among ICU nurses due to the repetitive nature of occupational hazards and the fact that the availability of policies or evidence-based interventions to decrease the adverse effects of PTSD is scarce for ICU nurses (Park & Kim, 2013). Although humans have experienced traumatic events for centuries, it was not until the 1980s that the signs and symptoms of PTSD were formally identified (Missouridou, 2017). A significant finding by Missouridou (2017) reveals the continuous rise of secondary PTSD among multiple nursing domains due to the alarming trauma experienced in healthcare environments. CCNs can also suffer from compassion fatigue, noted as exhibiting a lack of empathy towards patients, negatively affecting patient care (Salmon & Morehead, 2019); and burnout, the inability to cope with repeated work-related stressors and suffer from depersonalization, emotional exhaustion, and a decrease in self-worth related to work (Vahedian-Azimi et al., 2019).

A study utilizing self-reported data of Canadian nurses (n = 3,969) that assessed lifetime and past-year suicide ideation found that 33% of that group reported a lifetime history of suicide ideation and 10.5% reported an occurrence within the past year (Stelnicki et al., 2020). Seventeen percent of that study's nurses had planned a suicide attempt in their lifetime but did not carry it out, with 4.6% reporting the development of a plan within the past year (Stelnicki et al., 2020). More importantly, 8% of the nurses reported an attempted suicide within their lifetime and 0.7% within the past year (Stelnicki et al., 2020). Stelnicki et al. (2020) also examined the associations of positive screening for mental health symptoms and suicidal behaviors, with results congruent with previously studied suicidal behaviors among nurses. The Canadian nurses also showed

higher rates of suicide behaviors than that of the general Canadian population (Stelnicki et al., 2020). Although the study was conducted to understand the prevalence of suicidal behaviors among Canadian nurses, the study did not assess specific examples of work-related experiences of the nurses.

In 2017, a cross-sectional survey conducted by Kelsey et al. (2021) had a response pool of 7,378 nurses who were members of the ANA. The survey examined the prevalence among U.S. nurses of suicide ideation and attitudes toward receiving help when compared to other U.S. workers, along with influencing personal and professional factors relating to suicidal ideation (Kelsey et al., 2021). Kelsey et al. found that 5.5% of nurses reported suicidal ideation within the past year, and 72.6% of those nurses responded with a willingness to seek help. Additionally, 38.2% had at least one symptom of burnout, 34.4% had high levels of exhaustion, 20.4% had high levels of depersonalization, and 43.3% screened positive for symptoms of depression (Kelsey et al., 2021). Burnout was strongly linked with suicidal ideation, and nurses had a greater prevalence of suicidal ideation and reluctance to seek help compared to other occupations (Kelsey et al., 2021). The researchers did not seek CCNs as the specific population, address work-related cultural influences on findings, or pursue individual nurse experiences to identify work-related events.

U.S. nurses, as compared to the overall general U.S. population, are at a greater risk of suicide (Davidson et al., 2020) by 18% (Davis et al., 2021; Choflet et al., 2021). A retrospective analysis of the Centers for Disease Control and Prevention National Violent Death Reporting System was conducted to compare data between U.S. nurses (n =2,306) and the U.S. general population (n = 185,620) who died by suicide from 2003 to 2017

(Choflet et al., 2021). Choflet et al.'s (2021) critical study found a significant difference in the characteristics of U.S. nurses and that of the U.S. general population for suicidal behaviors: job-related issues. In addition, U.S. nurses were found to have a more substantial history of and/or a current mental health diagnosis combined with job-related issues (Choflet et al., 2021). U.S. nurses have a higher association with suicide completion by opioid use (44.6%) compared to non-nurses (11.8%) (Choflet et al., 2021). Although Choflet et al.'s data state that job-related issues are directly linked to suicidal behavior, the specified job-related issues or experiences of U.S. nurses are not mentioned.

The results of Choflet et al.'s (2021) study are reinforced by Ross et al.'s (2018) ethnographic study showing a disturbing pattern of substance use as a coping mechanism among nurses. Ross et al. interviewed 12 Canadian nurses who were currently practicing at the bedside and used substances as a way of coping with distressful clinical experiences. The nursing culture was found to discourage open discussion of distressful experiences, which notably often led to silence and/or the use of substances as a coping strategy (Ross et al., 2018).

Culture of Critical Care Nurses

Dodek et al. (2010) defined environmental culture as one that influences how the members (CCNs) within the culture define how interactions should occur, what is important within a specific event, and how the group's beliefs, values, and norms can be acknowledged. Scholtz et al. (2016) conducted an ethnographic study to explore and describe the culture among CCNs (n = 13), focusing on a 10-bed ICU. Five patterns of behavior and interaction within the culture were revealed from the study to include

patterns of patient adoption, patterns of armor display, patterns of sibling-like teamwork, patterns of despondency due to the demands of adjusting to the critical care environment, and patterns of non-support from management and the medical doctors (Scholtz et al., 2016). Interesting takeaways from the Scholtz et al. study included: the overall outcome of the well-being of the patient influenced the individual nurse's well-being; stressful working conditions that often challenged the nurse mentally, ethically, and physically; observations of the CCN having a defensive, protective armor-like personality to protect themselves; and observations of the CCNs to hold back emotion after the death of a patient and continue to the next patient as if they were emotionally disconnected. Coping mechanisms and adaption of difficult situations among the CCNs were focused on presenting as strong individuals who rarely speak of the event or seek help or counseling and a sense of the need to remain in control of feelings (Scholtz et al., 2016). CCNs would also make individual plans to leave critical care as a "great escape" without follow-through (Scholtz et al., 2016). Other notable findings of Scholtz et al. were a sense of pride and camaraderie among the unit, defensiveness towards other units, and stressful working conditions that often challenged the nurse mentally, ethically, and physically. Although crucial aspects within the CCN's culture were identified for one critical care unit, the study's researchers did not explore or represent the overall culture of CCNs among the different critical care specialties. Although cultural aspects reflecting coping mechanisms of CCNs were briefly mentioned, lack of research on self-identified traumatic events causing distress within the work environment for the nurse and influences from the culture are not discussed.

Moral Obligation of Support From Health Organization

Effects of distress, especially burnout and intent to leave, on nurses significantly impact costs to the healthcare organization. Epstein et al. (2020) argue that it is the moral obligation of the organization "to mitigate cost of caring," (p. 146) moral distress, and secondary traumatic stress while also fostering the action of understanding the healthcare professional's needs. Experienced distress involves the healthcare professional and the organization due to the individual experience causing distress and the incident originating within the organization due to present factors (Epstein et al., 2020). A call to adopt "moral communities" among healthcare organizations is a high priority to provide a sense of community, open communication, psychological safety, support systems and mentors, fairness, and a collaborative approach (Epstein et al., 2020). Moral communities encompass ideals that support a general moral purpose of personal standards and beliefs and the well-being of all involved. Epstein et al. continue to stress the importance of understanding that the responsibility lies with the leadership within the moral communities to implement the concepts and address the situations in which distress arises.

Berlin et al. (2023) emphasize that the findings from the American Nurses Foundation, Pulse on the Nation's Nurses Survey Series: Mental Health and Wellness Survey latest phase indicate that previous efforts by healthcare organizations lack sufficient support for nurses and must continue to address the challenges of sustained burnout (ANF, 2021, 2023). Contributing factors for burnout included insufficient nurse staffing to patient ratios and loads, poor and difficult nurse leadership, and excessive time spent on administrative tasks (Berlin et al., 2023). It is also important to note that

although there has been minimal improvement over the past few years related to anxiety, sense of being overwhelmed, and stress, there has been a steady decline in the nurses' sense of confidence, empowerment, and gratefulness in the workplace. These potential long-term health effects on nurses place a financial burden on the nurse, society, and the healthcare organization due to the overall influence on absenteeism, longevity, productivity, and retention (Berlin et al., 2023; Business in the Community, 2023). Berlin et al. urge stakeholders to identify, acknowledge, and address the root causes and underlying organizational issues that negatively affect the nursing profession and take necessary steps to assess the nurse's mental health and well-being. Recommendations for addressing the sustained adverse effects on nurses' mental health and well-being, such as burnout, are for stakeholders to apply process and operating-model interventions to address underlying drivers such as work environmental factors (McKinsey Health Institute, 2022); increase the availability, awareness, and accessibility of evidence-based supportive resources; and invest in training opportunities to proactively support the mental health of the nurse and nursing team (Berlin et al., 2023).

Among critical care units, traumatic experiences and stressful encounters can cause nurses to experience emotional distress and dissatisfaction within the profession. Debriefing is a valuable resource and tool for identifying medical errors, gaps in communication, team performance improvement opportunities, and providing emotional support after experiencing a critical incident. Even though healthcare providers know its importance, a lack of research regarding debriefing and its utilization remains (Ugwu et al., 2020). Healy and Tyrrell's (2013) study of ED nurses and providers who suffered from violence or trauma reported that 84% believed debriefing was vital, but 62% stated

debriefing had never been offered. Missouridou (2017) expresses the continuous rise of secondary PTSD among multiple nursing domains due to the alarming trauma experienced in healthcare environments. A noted implication by Missouridou for practice included psychological debriefing to aid in the awareness and processing of trauma.

Based on the research conducted by Forozeiya et al. (2019), notable findings of their qualitative study examined the perceptions of moral distress and individual experiences of coping among CCNs. The researchers identified that the group of nurses shared four themes: "Going Against What I Think is Best, Moral Distress- It's Just Inherent on Our Job, It Just Felt Awful, and Dealing With It" (Forozeiya et al., 2019, p. 25). This study provides numerous vital implications for clinical practice, including the fact that nurses experiencing moral distress should be identified, validated, and supported by management; allow and provide time and a safe space enabling social support to cope; identifying that novice nurses will need more support in acknowledging and understanding the skill to cope; and the use of critical reflective practice can allow the nurse to remain engaged in their practice morally and cope. Forozeiya et al. found that using shared decision-making, nurse-physician communication, organizational support, peer support, and overall recognition of moral distress aids in addressing needs and coping with the experiences.

Reflective debriefing is a necessary intervention that can aid nurses in responding to and coping with distress caused by an actual clinical issue or experience (Browning & Cruz, 2018). Browning and Cruz (2018) conducted a study focusing on reflective debriefing among ICU nurses. The researchers used a 10-question guided reflection among the staff to establish an "ethics voice" and allow individuals to process their

thoughts and emotions centered around moral distress. Social workers facilitated the debriefings among ICU nurses with reflective and educational components. A pre/post-test experimental design was used for the control group to obtain a baseline moral distress score, and then reflective debriefing was used once a month for six months post-incident (Browning & Cruz, 2018). Based on Browning and Cruz's findings, it is essential to note that reflective debriefing overall decreased moral distress among CCNs. According to Browning and Cruz, reflective debriefing also improves care performance and interprofessional communication of the patient's needs and prognosis among nurses. The researchers emphasize using debriefing as a vital component in an educational scenario and real-life clinical situations to improve interprofessional communication, improve healthcare professionals' psyche, and allow for a lasting systemic approach to patient care (Browning & Cruz, 2018). Limitations of the study included only including ICU nurses from one institution, inconsistency with participation during the six months post-incident, and a lack of a tool to determine the severity of moral distress.

GAPS IN LITERATURE

Much of the literature related to CCNs' experiences with traumatic events focuses on the individual effects of mental health symptoms rather than addressing the root cause and remediation of adverse events. There is a pressing need for research investigating detailed descriptions of CCNs' traumatic encounters and experiences of critical incident stress (Harvey & Tapp, 2020). Despite the body of research addressing moral distress during the past three decades, there is a substantial gap in research examining the CCNs' ability to cope in the aftermath of distress while continuing to provide safe and effective

patient care (Forozeiya et al., 2019). It is possible that CCNs are not able to focus on mitigation and self-healing due to time constraints, lack of knowledge of available supportive resources, issues related to patient workflow, and work culture. Nurses experiencing traumatic events face challenges in identifying effective interventions to aid in crisis (Harvey & Tapp, 2020). Holbert and Dellasega's (2021) study reinforces the lack of strategies and resources to assist nurses in coping after a traumatic event, presenting a crucial need for real-time debriefing to be a standardized practice within the clinical setting. Berlin et al. (2023) stress the importance of continued research examining the root cause of the sustained adverse effects negatively impacting the nurse's mental health and well-being within the workplace.

RATIONALE FOR STUDY

The purpose of this ethnographic study is to examine self-identified traumatic events reported by CCNs in the clinical setting and how their workplace culture impacts the response. There is a limited number of studies examining the CCN's experience and events leading to distress in the clinical working environment. The rationale for addressing a specific self-identified traumatic event by the CCN compared to previously identified traumatic events within the clinical setting is to explore individualistically unique and categorical experiences causing distress and/or mental health symptom(s).

The current study will provide an opportunity for CCNs to share self-identified traumatic event(s) that may negatively affect them on a personal level. The results of the study may contribute to a better understanding and awareness of CCNs' perceptions and experiences of self-identified traumatic event(s). Additionally, the study's findings may

illuminate the availability and use of supportive resources, or the lack thereof, after a self-identified traumatic event for CCNs. Understanding the experiences of CCNs following a self-identified traumatic event could help prevent future distress and allow for the availability of needed supportive services. The results of the study have the potential to positively influence advocacy behaviors for nurses who experience self-identified traumatic events that will undoubtedly impact the quality of life for the nurse and the ability to provide safe patient care. Additionally, the study findings may benefit all areas of nursing and other professions facing traumatic events in the workplace.

SUMMARY OF CHAPTER TWO

Chapter Two has provided an extensive review of the literature addressing trauma traumatic events in the work environment among CCNs. The Chapter examined current literature on the current state of the nursing profession in the U.S., contributing factors and characteristics of adverse effects on the nurse's mental health and well-being in the workplace environment, scant research on the generalization of workplace culture among CCNs, and the obligation of healthcare organizations providing supportive resources to nurses and recommended interventions. Chapter Two concluded with an analysis of the significant gaps in the extant literature and the relevance and necessity of the current study.

PLAN FOR THE REMAINING CHAPTERS

Chapter Three will provide a discussion of the ethnographic methodology (Roper & Shapira, 2000) and the application of those techniques specific to nursing research

design. Chapter Four will present the study findings, including participant demographics and a discussion of emerging themes from the study data analysis. Chapter Five provides a discussion of the study and its findings.

CHAPTER 3: METHODS

INTRODUCTION

Chapter Three identifies the research design of the study implemented through this focused ethnography (FE) (Roper & Shapira, 2000; Fetterman, 2020) study to explore perceptions and experiences of self-identified traumatic events among Critical Care Nurses (CCNs) that caused distress in the clinical setting. Chapter Three begins with a description of FE and its appropriateness for this research study. The Chapter will explain methods and procedures for the research study, recruitment and sampling, data collection, and data management. Chapter Three also establishes the study setting, study participant inclusion/exclusion criteria, procedures for data analysis, and scientific rigor as described by Beck (1993). The Chapter concludes with issues and limitations related to the study and the ethical considerations for the study's human subjects.

DESCRIPTION OF ETHNOGRAPHY

The study utilized a qualitative FE method as described for nursing research by Roper and Shapira (2000) which draws on seminal work of Fetterman (2020). This FE investigated the experiences and responses of CCNs after a self-identified traumatic event. The strength of the FE method is its holistic focus on the problem or phenomenon in an effort to gain knowledge and insight about individuals in a smaller cultural group and their interactions with the phenomenon (Roper & Shapira, 2000). Research questions of focused ethnographies are articulated before the researcher enters the field, with an expectation of the gained knowledge to aid in the practical application among healthcare

professionals (Roper & Shapira, 2000). The intent of focused ethnographies with a concentration on one main research question allows accomplishment of the study in a shorter amount of time than a traditional ethnographic study (Roper & Shapira, 2000). FE studies not only allude to findings of practices within a diverse culture or subculture group but also are used to discover and focus on nursing as a phenomenon (Roper & Shapira, 2000). CCNs are viewed as a subculture for this study to allow for the discovery of unique and specific beliefs and practices (Roper & Shapira, 2000) in response to self-identified traumatic events causing distress among nurses in the ED or ICUs clinical setting. Roper and Shapira state that comparing healthcare environments within ethnographic nursing research provides a better understanding of complexities among "common situations" (pg. 9), such as experiencing self-identified traumatic events causing distress among CCNs. Roper and Shapira reiterate that such comparisons present the opportunity for theories to be formed and potentially examined in other relatable events or situations.

The process of conducting an ethnographic study begins with selecting a problem of interest and then developing a research question examining what is occurring in a given cultural group related to the phenomenon of interest from the emic, or insider's viewpoint (Fetterman, 2020). Ethnography focuses on collecting shared patterns, perceptions, and behaviors within a specified cultural group, through observations and interviews (Creswell & Poth, 2018; Fetterman, 2020; Roper & Shapira, 2000). The ethnographic researcher approaches the study like an investigative reporter who uses fieldwork to observe, interview, assess records, and appraise the insights and opinions of participants among the specified group (Fetterman, 2020; Roper & Shapira, 2000). Data are then

analyzed for common themes that describe how the culture-sharing group works, and then the study is presented in a compiled report (Creswell & Poth, 2018; Fetterman, 2020; Roper & Shapira, 2000).

Objective and Specific Aims

The overall objective of this ethnographic study was to examine self-identified traumatic events reported by CCNs in the clinical setting and how their work-place culture impacts the CCN's response. The study also examined ways the CCNs culture influenced the nurse's ability to cope and manage distress after experiencing the self-identified traumatic event. There is a limited number of studies examining the CCN's experience in response to events leading to distress in the clinical working environment. The rationale for addressing a specific self-identified traumatic event by the CCN compared to previously identified traumatic events within the clinical setting is to explore individualistically unique and categorical experiences causing distress and/or mental health symptom(s).

Recruiting, Sample, and Setting

The study proposal was submitted to and approved by the UTMB IRB (See Appendix A). Following IRB approval, the researcher recruited licensed registered nurses (RN) who had been CCNs for at least one year and met the inclusion criteria. Sampling for ethnographic research utilizes an approach to include participants who are experts or directly related to the phenomenon of interest as defined by the study's research question (Fetterman, 2020; Roper & Shapira, 2000). Two types of sampling were used for the

study. Initially, the researcher used purposive sampling to recruit participants who represented the cultural group of interest and who could speak to the phenomenon of interest (Polit & Beck, 2017); in the case of this study, CCNs who have experienced a self-identified traumatic clinical experience(s) and were willing to reflect on their personal experiences and participate in the study (Spradley, 1979). Snowball sampling was used by asking study participants and CCN contacts to share study recruitment materials and information with other CCNs who might have experienced a traumatic event (Polit & Beck, 2017).

Participants in the study were CCNs who had a minimum of one year experience in an ED and/or ICU and experienced a self-identified traumatic event causing personal distress in the clinical work environment. Although all specialties of nurses can experience unique and specific self-identified trauma, this study only focused on CCNs due to the daily high-stress work environment. No CCNs were excluded from participation based on identified age, gender identity, sexual orientation, race, ethnicity, or spiritual/cultural beliefs. A total of eleven CCNs volunteered to participate in the research study. The emergence of common themes and data saturation was utilized to guide when a sufficient sample size was achieved. Saturation means that data analysis has revealed a preponderance of common themes and similarities among the collected data (Polit & Beck, 2017).

Recruiting

Study participants were recruited using a recruitment flyer (See Appendix B) summarizing the study's purpose and inclusion criteria. The flyer also provided the researcher's contact information, so interested nurses could request and receive more

information about the study and participation. Permission to post the recruitment flyer was obtained from social media sites with CCN pages, such as Facebook. A total of three Facebook pages directly related to emergency, trauma, and intensive care nursing were utilized for recruitment once the page moderators gave permission to post. The recruitment flyer was also posted on the researcher's personal LinkedIn profile page. The recruitment flyer was shared with CCN contacts at regional healthcare organizations in Texas and one in Southern California (e.g., Baptist Hospitals of Southeast Texas, Baylor Scott and White Health, CHRISTUS Southeast Texas, Pomona Valley Hospital Medical Center, and UTMB Health) to disseminate amongst colleagues. Study participants were encouraged to share the recruitment material with fellow CCN colleagues. Eight participants were recruited through social media and the researcher's LinkedIn page, two participants were recruited through professional contacts, and one participant was recruited via snowball sampling.

Once the CCN contacted the researcher by email or text for interest in participating in the study, a response with a scripted letter (See Appendix C) was sent by the researcher using the same method as the initial contact. The researcher thanked the potential participant and scheduled a brief telephone conversation to verify that all inclusion criteria were met and discuss the study. If the CCN continued to be interested to voluntarily participate and was eligible for the study, the researcher informed the potential participant that the interview would be recorded, using video and audio methods, through the platform of Zoom®. One of the 11 potential participants shared a concern of being video recorded. A thorough discussion between the researcher and potential participant resulted in the full participation of the CCN in the study. The

potential participant was satisfied with the study procedures to provide confidentiality and verbalized the understanding of the potential for richer data collection by utilizing video data collection to observe nonverbal cues.

Sample

The study sample consisted of 11 participants practicing in the United States who identified themselves as licensed RNs who were CCNS either in the ED and/or ICU clinical setting for a minimum of one year. Each CCN reported having experienced distress related to a self-identified traumatic event in the clinical work environment. Inclusion criteria for participation in the study were RNs who have worked in critical care areas, ED and/or ICU, for a minimum of one year. CCNs must also have experienced a self-identified traumatic event in the ED or ICU clinical setting causing distress to the nurse, have access to a computer or tablet with internet capability, were able to participate in a 90-minute recorded interview through Zoom®, and were able to read, write, and speak English. Chapter Four will further discuss the study sample.

Setting

The audio and video recorded interviews took place using the online conferencing platform Zoom®. Subjects took part in the study in a location of their choosing that offered convenience, comfort, and privacy and was free from interruptions during the video conference. The researcher conducted the data collection from the privacy of his home office. The locations for both the study participant and the researcher also provided protection of the participant's confidentiality.

DATA COLLECTION PROCESS

Data collection for the study began on May 7, 2023, and ended on May 25, 2023, which included recorded audio and video and transcribed interviews, field notes, and a reflexive journal of the researcher (Lincoln & Guba, 1985; Roper & Shapira, 2000; Fetterman, 2020). Data collection was guided by Roper and Shapira's (2000) approach to ethnography in nursing research. A copy of the "Fast Facts" sheet (See Appendix D) was emailed to the study participant before the scheduled data collection session, which included the study's description, methods, and procedures. Participants accessed an electronic invitation link to join a scheduled Zoom® conference call for the semi-structured interview in a private and comfortable location of their choosing, at an agreed upon time between the researcher and participant. The session began with the researcher greeting and thanking the potential participant followed by asking the participant if there were further questions or clarification needed to be resolved about the study. Once all questions and clarification were appropriately addressed, the researcher verified with the participants that they remained interested in the study. The researcher then obtained oral consent by verifying that the participant had reviewed the oral consent narrative (See Appendix E). Once the potential participant agreed to continue as a participant in the research study, the recording feature was initiated for Zoom® and the study participant was notified of recording in progress. The study participant was then asked to restate that they had received the oral consent narrative and reiterated verbal consent to participate in the study. The participant was reminded that they may withdraw from participating in the study at any time, had the right to decline to answer any question, or may pause if needed

at any moment during the interview. At the time of the scheduled interviews, there were no potential participants that declined to participate in the study.

Data collection began with the researcher asking the participant to answer the demographic questions (See Appendix F). The electronic demographic collection form included questions to gather data related to the CCN's current critical care unit, critical care specialty, state of practice, age, identified gender, highest level of nursing education, years of experience as a CCN, and current nursing position. The researcher ensured that each response was recorded clearly for transcription and verified with the collection form.

The interview portion began with the grand tour question: "Would you please tell me about a self-identified traumatic event you experienced within the clinical setting that caused you distress as a critical care nurse?" The researcher continued with data collection utilizing the semi-structured interview guide (See Appendix G) for the study using open-ended questions to "gently" guide the conversation with the participant (Roper & Shapira, 2000, p. 75). At times, the researcher used probing questions such as "you stated…tell me more about that" and "you seem to be visibly upset about that…" to elicit greater detail (Roper & Shapira, 2000) and a deeper understanding (Fetterman, 2020) of the participant's response. The data collection session lasted no longer than 90 minutes. If the participant verbalized or showed indications of distress or fatigue at any point during the data collection process, the researcher would offer breaks for the participant, terminate the data collection session, or continue the data collection session per the participant's preference. Multiple participants showed signs of potential distress when sharing their traumatic events through the expression of visible tears, pausing to

collect their thoughts, reaching for facial tissues, facial expressions and faces turning red. Participants also verbally stated how they were currently feeling or how a memory brought up a feeling they did not recognize before. No participants in the study opted to terminate the interview or withdraw from the study.

Prior to concluding the interview, the researcher asked participants if they would like to share anything that has not been discussed or further elaborate on a previous response. The researcher also asked if the participants would agree to be reached at a later date and time to perform a potential second interview lasting no more than 30 minutes for member checking to verify the findings from the collected data for further clarification and credibility (Lincoln & Guba, 1985). The researcher offered his email address again to the participants if they would like to contact him with any questions or to elaborate on previously collected data. The researcher offered the participants available online resources, (See Appendix H), to aid with any experiences of distress from reflecting on previous traumatic events. The researcher then concluded the data collection session by thanking the participants for their time and closed the interview. The 11 data collection sessions ranged from 26.25 minutes to 80.75 minutes, with a mean of 56.4 minutes.

Once the participants successfully logged off the recorded Zoom® session, the researcher verbally recorded the field notes from the session. As a part of the data collection transcription, the field notes added depth and richness to participants' responses. The transcribed participants' responses and the researcher's field notes also contributed to the audit trail for the study. Once the field notes from the session were successfully recorded for transcription, the researcher terminated the recording function of the Zoom® session.

Additionally, the researcher continued to document thoughts, conclusions, reflections, and ideas in a reflexive journal. During the data collection session of the study, the researcher recorded reflexive notes in an electronic template (See Appendix I) to include observations of the interaction with the participant. Non-verbal behaviors and cues such as inflection in voice, facial expressions, crying, pausing for extended periods of time, change in breathing patterns, and being visibly distraught were noted. The reflexive journal also assisted the researcher in recognizing his own feelings, experiences, and assumptions of the phenomena, aiding in the prevention of personal bias. This researcher's dissertation research advisor reviewed the collected data (de-identified) and provided feedback throughout all phases of the research study. The continuous review by the research advisor aided in the assurance that the researcher's preconceptions nor personal bias was included into the study's data analysis and emerging themes or sub-themes. Both the reflexive and field journals were handwritten/typed and later dictated and transcribed for accuracy. All journals for the study were included as items within the audit trail.

DATA MANAGEMENT

The researcher utilized an encrypted and password protected personal laptop to record and manage the study's collected data, data analysis, and file storage. Additional methods to ensure the security of the study's data included the use of password protected external hard drives and UTMB's OneDrive cloud storage system, which is equipped with Health Insurance Portability and Accountability Act (HIPAA) compliant security. Separate lockboxes for each external hard drive, printed documents, and personal

computer were utilized and stored in separate locations within the researcher's personal home office. Participants' confidentiality and privacy were managed using unique coding on all forms of data with a master list code book, which remained on a separate password protected external hard drive secured and located separately from all other study material. The code book contained the names of study participants, the uniquely assigned code, the initial date of contact with the researcher, the date and time of the data collection interview, obtainment of verbal consent, and any participant concerns.

Data collection sessions were recorded utilizing the Zoom® video conferencing platform. The researcher utilized a voice recorder for back-up recording of audio from the participant interviews. Each interview had individual session identification codes and passwords to ensure each participant had a secure and confidential data collection session. The researcher enabled the end-to-end encryption featured within the Zoom® platform to ensure a secure connection and prevent unauthorized individuals from entering the Zoom® meeting using the waiting room and passcode features. Zoom® utilizes the Transport Layer Security, and the content is encrypted using a 256-bit Advanced Encryption Standard for End-to-End Encryption (Zoom®, n.d.-a). The International Organization for Standardization 27001 Standard, the Health Information Trust Alliance Common Security Framework, and the Federal Risk and Authorization Management Program have certified Zoom® for their cloud-based platform security (Zoom®, n.d.-a). All recordings were then uploaded seamlessly using only the audio file and transcribed through the secure artificial intelligence technology of Otter.ai™. After confirming successful uploading of the transcription, all Zoom® cloud-based files were then deleted. The researcher compared the recorded interviews and dictated journal notes

with the transcriptions for accuracy and corrected any errors or omissions. A second review of the transcripts compared to the audio files was conducted by the researcher to confirm accuracy. Once the transcriptions were free from error and downloaded from the Otter.ai™ portal, the recordings and transcriptions were permanently deleted from Otter.ai™, as verified by Otter. ai's™ confidentiality agreement (See Appendix J) and downloaded on a password protected external hard drive. A second copy of transcripts were de-identified and masked of any collected information that could potentially identify a participant or specific critical care environment or geographical location. The second de-identified and masked copy of transcripts were securely saved on a separate password protected external hard drive and utilized for data analysis.

All materials related to the study will be destroyed at the conclusion of the research.

DATA ANALYSIS

Data analysis within an ethnographic study utilizes triangulation of information within the collected data and documents through the form of content analysis (Fetterman, 2020). Ethnographic studies collect copious amounts of information that is often in the form of written words (Roper & Shapira, 2000). Fetterman (2020) says the ethnographer needs to conduct multiple analyses and forms of analyses, which occur from the researcher's selection of the study's problem through the final stages of completing the study's written report. The purpose of data analysis within an ethnographic study is to discern and organize the data that the researcher has collected and observed phenomena of interest within the culture (Roper & Shapira, 2000). Roper and Shapira (2000) express

that ethnographic research does not tend to have one specific method of data analysis but a combination of other qualitative research methods to analyze data with the main components being coding journal notes and transcripts, sorting to identify patterns and themes, generalizing constructs, and memoing the researcher's personal thoughts and reflections.

The constant comparative method (CCM) guided the qualitative data analysis to provide a systematic approach to continuously compare data as it was collected (Glaser, 1998; Glaser and Strauss, 1967). CCM allowed for a rich analysis of emerging themes and sub-themes and began from the first contact with the study participant (Glaser, 1998). The demographic data for the study was analyzed for descriptive and nonparametric statistics analysis (modes, means, frequencies, percentages) (Fetterman, 2020). The collected interview data analysis began at the time of data collection and continued throughout the entire study (Roper & Shapira, 2000; Fetterman, 2020). The field notes and journals were regularly reexamined for contributions and patterns of findings throughout the study for significant key terms, statements, or observations of the CCN culture (Fetterman, 2020).

Thorough data and content analysis are achieved when the researcher filters through the data to find patterns and themes within the recordings and dictations (Roper & Shapira, 2000; Creswell & Poth, 2018; Fetterman, 2020). Interview, journals, and field note transcripts were coded and correlated with a codebook to protect participant identity. The transcripts had line numbering for ease of reading and reference. The interview transcripts were printed for ease of marking, highlighting, and note-taking. Reading and rereading the notes and transcripts collected from the recorded interviews was imperative

to dissect and narrow the data and refine the interpretations (Hammersley & Atkinson, 2019). Further reducing the data using coding (Glaser 1998), the researcher sifted through the observational notes collected during the recorded interviews of the CCN transcripts and journal memos for potential themes, patterns, and interpretations in the margins of the observational notes collected during the recorded interviews of the CCN. Data was then filtered into pieces that 'fit together' to present a more precise depiction of the perceptions and experiences of the CCN sub-culture after a self-identified traumatic event.

Member Checking

Member checking involves discussing and reviewing data findings and emerging common themes from the interviews between the researcher and participants to determine whether the researcher's interpretations reflect those of the participants in member checking for accuracy derived from collected perceptions (Polit & Beck, 2017; Lincoln & Guba, 1985). Member checking was utilized to verify with three study participants to enhance the accuracy of the emerging study themes and sub-themes to describe the CCN's perception and experience of the self-identified traumatic events and the CCN workplace culture. The participants were contacted as outlined in the procedures previously explained for Zoom®. Member checking included the researcher and participant reviewing the themes and sub-themes from the collected data with brief descriptions. The researcher asked the participants if the data analysis findings were applicable to their experiences and the overall CCN workplace culture as they have perceived and experienced it. All the member checking participants agreed that the data analysis findings were fitting, and no recommendations or changes to the findings were

presented to the researcher. As presented in this chapter's Data Collection and Data Management sections, the member checking follow-up interviews and transcriptions were conducted according to the previously mentioned procedures to ensure accuracy and confidentiality.

TRUSTWORTHINESS

According to Lincoln and Guba (1985) a qualitative study's scientific trustworthiness, or rigor, communicates integrity through credibility, applicability/transferability, dependability, and confirmability. The proposed study used Beck's (1993) modification of Lincoln and Guba's criteria; Beck's criteria for demonstrating scientific rigor are credibility, fittingness, and audibility.

Credibility

Credibility measures the truthfulness and depiction of how well the phenomenon is described (Beck, 1993). The informants, and individuals reading the study report who have experienced similar life events, should be able to identify the researcher's depictions as their own lived experiences (Beck, 1993). This study used the strategies of field journaling, triangulation, transcription of dialogue, and member checking to meet the criterion of credibility. Beck, along with Lincoln and Guba (1985), explains field journaling as documentation of observations of study participants' behaviors and interactions as well as the researcher's thoughts about the data collection process. Triangulation is a process of using multiple forms of data to interpret the data and formulate a comprehensive understanding of the phenomena (Beck, 1993; Lincoln &

Guba, 1985). In this study, data consisted of transcripts as well as the researcher's field notes and journal memos. The credibility of the study findings was supported by member checking, as presented previously in this chapter.

Fittingness

Fittingness measures how the study findings, which can be viewed as working hypotheses, correlate with populations or contexts other than that of the initial study (Beck, 1993; Guba & Lincoln, 1981). The characteristics of the participants' demographical data and work experiences aid in addressing fittingness. The sample was diverse in terms of education, age, sex, years of experience, critical care specialty units, and geographical location in the U.S., as further discussed in Chapter Four. Relatability in nursing can cross into multiple patient care arenas. Within the CCN sub-culture, experiences were collected from nurses who practice in critical care areas, including the ED and specialty-specific ICUs.

Auditability

Auditability measures whether other investigators would be able to follow the researcher's thinking and decision-making processes from the beginning of the study through the written reports and could agree with the decisions made by the researcher (Beck, 1993; Guba & Lincoln, 1981). Auditability was ensured by creating a detailed audit trail maintained by the researcher. Audit trails, also known as log trails (Richards, 2021), elicit evidence that the researcher kept records of thoughts, interactions, events, and decisions (Richards & Morse, 2013). These audits provide an evaluation and

explanation of the study (Richards & Morse, 2013). Lincoln and Guba (1985) describe an audit trail to include raw data such as field notes, data reduction, and analysis summaries from collected notes. The audit trail consisted of the study proposal and research question, bio-demographic data, interview guide, interview transcripts, field notes, reflexive journal, peer debriefing, and member checking. The researcher's research advisor and other dissertation committee members who were not identified as a part of the research study assisted as a voice for ideas and held the researcher accountable to keep the focus objective and grounded throughout the study.

HUMAN SUBJECTS PROTECTIONS

Approval from the UTMB's IRB was obtained before initiating the study, including all study procedures and appendices, or recruitment of participants to adhere to the Protections of Human Subjects guidelines.

While the study posed minimal risk to participants and does not include a vulnerable population, any research study with human subjects always will pose some risk to the study participant. Risks of participation posed by this study included the potential for breach of confidentiality, loss of privacy, and emotional distress or fatigue from recalling the traumatic incident. Verbal consent was obtained as a requirement for study participation utilizing the narrative presented in Appendix E. Participants were reminded at key points in the study process the study of their right to withdraw at any moment of their choosing with no repercussions.

All participants were consenting adults; all data collected was labeled by unique participant identification numbers to reduce the risk of breaching confidentiality or loss

of privacy. A master list of participant identification coding was securely locked and password protected as discussed in the data management section. Any identifiable information linked directly to the participant or specific critical care environment was masked by the researcher. Only the researcher has access to the original collected data or any other unredacted data.

As this study targeted CCNs who experienced self-identified traumatic events during their clinical practice, participating in the study might have resulted in emotional distress and fatigue. To mitigate fatigue, data collection sessions did not exceed 90 minutes. The researcher remained alert for any non-verbal and verbal cues that could indicate if the participant was becoming distressed or fatigued. During the data collection sessions, nine out of the eleven participants appeared visibly upset be means of crying, stopping mid-sentence to recollect thoughts, or staring off to the side of the screen for short periods of time to collect themselves. Periodically, the researcher asked questions such as "Are you okay to continue?" "How are you doing?" or "Is it okay to continue?" to assess how the participant was coping with the interview process. The researcher, experienced in post-traumatic debriefing events, is trained to recognize emotional distress. If there were any indications that the participant was distressed or fatigued, the researcher offered to take a break and resume data collection, terminate data collection altogether, or continue data collection in accordance with the participant's stated preference. During the assessment of the participant and provided break, participants would then determine how much time was needed for recovery and when the interview was to resume or be terminated. After the researcher paused the data collection session to assess the participant, none of the participants wanted to reschedule or terminate the

interview and agreed to continue with data collection. Supportive resources were readily available for all participants prior to the data collection session, such as the Emotional PPE Project website for healthcare workers impacted by the COVID-19 pandemic, the National Alliance on Mental Illness helpline, the Substance Abuse and Mental Health Services Administration helpline for natural or human-caused disaster distress, and Therapy Aid Coalition website for U.S. healthcare professionals and first responders. At the end of each interview, the researcher offered and reminded all participants of the availability of the supportive resources mentioned above.

SUMMARY OF CHAPTER 3: METHODS

Chapter Three has provided the reader with an overview of ethnographic research (Roper & Shapira, 2000; Fetterman, 2020) used for this study exploring self-identified traumatic experiences causing distress among CCNs in the critical care clinical work environment and influences of work culture. This chapter has explained the study design including the techniques and methods for study participant recruitment, sampling, and setting, and the procedures for data collection, data management, and data analysis. This chapter also detailed how the study followed scientific rigor and trustworthiness of a study and ethical considerations for the protection of human subjects.

PLAN FOR REMAINING CHAPTERS

Chapter Four will provide a detailed description of the study findings and common categories and themes which emerged from the experiences of self-identified traumatic events. Chapter five will provide a discussion of the study.

CHAPTER 4: FINDINGS

INTRODUCTION

Chapter Four discusses the findings of this ethnographic study that examined self-identified traumatic events reported by CCNs in the critical care clinical setting and how their workplace culture impacts the CCN's response. Three specific aims of the study were:

1. to describe the CCN's specific self-identified traumatic event(s) and experience(s) in the critical care setting;
2. to explore the impact of workplace culture on the CCN's response to and treatment of self-identified traumatic event(s); and,
3. to examine formal and/or informal supportive interventions offered to the CCN related to work-related traumatic events.

The Chapter will begin with a description of the study's sample, followed by a discussion of the study findings presented through the emerging themes of *normalizing the abnormal*, *suffering in silence*, *badge of honor*, and *resilience: we are CCNs*. These themes will be used to describe the self-identified traumatic events experienced by participants and the influences of the CCN workplace culture on the response to and coping with experienced distress. Chapter Four concludes with a summary of the study findings and the plan for Chapter Five.

DEMOGRAPHIC DATA

The study sample consisted of eleven registered nurses (RNs) with a minimum of one year of experience in critical care within an ED or ICU specialty unit at the time of data collection. All participants reported that they had experienced at least one self-identified traumatic event while working in the ED or ICU clinical setting, which caused them distress. Seven of the participants identified as female, and four identified as male. The participant's demographic data is displayed in Table 4.1. Demographic data such as participant's age, years of nursing experience, and number of licensed beds within the facility were presented in ranges to protect confidentiality further. At the time of the study, the largest represented age group among participants was 31 to 40 years old (54.6%). The majority (54.6%) of participants had a Bachelor of Science in Nursing (BSN) as the highest level of nursing education at the time of data collection. The average years of nursing experience for participants was five years, with four (36.4%) participants having 1-5 years of experience and four (36.4%) participants having 6-10 years of experience as an RN. At the time of data collection, the current nursing positions held by the participants were five (45.5%) staff nurses still serving in the critical care setting, with the remaining participants in positions other than bedside critical care nursing. Interestingly, those participants with less than six years of nursing experience remain as staff nurses in critical care areas compared to most study participants with six or more years of experience who have left the critical care bedside.

Table 4.1

Study Sample Demographics

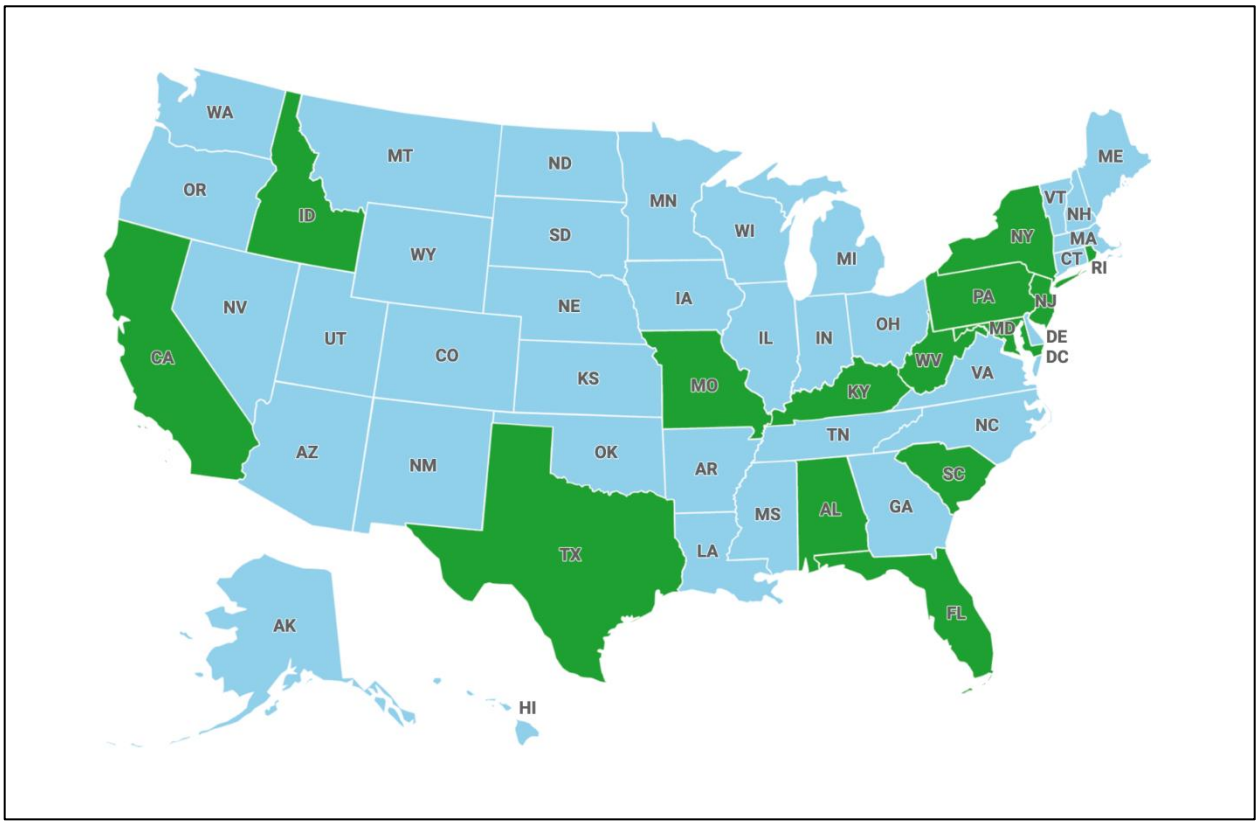
Demographic Data	Variables	Frequency
Gender	Female	7 (64%)
	Male	4 (36%)
Age in years	20 - 30	3 (27.3%)
	31 - 40	6 (54.6%)
	41 - 50	1 (9%)
	51 - >60	1 (9%)
Highest level of nursing education attained	ADN	2 (18.2%)
	BSN	6 (54.6%)
	MSN	1 (9%)
	DNP	1 (9%)
	PhD	1 (9%)
Years of nursing experience	1 - 5	4 (36.4%)
	6 - 10	4 (36.4%)
	11 - 15	1 (9%)
	> 16	2 (18.2%)
Current Nursing Position	Staff RN	5 (45.5%)
	Flight RN	1 (9%)
	Travel RN	1 (9%)
	Nurse Faculty	1 (9%)
	Nurse Faculty & PRN RN	1 (9%)
	Nurse Faculty & Nurse Practitioner	1 (9%)
	Nurse Manager	1 (9%)

The participants have all practiced in the U.S., with some practicing as CCNs in more than one state. Image 4.1, as developed by the researcher, provides a visualization with states colored green to depict which states were practiced in as a CCN. At the time of data collection, three nurses practiced solely in Texas, one in Idaho, one in Missouri,

and one in South Carolina. The remaining participants have practiced in multiple states as a CCN, one in New Jersey, Pennsylvania, and Rhode Island; one in Kentucky and West Virginia; one in Maryland and Pennsylvania; one in Alabama and Florida; and one in California, New York, and Texas.

Image 4.1

Participants' State of Practice as a CCN



Note. Green-colored states represent the states the study participants have practiced as a CCN

Critical care experience among participants ranged from the ED solely (N = 1) to singular ICU specialty units (N = 2), with others practicing among multiple ICU

specialties (N = 7), some working primarily among all adult ICU specialties (N = 3), and some floating to the ED (N = 2), as depicted in Table 4.2.

Table 4.2

Participant Work Settings

Workplace Environment	Variables	Frequency
# of Licensed Beds in Facility	< 100	1 (9%)
	100-499	5 (45.5%)
	> 500	5 (45.5%)
Critical care specialty area *These numbers are a total representation of all participant's (N = 11) CCN experiences in the different critical care environments thus far in their career	Emergency Department	3 (27%)
	All Adult ICU Specialties	3 (27%)
	Cardiac ICU	3 (27%)
	Medical ICU	5 (45.5%)
	Neuro ICU	1 (9%)
	Pediatric ICU	1 (9%)
	Surgical ICU	3 (27%)
	Trauma ICU	3 (27%)

STUDY FINDINGS

The study findings present the perceptions and experiences of CCNs in response to self-identified traumatic events that occurred within the clinical workplace environment, which caused them distress. The study findings also present the CCN's workplace culture and influence on the CCN's ability to respond to and cope with the self-identified traumatic event(s). The discussion will include descriptions of the common themes and sub-themes derived from analyses of the data collection sessions of study participants. Furthermore, themes and sub-themes (Table 4.3) may be illustrated through

participants' direct quotes with citations utilizing "P#, L#" to indicate the participant and line numbers within the interview transcript.

Table 4.3

Study Findings by Themes and Sub-themes

Themes	Sub-themes
Normalizing the Abnormal	1. Detailed Encounters 2. Delayed Realization 3. Repetitive Trauma 4. Next Bed, Next Patient 5. This is the Job, Buck Up
Suffering in Silence	1. Losing Faith in the System 2. Compartmentalize and Disassociate 3. Be Seen and Not Heard 4. Knowledge and Resource Deficit
Badge of Honor	1. Others First, Nurse Second
Resilience: We are CCNs	1. Dark Sense of Humor 2. Hardened Armor 3. Self-Advocate

NORMALIZING THE ABNORMAL

The researcher asked each participant to share their experiences within the critical care clinical environment of a self-identified traumatic event causing them distress. As previously presented in Chapter 2, many incidents, especially traumatic, experienced by nurses are often repetitive. These experiences become the day-to-day working environment of nurses who are already meeting the high demands of the healthcare facility, factors from the current nursing crisis, and overall influences within the CCN's workplace culture. As a CCN, the nurse's experiences in the clinical environment were

often reported as what CCNs see is not normal, as expressed by multiple study participants. One CCN stated, "…it's like those times when you stop, and you're like, 'wow, that really is traumatic,' normal people do not experience something like that in their real life" (P2, L140-142). P7 emphasized, "…it's not normal…what we're seeing" (L643). The workplace culture of the CCN involves *normalizing the abnormal* daily with the repetitive nature of traumatic events that each nurse experiences subjectively. Another participant shared the feeling of not being able to let go of the CCN role and compared it to a bad relationship where they just cannot leave,

> …we'll see people that are in domestic violence…it'll be verbal, it'll be physical, mental, whatever. And then you get to nursing, and you go to ICU, or ER, wherever these horrific events happen that most people don't see daily…there is good in this job, and it's incredible. When the good is good, it makes it all worth it, but when it's bad…it just completely tears you apart… (P8, L303-309)

The study participants reported their individual experience(s) in detail, with multiple events occurring more than one year before data collection. The self-identified traumatic event(s) of the participant was often described in vivid detail. The CCN would recall sensations such as sound, smell, touch, and sight that illustrated a distinct and clear depiction of the traumatic event. Each CCN presented their story(s) and experience(s) with raw emotion that led the participant to, at times, weep, needing a moment to pause to collect themselves; express anger and/or sadness through verbal and nonverbal cues; and a sense of relief after sharing their experience. Several participants were grateful for a welcoming, safe space to share their experiences and perceptions. P5 shared a sentiment

like other participants, “I’ve been wanting to say that” (P, L689), after sharing their traumatic events, especially those speaking about it for the first time.

Participants described self-identified traumatic events throughout data collection as “very traumatic, heart-wrenching, terrifying, stressful” (P1); “repetitive stress, out of control” (P2); like being “in a fog” (P3); “extremely traumatic, emotionally draining, mortified, roller coaster” (P4); “this is the worst day of their (the patient) life” and the CCN relives it almost daily (P7, L622); “trying to orchestrate the mass chaos…you carry it with you always, but you just learn to grow around it” (P8, L933-934); “moral distress, a lot of anger, a lot of disbelief” (P10); and “remorse, feel like we could have done more” (P11). Several sub-themes of *normalizing the abnormal* daily experiences among CCNs included *detailed encounters*, a *delayed realization* of the adverse effects on the CCN, *repetitive trauma*, a *next bed, next patient* mentality, and *this is the job, buck up*.

Detailed Encounters

It is important to note that although the data collection occurred in the endemic phase of COVID-19, many of the self-identified traumatic events were not related to direct experiences of the COVID-19 pandemic. Participants described the self-identified traumatic events as unimaginable and of nightmares, “…it was something I would never want to relive, nor would I ever wish on anybody else or wish on my worst enemy…” (P10, L207-208). The vivid details of the participants’ encounters are unique and subjective. Although each participant experienced an individualized traumatic event, each event shared commonalities that are seen throughout the CCN workplace environment.

One CCN (P1) experienced a physical altercation among a patient’s family members while titrating lifesaving medications to manage the patient’s unstable blood

pressure. They vividly recalled how the family members began verbally attacking each other, suddenly escalating to a physical altercation while P1 was at the bedside and then served as a physical barrier to protect the ventilated patient from the violence. The family members were positioned across from each other over the patient's bed. They began to swing and hit one another while also entangling and moving medical equipment and the breathing tube. "I ended up just having to lay over the patient to try to protect his head. Trying to protect his ET [endotracheal] tube. I had all these lines going in him" (P1, L175-176). P1 recalls having to yell loudly with a delay in response from other CCNs due to their colleagues not being able to hear the cries for help as they attempted to protect the patient and themselves from harm. They also recall during and after the event, "…very much scared me, makes me nervous right now talking about it" (P1, L 194-195). P1 stated that even years after the traumatic event, they still are cautious in the clinical environment, have become more nervous around others, and have become more protective of the patients,

> …when I go in patients' rooms, you know, I do things, I look behind the door, make sure nobody's back there…you can't always assume that just because you're in a hospital, you're in a safe place, and you're in a safe environment that only good people are, and people are not going to try to hurt patients that you're taking care of. And in the midst of that, we as the nurses can become injured also. (P1, L200-204)

P1 also expressed being very stressed with attempting to focus on the care of the critical patient and keeping them alive while also thinking of protecting their own life. They recall a rush of questions filling their head during the event and questioning if the family

members wanted to harm the CCN, if they had a gun, and thinking of places to hide for safety,

> Things that you should not have to think about as a nurse. You should not have to think about how would I protect myself while I'm taking care of that patient because that makes you think you're on a battlefield. And in a hospital, a nurse should not have to think that they're in a battlefield. But it made me, from that point on, to recognize that a battlefield can be anywhere where you have to protect yourself. And so, I carried that throughout the rest of my nursing career. (P1, L289-293)

The first shift of one CCN during the COVID-19 pandemic was described as "cadavers behind doors" (P2, L381) for the patients who lost their lives while the entire unit's staff was tending to other patients who were coding simultaneously on the unit. Within a minute of beginning their shift, one CCN recalls hearing one code after the other being announced overhead and realizing the true impact of the pandemic, "holy shit, this is happening" (P2, L365). P2 remembers their hands shaking while retrieving medications for one of the patients and having to shut the medication drawer because they could not focus and complete the task, asking themselves, "How am I going to do this?" (P2, L380). P2 emphasized that this shift was one of their career's most traumatic experiences. "Obviously, it's disturbing when anybody dies, three people so fast. But also, this sensation of being kinda like, in a movie, that you're a part of this event that [is]…out of [your] control" (P2, L391-393). On their first day back from vacation, P5 recalls during the third wave of the COVID-19 pandemic being assigned two patients who were not intubated but were quickly deteriorating, and intubation was imminent. P5

remembers holding the hand of the first patient who was scared to be intubated until they were sedated. The second patient continued to deteriorate,

> She's de-sating, not doing well. And, you know, she says, "…I want the ventilator. I'm tired." …my words to (the patient) were, "If you go on this ventilator, you know, I can't promise that you're gonna come off of it." And she said, "I have my God with me." (P4, L119-122)

P5 remembers having an anxiety attack immediately after stepping out of the second patient's room and having to be relieved of her assignments to go home. "I never went back after that. I was put on short-term disability. I tried to go to the hospital to meet with my manager and supervisor, but I couldn't even walk through the doors" (P5, L123-125). P5 also recalled the overall COVID-19 pandemic experience to include not enough staff to provide rapid response or code blue teams, newer nurses leading code blues, CCNs serving as surrogate family members until the patient's last breath, and giving post-mortem care to multiple patients while stacking "body bags on top of body bags" (L152) in the morgue and extra refrigeration trucks behind the hospital.

One CCN (P6) recalled a patient who quickly changed from stable to asystole on the cardiac monitors. The patient had an internal cardiac defibrillator that appeared not to be capturing or delivering shocks when necessary, upon P6's arrival to the patient's room. The patient was unconscious,

> …in the process of doing CPR [cardiopulmonary resuscitation], he's waking up and talking to me. If I stopped doing CPR, he goes unresponsive. Keep doing CPR. He wakes up and talks to me. And I'm the only one in the room. And he just kept begging me not to let him die. (P6, L116-118)

P6 remembers the patient not only begging them to continue CPR but also asking for all lifesaving interventions to be attempted. Once other team members arrived to assist with the code, another CCN took over the patient's care while P6 attempted to collect themselves in the hallway. While doing so, the patient succumbed to factors beyond their control. P6 felt as if they "failed" (L158) the patient, and blamed themselves for leaving the room, "if I would have stayed in the room, maybe (death) wouldn't have happened" (L158-159). P6 expressed that even several years after the event, they still hold a fear of patients waking up during chest compressions and talking to the CCN, "every once in a while, I'll think of that night. And I just can't help but cry. I always want to ask myself 'what if…'" (P6, L227-228).

Several CCNs shared traumatic events of caring for critical pediatric patients. Sometimes, the care of pediatric patients was in an adult ICU setting due to the lack of a higher level of care in the area or weather-related grounding of transportation to pediatric facilities. Nurses, at times, were faced with caring for patients who were not necessarily in the direct scope of the specialty unit. P3 reflected on a pediatric patient whose airway clearance was not easily manageable. When the CCNs stabilized the child's airway, the paralytics soon wore off, requiring the team to rework everything previously done. P3 distinctly remembers the child wearing a hat that their own child had. "This image in my head was this little kid he looked just like my son when he was that age, except he had all these tubes and stuff poking out of them…that image is always…stuck with me…just like somebody hit me in the gut" (P3, L284-287). P3 recalls feeling queasy and anxious with a strong sense of sympathy for the patient's parents due to the unknown nature of the child's prognosis and the inability to reassure them of a positive outcome. P4

reflected on an experience when a pediatric ICU patient was in the dying process and the difficulty of having physicians provide enough pain medication for the patient's comfort. P4 remembers the patient gasping for air and needing further comfort measures, "I went to the physician to try to advocate for her where we need to give her something else. 'If we give her anything else, she may die'" (L157-58). P4 attempted multiple times to escalate the concerns of controlling the patient's pain and comfort through the chain of command with pushback. Another problem was that the patient's parents had a language barrier and did not fully understand English or how to communicate their concerns. "I felt as though my hands were tied…I felt helpless…I felt as though I was failing her" (P4, L175-179). After several shifts of requesting to be reassigned to other patients and experiencing nightmares, P4 remained caring for the patient until their death. P4 states the event caused her to lose trust in the administration and physicians due to the lack of support when advocating for the patient and family's best interest. Language barriers between the healthcare team and the patient's parents were at times challenging; however, at the time of the patient's death, P4 distinctly recalls the parents saying, "just please take care of our daughter" (L103) and the heaviness of consoling the parents while also assuring dignity for the patient's fragile body. Although it was out of the hands of P4, a feeling of guilt continues to follow P4 after more than five years, "I really wish I could call that mom and just make sure that…she forgives me" (L122-123).

CCNs face external mandates from healthcare institutions in critical care environments, which can cause distress. P3 reflected on a traumatic event when the unit was forced to take on more than one patient needing extracorporeal membrane oxygenation (ECMO) with limited CCNs who were ECMO trained. The CCNs trained

for ECMO did not regularly have ECMO patients within the hospital. The hospital was beginning its ECMO program and attempting to prove "that we could do it more often at the time." (P3, L111). Initially, the hospital administration had the trained ECMO CCNs working four to five 12-hour shifts a week with minimal incentive and then mandated the overtime shifts shortly after with no additional compensation, "hospital administration initially was supportive, and then…partway through said, 'now they just need to come in and do it, and all they're getting is their overtime pay'" (P3, L114-115).

CCNs are often faced with caring for high-profile patients. High-profile patients may include local and governmental officials, criminals, and those involved in active investigations by law enforcement. Sometimes, high-profile patients may not require critical care; however, they may be placed in a critical care unit for more privacy and catered care. CCNs may face internal and external pressures in the workplace related to pressures that cause undue stress. P3 recalls a distressing time when they had a patient whose career made the physicians extremely cautious when communicating with the family members. P3 remembers being told, "No, you can't be honest with the family about this, even if they ask." (P3, L125-126). The CCN was instructed to "run the machines" and not communicate with anyone about the patient's care (P3, L128). P3 mentioned feelings of frustration, anger, and a shorter temper following the traumatic event. P3 also stated, "I tend to not trust administration as much" (L147) since the traumatic event due to the feeling of CCNs not being supported by the administration of physicians when the patient's best interest is at stake. P7 reflected on a high-profile patient who succumbed to the injuries experienced from a suspected homicide. P7 emphasized the burden was centered around the publicity, additional security detail at the

bedside and in the hospital, the inability of being able to speak to anyone due to the nature of the case, and the mental visualization of the family members' reactions, screams, and sobs. "I can still hear like the screams of like, the families like that is what like really, like etched on my heart forever" (P7, L205-207). P7 noted that they left the critical care environment less than a year after the event. "This is the worst day of their (the patient's) life…I replayed the worst day of these people's lives…every day for…three years" (P7, L622-623).

CCNs also unexpectedly encounter patients who are family members or close family friends. Among the many tasks a CCN is assigned, some serve on a rapid response or code blue team. These teams respond to medical emergencies throughout the hospital facility. P3 reflected on their experience serving on the code blue team and responding to a patient in the ED. P3 recognized certain features of the patient and quickly realized that the patient was a close family friend. The patient's family was unable to be reached at the time, and P3 knew from personal conversations with this good friend prior that the patient would not want to be coded. Due to the patient's wishes not being presented to the healthcare team in writing or by a next of kin, the patient was to be fully coded per the hospital's policy. P3 voiced the patient's wishes, knowing the team could not withhold care until the patient's next of kin was contacted. As P3 watched their dear friend receive multiple attempts of lifesaving interventions, they insisted on delivering the defibrillated shocks to the patient, "What I wasn't willing to do is allow anyone else to shock him…" (L420). P3 vividly remembers their friend after every shock, "would open his eyes and kind of have that 1000-yard stare…" (L434-435), and the heaviness of attempting to

reassure the patient that the team was trying to make contact with the next of kin to stop prolonging life-saving procedures.

Delayed Realization

Many study participants did not realize the severity and magnitude of the event's effect(s) on them until the end of the scheduled shift, days to weeks after, or until a similar traumatic event occurred. One participant stated, "…it isn't really until reflection afterwards like you realize how upsetting something was" (P2, L91-94). "The next day, you're sitting there, and kind of reflect…and you're just like, 'holy shit, I cannot believe this is my life. I can't believe I'm experiencing this" (P2, L283-285). P3 recalled the effect in the immediate aftermath of the event, "I just felt drained afterward because that really kind of registered as they were wheeling him (the patient) out of the room" (P3, L306-307). Another participant discussed the *delayed realization* that occurs much later due to the normalizing nature of the type of work and environment in critical care. P5 stated,

> But you really don't become aware of it until it's too late. Because like I said, me. I was just working. I was doing what I had to do. I didn't realize I was struggling. So it's hard for people to become that self-aware, to say, "Oh, wait, this isn't normal…" you don't realize you're in this traumatic event until afterward. (L525-530)

Repetitive Trauma

Participants reported that repetitive exposure to distressful and traumatic events occurs daily for many CCNs due to the nature of the beast, that is, critical care. Traumatic events that CCNs experience were also noted to occur within the same shift, same week, or months to come. The repetitious cycle of the events within the CCN's workplace environment contributed to the short- and long-term adverse effects on the participants,

leading many to voice a sense of burnout and leaving or having thoughts of leaving the job. One participant reported, “at some point, it just becomes too difficult to continue to see the same things like over and over with, like no resolution” (P7, L215-216). The traumatic events among CCNs also cause fear and anxiety of the event occurring again. “…it gives me increasing anxiety every time I get one of those (patients)…I’m probably not functioning at 100%, not able to think clearly…” (P9, L398-400). Other participants self-reported that exposure to repetitive traumatic events led to moral distress, PTSD, and anger issues. Participants shared the realization that many CCNs depend on pharmacological interventions to decrease the severity of the adverse effects that the traumatic events cause.

Next Bed, Next Patient

The critical care environment is known for its fast pace and rapid patient turnover. Often, unstable patients are waiting for hours in the ED, and sometimes days, for an available hospital bed in the ICUs. Study participants shared experiences of being rushed by unit management and hospital administration and, at times, pressured immediately after a traumatic event to clear the room due to it being needed for a new patient,

> …it's very much "Okay, here we are, we dealt with this…patient died. Bag them up. Clean the room. Next…it's like, “Oh, Well. Okay. Next.” …I don't think there's ever been a time in my career where I had anybody come up and be like…“Are you okay?” (P10, L265-267)

Participants also reported the *next bed, next patient* mentality does not allow for the CCN to take a moment to reflect on the traumatic event that occurred just moments before. CCNs are forced to receive the next patient or move on to their other assigned

patients without reprieve to process the potential trauma that may influence the delivery of care to the next patient. Participants recalled the traumatic events being distracting but leaving no other option but to carry on and take care of the patient(s).

This is the Job, Buck Up

Study participants shared their experience within the CCN culture of continuing no matter what because it was the job they were hired to do. Participants reported that more experienced and older CCNs are known to downplay the traumatic event experienced by another CCN and state that it is just part of the job. One participant recalled the attitude and response of unit management and other CCNs to say, "This is just part of the job. Sometimes this happens; you just have to learn how to deal with it and push through and take care of your patient" (P1, L396-397). No matter the circumstance or the distress caused by an event, the CCN is expected to continue to provide the best care possible and handle whatever comes at them. "…you put the poker face back on, you go back to work, you do what you have to do" (P8, L263-264). P8 also shared the lack of offered supportive resources leaves the CCN with no other choice but to just "buck up" and do the job.

Suffering in Silence

The CCN culture can be one of isolation for many nurses. Study participants discussed the loneliness of being a CCN, often caused by the influence of the workplace culture; hospital and regulatory body policy and procedures related to confidentiality and privacy, such as HIPAA; the lack of therapeutic resources with licensed professionals who have experienced similar workplace culture and/or traumatic events; and the fear of

being vulnerable and appearing weak to colleagues, patients, and society. “I felt like I couldn't even say anything to my family, my sister, my dad…I just had to suffer in silence” (P7, L145-146). P9 stated, “…we don’t want to violate HIPAA…who can you talk to without violating HIPAA…I don’t want to lose my license” (L570-571). The theme of s*uffering in silence* is supported through the sub-themes of *to be seen and not heard*, *losing faith in the system*, *compartmentalize and disassociate*, and *knowledge and resource deficit*.

To Be Seen and Not Heard

Data analysis revealed a common practice in the CCN culture was *to be seen and not heard*. The mentality of not speaking of or showing emotions caused by traumatic events and the adverse effects on the CCN was a consensus, especially within the workplace environment. P1 recalled going to the restroom on the unit to cry away from other CCNs, “I didn't want any of the staff members because I was brand new…to think I was weak because I was crying…That was when I really learned how I could…bottle up my emotions…” (P1, L470-479). Speaking of one’s experience that may cause distress or trauma for the CCN was viewed as a sign of weakness within the CCN culture. Participants also mentioned the fear of being questioned by other CCNs, especially experienced and older CCNs, if they were mentally fit and capable of caring for patients. Some participants reported the lack of speaking up about their experiences influenced them to not participate in supportive resources after experiencing a traumatic event due to the stigma among their peers. One participant stated,

> I didn't know what I should say and when I shouldn't say…I was concerned about what I said and whether it [would] be perceived in a certain way…and I think a

> part of that was I did want to be tough at work…I didn't want anybody to think that I couldn't handle it or that this was affecting me, even though it definitely was. (P7, L377-380)

Another participant stated that if their CCN mentor had encouraged them to speak about their trauma or to utilize a supportive resource, the effects of the trauma might have been different.

Losing Faith in the System

Multiple participants experienced a lack of support from the hospital administration. Participants experienced the administration and the institution to "…do just about anything to protect their brand and protect the institution if you will, versus…coming out and making a stand that probably would have supported the staff" (P10, L140-142). Administration was also seen as supportive and upholding the concerns and wants of physicians above the overall healthcare team's best interest for the patient. "I always feel like nursing leadership, especially in critical care…had some type of agenda, and that agenda being 'I'm gonna save my ass…and if we have to sacrifice the lambs [nurses], then so be it'" (P10, L423-426). CCNs followed the chain of command within their units to advocate for the patient with similar responses of, "I agree with you 100%. I'm being told from other entities that this is what's going to happen, and there's not much I can do about it either" (P3, L158-160). Other participants feared voicing concerns to unit management due to potential retaliation or being reprimanded for doing their job. "I remember kind of feeling like, I can't talk about this because I'm gonna get in trouble if I talk about it…not being able to express and like talk about what happened, I think really hurt me…I felt very…isolated and alone" (P7, L146-149). One participant

shared, “I laugh at the irony…one of our mottos is [care for them as if they were family] …that’s how we’re supposed to care for our patients, but yet, they [administration] don’t care about their staff like that” (P9, L579-580). P9 went on to say, “I think that staffing and burnout and retention would be a hell of a lot better…if they [administration] made their nurses their priority, or more of a priority, and cared like family the way they want us to care for our patients” (L591-593).

Compartmentalize and Disassociate

When faced with traumatic experiences, participants noted the act of compartmentalizing, disassociating, or pushing down details of the event(s) allowed them to cope and forget vivid details of their distress. Participants reported the difficulty of removing themselves from the critical care environment to take a moment or to breathe in the immediate aftermath of the distress. Compartmentalizing and disassociating the thoughts and feelings of the traumatic event serve as a defense mechanism for CCNs. “I think being an experienced and good nurse is being able to…compartmentalization” (P7, L286-287). P8 recalls removing themselves from the patient’s room shortly after the traumatic event, “I didn't feel anything…didn't feel a damn thing. I just needed a second to just be there…dissociate completely…not thinking about anything” (L230-232).

“It's much easier to suppress it than deal with it” (P9, L726). Participants reported remembering details of the traumatic event only by common identifiers; however, “…the exact nitty gritty details, like I said, I've probably forgotten because I probably started…disassociating myself, because I didn't want to close my eyes and see that woman and how she suffered” (P10, L157-159). P10 recalled completely disconnecting mentally and emotionally at the peak of the COVID-19 pandemic, stating, “…it took me

like a year to really, you know, gather myself from that. And that's part of the reason why I don't even work in ICU anymore" (P10, L574-575).

Knowledge and Resource Deficit

Most study participants noted supportive resources directly offered by unit management and/or hospital administration as nonexistent. Some participants discussed the lack of acknowledgment from unit management and administration as contributing to the overall deficit of available resources to the CCN. Data analysis also revealed some participants thought there was a deficit in the offering of supportive resources and in the knowledge of the availability of resources and how to implement them by leadership. Only one out of eleven participants was directly offered a supportive resource in the immediate aftermath of the traumatic event. P10 attended a debriefing that was organized for a traumatic event that the staff experienced. The participant recalled being the only CCN and only staff member who attended. Another participant attempted to participate in the hospital's employee assistance program but, due to the COVID-19 pandemic, could not see a licensed professional because of the lockdown,

> So how can we do anything but, you know, "Buck up" if we don't have those immediate resources? We don't have…debriefs. It's what we do because that's all we can do or know to do. Because no one's pushing for anything different (P8, L916-919)

Another participant recalled the unit charge nurses acknowledging their lack of support for the CCN,

> I went to the charge…and they just saw my face. And even they said, "We should have checked on you a little bit more because you kept saying, 'I can't do this

anymore. I'm tired.'" And it made them realize when people say that, they need to dig a little deeper. (P5, L276-279).

Other participants shared their experiences obtaining hospital-assisted supportive resources as a scavenger hunt. P2 recalled flyers on a bulletin board in the breakroom and links within the hospital's intranet, but to find them, the CCN would need to search among the stacks of potentially outdated materials. Some participants stated that they recall system emails being sent out or knowing of hospital supportive resources that the nurse would have to seek out, but the units or other CCNs did not utilize them or initiate them. Some participants mentioned that if they had been supported by resources or management, they would have remained at the bedside, "I would have stayed at the bedside longer if I was supported as a critical care nurse" (P4, L357-358). All participants stated that if a supportive resource had been offered by unit management or hospital administration immediately following the event that they feel CCNs would participate, the issue is most are not offering.

BADGE OF HONOR

The critical care environment, as presented in Chapter 2, is one of caring for the sickest of the sick in healthcare. Within the CCN culture, nurses wear a *badge of honor* to show the nurse's advanced skill set and as a coping mechanism to prove to their colleagues that they are tough enough to handle the environment,

> …it was a badge of honor to be tough…you had to be tough as nails and, like, any sign of weakness. They were like, 'Oh, well, *** can't handle that patient'…you were trying to impress the senior nurses…of how good you could be, or how well

> you could do at taking care of a sick patient. It was a badge of honor to, like, take care of the sickest patient and do a good job, and maybe not so respected, to cry, feel, fall apart" (P7, L291-299)

CCNs take pride in their work. When the participants were asked about removing themselves from the critical care environment or to a different hospital, they responded that there is nowhere else they would necessarily go because this is what they do,

> I've thought about going to other hospitals. I've thought about…doing other things in nursing, but not many people can do the job I do as well as I do it…I feel like I would be doing a disservice if I did leave ICU (P9, L647-649)

Some participants also reported the competitive nature among CCNs was a *badge of* honor to prove their ability to care for the sickest patient on the unit or boast the excellence they provide.

Others First, Nurse Second

Study participants reported a sense of obligation to the patient and a sense of pride in care delivery, no matter the cost. P1 recalls being "rattled" and "really had to focus and really try to knock that stuff [nursing interventions] out" (L304-305) during and in the immediate aftermath of their traumatic event due to the responsibility of caring for the patient. Some participants emphasized the meticulous work and the priority of the CCN in delivering care, documentation, and overall clinical judgment. "I have to live with the care that I gave my patients at the end of the day. I take it personally" (P9, L803-804). Participants prioritized the needs of the patients, the patient's family members, and colleagues of the CCN above their own. Some participants shared a feeling of burdening

others if they were to ask for help or make their needs known. It is not like the CCN to care for oneself due to the overall duty of caring for others.

RESILIENCE: WE ARE CCNS

The American Psychological Association (2022) defines resilience as "the process and outcome of successfully adapting to difficult or challenging life experiences, especially through mental, emotional, and behavioral flexibility and adjustment to external and internal demands." *Resilience* was seen in participants as navigating difficult circumstances while developing coping mechanisms, both healthy and unhealthy, and doing what is needed to simply survive. "…critical care nurses are very resilient…they handle these emergency situations, just like clockwork…especially code blues…intubating, and doing procedures. I mean, that's what we're there for, we're there to assist in and to…save these lives" (P10, L308-311). Study participants had a sense of resiliency through a *dark sense of humor*, developed a *hardened armor*, and were *self-advocates* by seeking supportive resources and other coping mechanisms.

Dark Sense of Humor

All study participants reported the presence of an inappropriate or *dark sense of humor* within the CCN workplace culture as a survival and coping mechanism. One participant stated, "It's always comedy and tragedy, so why not have them both?" (P8, L592-593). Examples of the *dark sense of humor* were noted as cracking jokes during a code blue, making inappropriate statements around a patient in a coma, or speaking ill of another human in the nurse's station. One participant recalled a time when they used a *dark sense of humor* for a brain-dead patient,

> The next day, you come in, and it's so messed up. But you'll say some out-of-pocket comment. Like, "I'm taking care of Cabbage Patch today." …something

> completely inappropriate, horrible for a normal person to hear. And your coworkers just kind of chuckle, and they're like, "Let me know when you need to turn." (P8, L539-542)

P8 continued to state that the *dark sense of humor* within the CCN culture is a form of bonding that provides a release from the reality of the trauma.

Some participants expressed that the crass nature of the CCN culture at times may appear dehumanizing, and they felt a sense of remorse. One participant reported the statements and jokes made around patients or during traumatic events allow the CCN to disengage and desensitize from the reality of the situation, at times removing themselves so much that they may forget it is a human they are caring for. One participant stated, "…it's good that I got those defense mechanisms because I can't do my job otherwise, but also, like, am I a human when I don't feel that way?" (P2, L553-555).

Hardened Armor

Study participants reported that as newer CCNs, they encountered the hardened personalities of experienced CCNs. It was noted that the CCN culture not only encourages the coping mechanism of *hardened armor* but almost expects it to be seen as "one of us,"

> …you better hope that when your loved one lands in the ICU, that nurse has defense mechanisms in place so that they can conduct themselves and take good care of you and do the things that they need to do. Because otherwise, we would just be crying and freaking out and screaming. (P2, L542-544)

Participants also reported the *hardening armor* mechanism supports the culture of not sharing emotions, and to be tough is not to show you are affected by the traumatic event. P2 also reflected on CCNs wearing a "badge of courage" (L568) to show who feels the

least. "…one thing I do resent is the culture in nursing, where people are just like, 'oh, I don't feel anything,' like almost like a brag or something" (P2, L566-567). Another participant discussed the bitterness among CCNs,

> I think part of that has to do with just the culture of nursing in general right now: overworked, underpaid, understaffed. They've been doing this stuff for way too long, and they're mad about it because this should be their golden years…and it's probably the hardest I've ever worked. (P8, L626-628)

P4 states the hardening of the CCN was also a means of protection and to mitigate further damage to the psyche,

> I've still been working on my mental state, and it's taken me years…if I didn't develop this hard exterior towards these patients and these families, I think I would be in a much darker, darker place. That one [traumatic event] took me from…a good headspace to a bad headspace. (P3, L417-420)

Self-Advocate

Self-advocacy for patients is a vital component of being a nurse. The CCN advocates for patients daily, from physician order verification and requests for comfort interventions to upholding the patients' wishes for end-of-life care. Study participants reported *self-advocacy* related to seeking professional support outside of the hospital as a coping mechanism for traumatic events. Participants noted using non-affiliated therapists and counselors to provide sessions to discuss the events and manage the potential negative influences from the workplace culture. Participants also shared that they have spoken up to unit management and administration in recent years about better working conditions for nurses and better care to be delivered to patients. It was noted that the

experienced CCNs were more inclined to begin to speak up for themselves and the patient's best interest, "I was far enough into my career at that point that … I didn't have a problem with poking buttons…" (P3, L175-176). Other forms of being a *self-advocate* among the participants included participants seeking supportive resources, such as a licensed therapist or counselor, due to the unit management and hospital administration not directly aiding the CCN at any moment during or after the traumatic event. Participants noted that the supportive resources they sought after themselves directly decreased the adverse effects caused by the traumatic event. One CCN noted, "…it helped me substantially because through therapy, I was able to really verbalize and parse through my true feelings instead of the default of just mad as hell" (P10, L614-615). However, one participant shared their experience with a therapist who was unable to relate to the CCN's experience, "So to have someone validate those feelings, it's like, okay, 'Well, thank you, even though you don't know what I'm talking about'" (P10, L619-620). The struggle for P10 was finding someone to talk to who could relate and truly empathize with the CCN's experience, someone who had simply performed chest compressions on a dying patient, or stepped foot in the critical care environment. Another participant recalled, after a few meetings with their therapist, that the therapist could not fully comprehend the magnitude of the CCN's experience and could no longer be of service. Data analysis did, however, reveal that some of the participants shared the sentiment that licensed professionals did assist in some way in their trauma, although it was difficult for the licensed professional to relate to the traumatic experiences. Multiple participants also sought anti-anxiety and anti-depressant medications since becoming a nurse just to cope with the job, environment, and work culture. Other participants stated

that they began new hobbies outside of work to destress and detach themselves from work. Some hobbies included biking, taking walks, physical activity, and reading. Many of the participants also stated that it was not uncommon for themselves and/or other CCNs to cope using alcohol and other substances, binge-watching TV shows, secluding themselves from others, and sleeping for long periods of time. Many participants stated the use of alcohol in general and the common gathering of CCNs at a local bar to decompress after a long shift was used as a coping mechanism within the CCN culture.

SUMMARY OF CHAPTER 4: FINDINGS

Chapter Four presented four major themes: *normalizing the abnormal*, *suffering in silence*, *badge of honor*, and *resilience.* The major themes of the study depict self-identified traumatic events experienced by the study participants, how the CCN workplace culture influences the nurse's response to and coping with distressful encounters in the clinical environment, and what supportive resources were available to the CCN.

Normalizing the abnormal daily encounters revealed the study participants' detailed self-identified traumatic experiences. Sub-themes emerged, including the *detailed encounters*, a *delayed realization* of the adverse effects on the CCN, *repetitive trauma*, a *next bed, next patient* mentality, and *this is the job, buck up*. Participants shared that their experiences within the critical care environment are not "normal" compared to others' experiences in the workplace or daily life and found that non-CCNs could not relate, which added to their feelings of isolation. The chaotic, high-stress environment of critical care includes repetitive events that the CCN may experience. Experiences of

CCNs in the clinical setting were seen to include failed resuscitations, forcing nurses to care for more than the expected patient load, working in short-staffed conditions, providing emergent lifesaving medical treatment, physical violence, caring for high-profile patients, and lack of support from leadership and members of the healthcare team. Most participants recall the realization of the delayed adverse effects, which often did not become known until arriving home after the shift, days to months after the experience, or after leaving the position. Data analysis also revealed a CCN culture mentality of *next bed, next patient,* to demonstrate the inability of CCNs to have a moment to process the traumatic event in the immediate aftermath. The CCN workplace environment was described as one that quickly assigns a new patient to a nurse once a previous patient is deceased with a quick turnover or the expectations of CCNs continuing to the next patient within their shift assignment. The CCN culture was also noted to be non-supportive of the nurse's experienced trauma by normalizing the experience as being "just part of the job" and moving on.

The workplace culture of the CCN supported an environment that caused the nurse to *suffer in silence*. Sub-themes emerging from the data included *losing faith in the* system, *compartmentalize and disassociate*, to *be seen and not heard*, and *knowledge and resource deficit*. Some of the participants described the isolation that many CCNs experience related to the overall CCN culture, fear of violating HIPAA, the lack of supportive resources, and licensed professionals lacking knowledge or experience of the lived experiences, and the vulnerability and fear of appearing weak to colleagues, patients, and society. Data analysis revealed a lack of support from hospital administration towards CCNs, especially when the patient's best interest was at stake.

Participants stated there is a fear among CCNs to voice their concerns or details of events due to the potential of retaliation and/or being reprimanded for simply doing their job. Participants reported using coping mechanisms of compartmentalizing and disassociating from the traumatic event(s). Participants reflected on the necessity of pushing down the thoughts, details, and emotions from the experienced trauma to be able to function effectively in their personal and professional roles in the immediate aftermath of the traumatic event. Another silencer within the CCN culture includes the attitudes of CCNs, especially experienced and older nurses that downplay the traumatic experience of another CCN and discourage talking about the adverse effects of the event. Participants also voiced the fear of being questioned about their ability to be a CCN and care for patients if they voiced being affected by an experience. Lastly, only one out of eleven participants was directly offered a supportive resource from the hospital following a traumatic event. Participants shared a common feeling of a lack of knowledge among staff and leadership of supportive resources that could be provided to the affected CCNs. Also, participants felt there was a lack of knowledge among leadership on implementing a supportive resource for the staff.

CCNs were also noted to wear a *badge of honor* with a sub-theme of *others first, nurse second*. Data revealed that CCNs are proud of their ability to serve the sickest of the sick and the requirement of being tough. Participants voiced that CCNs take pride in their work and the meticulous nature of their skill set and care delivery. Participants also described the prioritization of other's needs above all else as a mentality and a way of life for the CCN. The CCN culture was noted to not ask for assistance or divulge information relating to experienced trauma due to fear of being a burden to others.

Finally, the data analysis revealed CCNs to have *resilience* as a means of survival from the workplace culture, environment, and experienced trauma. Sub-themes from the data included a *dark sense of humor*, having *hardened armor*, and being a *self-advocate*. All participants described the CCN culture as having a sense of humor that is dark and crass to immediately cope during and after a traumatic event or to simply survive in the critical care environment. Participants noted that making inappropriate statements and jokes allowed the CCN to desensitize the situation and disengage from the trauma being experienced. Even though humor was pointed out as a needed defense mechanism, it was also noted that some participants felt remorse for having this type of humor within the culture. The hardened personalities of CCNs were also noted as a potential expectation within the CCN culture. Participants shared experiences of the defense mechanism, including not sharing emotions and proving to be the toughest of the group by not showing how an experience affected them. Lastly, the data analysis revealed the necessity of the CCN to seek supportive resources or coping mechanisms on their own, whether healthy or unhealthy. Many of the participants sought non-affiliated licensed professionals for therapy and counseling to discuss the trauma and to seek pharmaceutical interventions. Participants also mentioned the emerging advocacy of speaking to unit management and administration for better working conditions. Data analysis also revealed the use of healthy and unhealthy coping mechanisms among CCNs, including newfound hobbies and the use of alcohol to decompress.

PLAN FOR REMAINING CHAPTER

Chapter Five will review the study's methodology, a brief discussion of the findings, and implications of the study findings. The Chapter will also compare the

findings to the extant literature and identify the study's strengths and limitations. The Chapter will conclude with suggestions for future research related to the study.

CHAPTER 5: CONCLUSIONS, DISCUSSION, AND RECOMMENDATIONS

INTRODUCTION

This research study focused on the self-identified traumatic events from the perspectives of CCNs in the U.S. and the exploration of the influences from the workplace culture. The FE study (Roper & Shapira, 2000; Fetterman, 2020) was utilized to explore the impact of workplace culture on the CCN's response to and treatment of self-identified traumatic event(s) and to examine the supportive interventions offered to the CCN. Chapter Five will provide an overview of the study's problem statement and discuss the methodology used to answer the study's research question. Chapter Five will also briefly review the study's findings and compare them to the extant literature. The Chapter continues to discuss the implications of the study findings and identify the study's strengths and limitations. Chapter Five concludes with suggestions for future research related to self-identified traumatic events among CCNs and a conclusion of the study.

STATEMENT OF THE PROBLEM

The NIOSH (2022) issued a statement that 20 million healthcare workers in the U.S. are at risk for adverse effects from mental health disorders, which are directly related to the workplace environment and experiences. The COVID-19 pandemic illuminated the pre-existing conditions for nurses leading to the decline in nurses' mental health (Bowie, 2022). A four-phase study of the ANF and McKinsey (2023), Pulse

Survey revealed nurse turnover rates have surpassed pre-pandemic numbers, increased rates of nurse burnout and emotional exhaustion related to their job, and the lack of offered supportive resources for mental health support (Berlin et al., 2023).

The CCN, as defined for this study, includes nurses working in the ED and ICU who experience a variety of traumatic and distressing events such as witnessing failed resuscitations, caring for patients at the end of life, deaths of young children, traumatic injuries, and treatment errors. A traumatic event is defined as any extreme event causing one's ability to cope to be threatened, resulting in unusual and strong cognitive, emotional, or behavioral reactions (Kleim et al., 2015). The American Psychological Association (2018) defines trauma as "any disturbing experience that results in significant fear, helplessness, dissociation, confusion, or other disruptive feelings intense enough to have a long-lasting negative effect on a person's attitudes, behavior, and other aspects of functioning" (trauma, para. 1). It is important to note the single term ‘trauma’ is often complex to define due to its subjective nature related to the individual victim (Hoon, 2012).

While nursing research has identified the quantifiable presence of mental health disorder symptoms among nurses (AACN, 2022; ANF 2021, 2023; Berlin et al., 2023; Choflet et al., 2021; Kelsey et al., 2017; Stelnicki et al., 2020), the review of the literature revealed a lack of qualitative research exploring the root cause of the mental health symptoms among CCNs and a lack of exploration of the perceptions of CCNs and the subjective nature of self-identified traumatic events. Extant literature is limited in using ethnographic methods to explore the CCN workplace culture. The literature review also revealed no prior ethnographic studies focusing on the CCN’s perceptions and

experiences of self-identified traumatic events and the workplace culture's influence on the CCN's response to and coping with trauma.

REVIEW OF THE METHODOLOGY

The study utilized Roper and Shapira's (2000), drawing on the seminal work of Fetterman (2020), nursing research approach of FE to address the research question: "What are critical care nurses' experiences and responses to a self-identified traumatic event(s) in the emergency department or intensive-care unit settings that caused them distress?" The ethnographic methodology allows for a holistic approach on a specified problem or phenomenon to gain insight and knowledge about an individual within a smaller cultural group (CCNs) and their interaction with the phenomenon (self-identified traumatic events) (Roper & Shapira, 2000). Roper and Shapira emphasize the use of ethnography allows for the discovery of unique and specific beliefs and practices of CCNs in response to self-identified traumatic events causing distress within ED and ICU clinical setting. Such comparisons allow for the opportunity of theories to be developed and potentially be examined in other relatable events or situations.

The UTMB IRB approved the study and all procedures. Eleven RNs who have served as CCNs for a minimum of one year and experienced distress from a traumatic event in the clinical setting were recruited as study participants by purposive and snowball sampling. Study data was collected using recorded video and audio encrypted Zoom® conference calls for the semi-structured interview. The study participants' demographic data and responses to interview questions were recorded and then transcribed through the secure artificial intelligence technology of Otter.ai™ for

accuracy. De-identification of transcripts and the researcher's memos and journals were used for data analysis. The CCM (Glaser, 1998; Glaser and Strauss, 1967) guided the qualitative data analysis for continuous data comparison to allow for a rich analysis of emerging themes and sub-themes, beginning at the first contact with participants. Redundancy and data saturation were achieved within the data once all emerging themes and sub-themes had been identified during data collection. Beck's (1993) criteria for scientific rigor, consisting of credibility, fittingness, and auditability was utilized as a guide for trustworthiness in the study procedures. Member checking was utilized to confirm the interpretations of the data reflected the participants' traumatic events and the beliefs and practices of the CCN workplace culture.

INTERPRETATION OF THE FINDINGS

The study used Roper and Shapira's (2000) FE approach to examine the perceptions and experiences of self-identified traumatic events causing distress among CCNs in the clinical work environment. Data analysis revealed the emergence of four main themes: *normalizing the abnormal*, *suffering in silence*, *badge of honor*, and *resilience: we are CCNs*. Despite the recent COVID-19 pandemic illuminating the current state of the nursing crisis and workplace environment, traumatic events continue to negatively affect the mental health of CCNs in the U.S. The CCNs who participated in this study shared raw and subjective encounters with traumatic events that were psychologically, emotionally, and physically taxing on the participant. The CCN culture was presented as being influenced by both internal and external factors for the CCN leading to the abnormal and repetitive traumatic experiences being accepted as the norm

for the critical care environment. CCNs shared a sense of fear, isolation, and being unsupported and silenced after experiencing a traumatic event. CCNs also developed a loss of trust in the institution and experienced a lack of supportive resources in the immediate aftermath. The CCN culture also influenced the CCN at times to have a loss of confidence in the ability to care for the sickest of the sick, develop a hardened armor for protection, compartmentalize and disassociate from the event(s), and develop an inappropriate and dark sense of humor. CCNs were also noted to adopt healthy and unhealthy coping mechanisms as a way of resilience to survive their experiences and to be self-advocates to receive the supportive resources needed to cope. Data analysis also revealed that most participants with more than five years of experience no longer work in critical care as bedside RNs.

COMPARISON TO EXTANT LITERATURE

There is a dearth of literature exploring the perceptions and experiences of self-identified traumatic events among CCNs in the clinical care environment. No studies to date have been located that specifically examined the subjective nature of the CCN's experience of traumatic events. Also, there were no studies found exploring the CCN workplace culture influence on how the CCN responded to and coped with a self-identified traumatic event in the clinical setting. Current studies addressing trauma experienced by CCNs or the nursing profession, in general, examine the quantifiable data of adverse effects from the nurse's experience and not the root cause or subjective nature of the self-identified traumatic event.

Nonetheless, the findings from the current study support findings from other relatable studies that have explored nurses' recent mental and emotional states, potential barriers to supportive resources of nurses, and the CCN workplace culture. Participants in the current study experienced traumatic events in the critical care environment occurring before and during the COVID-19 pandemic that caused them to experience self-reported adverse effects on their psyche, such as stress and anxiety. This finding is consistent with that of Wang et al. (2015), Gu et al. (2018), Melnyk et al. (2018), and Hu et al. (2020), who reported adverse effects on the psyche of nurses, such as increased rates of anxiety and depression directly related to occupational stressors and experiences. The participants in the current study recalled the self-identified traumatic event(s) in detail, including vivid descriptions such as the environment, situation, individuals involved, and personal sensory effects. These findings are consistent with Kleim et al. (2015) study findings of nurses recalling traumatic events as intrusive memories, including smells, tastes, sounds, and thoughts. Each of the current study participant's traumatic event(s) was unique and individualistic, supported by Hoon (2012), who states that trauma is often complex to define due to the subjective nature based on the individual victim. All study participants were exposed almost daily to repetitive traumatic experiences in the clinical setting, causing some level of distress. The repetitive exposure to traumatic events among the participants was also noted to cause distractions during the delivery of care to patients in the immediate aftermath of the event. Dodek et al. (2019) found that distress negatively impacts the nurse and causes significant emotional consequences, leading to distraction during patient care. Shonkoff and Garner (2012) found that repetitive exposure to traumatic events can cause an individual to be overstimulated, leading to hyperarousal or

dissociative responses. Disassociation from the traumatic event was found in the current study as a response by many of the participants as a coping mechanism to separate themselves from the experience. Dorland (2007) stated dissociation relates to the disconnection from emotions, memories, sensations, and thoughts.

Multiple findings in the current study aligned with Scholtz et al.'s (2016) ethnographic study, which explored and described the general CCN culture. The current study's participants described the CCN work environment as demanding and stressful, with traumatic events that were taxing emotionally, mentally, and physically. The current study also found that participants had a sense of helplessness and feelings of guilt related to the traumatic event outcomes. Scholtz et al. found the CCN culture had patterns of behavior and interaction among the nurses, including despondency due to the demands of the critical care environment and stressful work conditions that challenged the CCN mentally, ethically, and physically. Scholtz et al. also found that the overall outcome of patients influenced the nurses' well-being. The current study found that hospital administration and physicians did not support participants when advocating for themselves or the patient during or after a traumatic event and had an expectation of "next bed, next patient." The study findings also found the CCN culture to adopt resiliency and defense mechanisms as a way of coping, such as having an inappropriate and dark sense of humor, hardened personalities, and compartmentalizing and disassociating from the event. Scholtz et al. found the CCN culture to have patterns of non-support from hospital leadership and physicians, a protective armor-like personality to protect themselves, to hold back the emotion after the death of a patient and continue

to the next patient as if they were emotionally disconnected, and rarely speaking of the event or seek supportive resources.

Approximately 80% of the current study's participants were not directly offered a supportive resource to cope with the traumatic experience(s). This finding is like the Berlin et al. (2023) fourth phase of the Pulse Survey's astounding finding that despite nurses reporting higher levels of burnout and other adverse effects caused by distress from the work environment, approximately two-thirds of nurses did not receive resources for mental health support. The current study participants stated that although supportive resources, such as debriefing, were not offered, they would have participated. Healy and Tyrrell's (2013) study of ED nurses and providers who experienced trauma reported that debriefing was vital; however, most participants were not offered debriefing. The current study also found that the CCN workplace culture may influence the individual CCN to not talk about their traumatic experiences, as it shows a sign of weakness and the inability to manage the critical care environment. This finding also aligns with that of Berlin et al. (2023) for barriers to receiving supportive resources after a traumatic event due to overall stigma among nurses. Ross et al. (2018) also found that the nursing culture discourages open discussion of distressful experiences, leading to silence and/or the use of substances as a coping strategy. Participants in the current study shared the use of alcohol and substances to cope with traumatic events, supported by the findings of Choflet et al. (2021) and Ross et al.'s (2018) studies showing a disturbing pattern of substance abuse as a way of coping with distressful clinical experiences among nurses.

The current study was the first to explore CCNs' perceptions and experiences of self-identified traumatic events causing distress in the clinical setting. The study findings of

this FE differ from the extant literature due to the nature of exploring the root cause of the adverse effects of trauma on the CCN and the influence of CCN culture to respond to and cope with the event. The findings provided detailed encounters of the participants to illustrate the true subjective nature of traumatic experiences in the daily lives of CCNs. The findings tell a story of the participant and the CCN workplace culture that a quantitative instrument or survey may not provide. The experiences of traumatic events discussed in the current study also indicate that trauma can be caused by more than a traumatic patient encounter and can include physical, mental, and emotional threats to the CCN by internal and external influences of the CCN culture.

STUDY IMPLICATIONS

This research study's findings have implications for researchers, nursing administration and healthcare organizations, individual nurses, and nursing education. The study allowed CCNs to share the self-identified traumatic event(s) that negatively affected them on a personal level and, at times, distracted them from providing safe patient care. Furthermore, the study illuminated the availability, or the lack thereof, and use of supportive resources after a self-identified traumatic event for CCNs. Understanding the experiences of CCNs following a self-identified traumatic event and the needed resources could help prevent future experiences of distress and allow for the availability of needed supportive services. Knowledge gained from the study has the potential to contribute to a better understanding and awareness for CCNs and the nursing profession on the perceptions and experiences of CCNs who experienced a traumatic event. The results of the study have the potential to positively influence advocacy

behaviors for nurses who experience self-identified traumatic events that will undoubtedly impact the quality of life for the nurse and the ability to provide safe patient care.

Implications for Researchers

The current study has shown that traumatic experiences among CCNs are unique and individualistic. Researchers should consider including the root cause of experienced trauma and adverse effects among CCNs to further analyze how the CCN culture is being affected. Additional qualitative research is needed to investigate nurses' experiences further. Also, quantitative research should be utilized with a focus on the correlation between traumatic experiences among nurses and the quality of patient care and patient safety. Researchers should also study the types of supportive interventions being offered, or the lack thereof, to CCNs in the immediate aftermath and long-term post-experience of traumatic events to better understand the effectiveness and overall implementation to mitigate adverse effects on nurses. More importantly, researchers should increase the research focus on evidence-based practices for caring for the nurse with as much importance and urgency as caring for the patient.

Implications for Nursing Administration and the Healthcare Organization

The current study findings suggest that CCNs lack support from hospital and organizational leadership to mitigate traumatic experiences and adverse effects. Multiple participants discussed the lack of support received when advocating for patients or themselves before, during, or after a traumatic event. The ANA (2015) stated nurses have the “ethical, moral, and legal responsibility to create a healthy and safe work

environment" (p. 1). The ANA speaks for all nurses, no matter the position held in an organization, who are obligated to address all types of traumatic events in the work environment and foster an environment that supports the overall well-being of the nurse. Epstein et al. (2020) emphasized the moral obligation of the organization to mitigate adverse effects and foster the action of understanding the healthcare professional's needs. Nursing and hospital leadership should be educated on identifying traumatic events and seeking the root cause of adverse events among their nurses. Leadership should also ensure that all members of the organization understand that traumatic events are subjective, what supportive resources are available, and how to disseminate the resources in a timely and effective manner. Moreover, leadership and the overall organization should address barriers to identifying traumatic events and CCNs receiving support. The goal of every member within the organization should be to feel safe and welcome to share potential and current traumatic events. It should also be adopted in the unit and organizational culture to offer and seek supportive resources to decrease adverse effects on the nurse and delivery of patient care while improving the overall well-being of the nurse and work culture. Organizations must seek immediate action to identify experienced trauma among staff and the availability and effectiveness of current supportive resource practices. Organizational policies and educational methods must be reviewed and revised periodically to best support the overall well-being of the workplace culture and individuals.

Implications for Individual Nurses and CCN Culture

CCNs may not realize the severity of the adverse effects of the experienced traumatic event based on the influence of the CCN workplace culture. Nurses should

reflect on their individual experiences and advocate for themselves when they feel their well-being is jeopardized. Nurses should also speak up and speak out regarding their self-identified traumatic experiences to advocate for themselves and influence change within the nursing culture and overall nursing profession. Nurses who are victims of traumatic events often are not supported by nursing or organizational leadership and must advocate for change in organizational policies to protect nurses and advocate for changes in the unit and organizational culture. Nurses also need to realize the beliefs or practices within the culture can change by addressing the toxicity within the unit culture. The normalization of responding to and coping with traumatic events should be directly addressed by the nurses within the unit to advocate for positive change. Positive change should include encouraging other nurses to speak about their experiences without judgment or degrading their professional character. Other positive changes should incorporate supportive resources such as debriefing as a normalized practice after a traumatic event to support the unit culture. Nurses should also ensure a welcoming and safe environment for one another and mentor new nurses with a positive attitude instead of "eating their young." Nurses should evaluate their unit culture and make positive changes to include a strong voice in advocacy for nurses' emotional, mental, and physical well-being. Nurses should stop normalizing the abnormal work environments and toxic behaviors within the culture and start normalizing healthy coping mechanisms and positive work culture.

Implications for Professional Nursing Organizations

Professional nursing organizations can bring local, national, and international attention to the pre-existing and current adverse effects nurses encounter repeatedly,

especially traumatic events. The COVID-19 pandemic illuminated a brighter light on the nursing stage, allowing ample opportunities for meaningful advocacy and policy change for nurses and their work environment. Professional nursing organizations should continue to advocate for significant policy change, including mandated organizational training and education on identifying trauma in nurses and implementing certified supportive resources with trained facilitators. Professional nursing organizations should also call for positive change in the unit and nursing culture to be inclusive of discussing personal and traumatic experiences, eliminating stigmas and judgment on the individual's professional character and reputation. Professional organizations should also promote research on evidence-based practices in caring for the nurse with as much importance and urgency as researching evidence-based practices for patient care.

Strengths and Limitations

This FE study has several strengths and limitations. Strengths of the study include results served as a platform for CCNs, and potentially all nurses, who are often underrepresented in research focused on perceptions and experiences with self-identified traumatic events. The study also provides the opportunity to present the availability of supportive resources to CCNs after experiencing a self-identified traumatic event and recommendations for future improvements. The influences of the self-identified traumatic experience can negatively affect the CCN's ability to return immediately to patient care and practice safely. The study allowed for a better understanding of the limitations and hindrances of traumatic events and provided opportunities to develop implications for

future practice. The study also draws on the researcher's clinical experiences and personal and professional knowledge of self-identified traumatic events.

Some elements of this study may be seen as potential limitations of the study. Limitations may include the sample size (n = 11) and specified population of nurses, overall decreasing potential transferability. Although the CCN population is open to all critical care areas within the ED and ICUs, participation may still limit the diversity of CCNs for the study based on the recruitment of nurses and their critical care specialty. Efforts were made to recruit from multiple CCN groups, such as ED and ICU specific. As with many qualitative studies, another potential limitation was that the participants were self-selected and self-identified as having experienced a traumatic event in the clinical environment that caused them distress as a CCN; therefore, it is not known why other CCNs who experienced traumatic events did not participate in the research study. Finally, limited availability to critical care environments, specifically that of all study participants, did not allow a truly immersive experience for the researcher to observe in the field.

RECOMMENDATIONS FOR FUTURE RESEARCH

Future research must focus on the perceptions and experiences of all nurses who experience a traumatic event and emphasize the individual nurse's definition of a *traumatic event*. Replicating the current study to represent a larger sample size, more diverse clinical settings, and a more diverse population of nurse specialties, as well as those who have left the nursing profession, may help confirm, add to, or refute the current study findings. Replication of this study may also be transferrable to other professions

and occupations that may experience traumatic events to enhance the exploration of traumatic events and the influence of workplace culture in the work environment.

Studies comparing supportive resources from other professions, such as the military, aviation, and first responders in the healthcare setting, are worthy of consideration. Furthermore, an emphasis on the quality and detail of supportive resources offered to nurses, the effectiveness of positively influencing the nurse's life, and the ability to provide safe patient care after the experience must be considered. Other areas of exploration include education on supportive resources and identifying signs and symptoms of distress to nurses, nursing leadership, and hospital administration.

Future studies utilizing other methodologies to gain additional knowledge and formulate theoretical frameworks related to perceptions and experiences of traumatic events may be warranted. Quantitative methods could be used to quantify the occurrence of traumatic events, explore the types of supportive resources offered, and determine the effectiveness of supportive resources. Other qualitative methods, such as Grounded Theory, could develop theories directly related to the CCN experiences of traumatic events in the clinical environment or the CCN workplace culture and traumatic events.

CONCLUSION

CCNs experience traumatic events nearly every shift in the clinical environment that causes distress, yet limited research has incorporated the perspectives and experiences of the CCN. This FE study explored the perceptions and experiences of CCNs who encountered a self-identified traumatic event(s) in the clinical setting that caused them distress. The study data comprised interviews with the eleven study

participants and the researcher's journals and memos. The CCM (Glaser, 1998; Glaser & Strauss, 1976) technique was utilized to analyze the data, allowing the emergence of the four main themes of *normalizing the* abnormal, *suffering in silence*, *badge of honor*, and *resilience: we are CCNs*. This study was the first to explore the perspectives and experiences of CCNs and how the CCN culture influences the CCN's response to and coping with traumatic events. The results of this study could potentially lead to significant change(s) to expand research and the development of related policies to assist not only CCNs but all nurses with identifying, mitigating, and responding to traumatic events.

APPENDIX A: IRB APPROVAL LETTER

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Institutional Review Board
301 University Blvd.
Galveston, TX 77555-0158
Submission Page

02-May-2023

MEMORANDUM

TO: Judson Lagrone
Grad School Biomedical Science GSBS9999

FROM: Jacqueline S. Meyer PhD
Vice-Chairman, IRB #1

RE: Initial Study Approval

IRB #: IRB # 23-0100

Submission Number: 23-0100.003

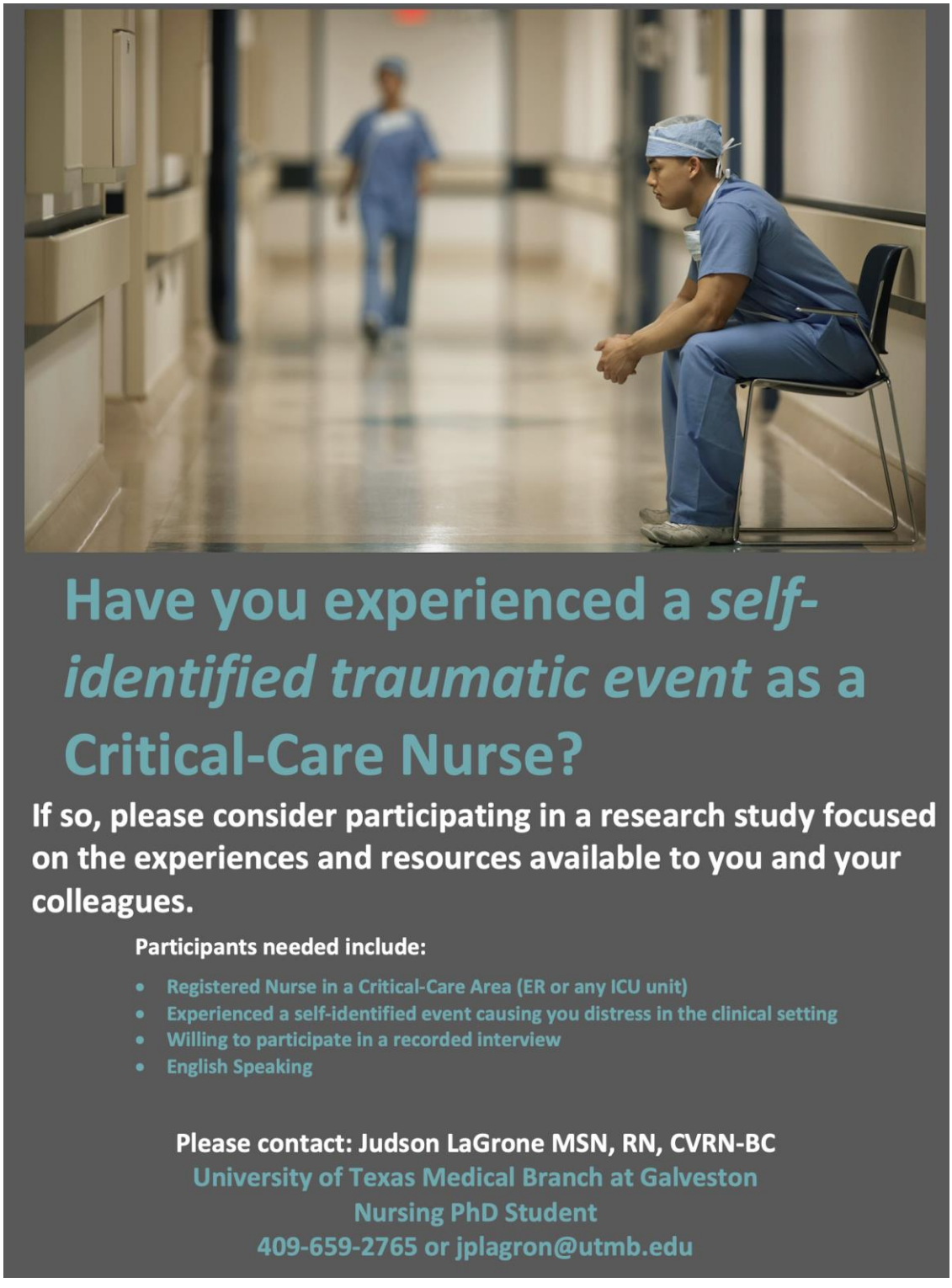
TITLE: An Ethnographic Study: Perceptions, Experiences, and Supportive Practices of Critical Care Nurses and Self-identified Traumatic Events

DOCUMENTS:
Research Protocol
Bio-Demographic Data Sheet
Email to Potential Participant
Fast Facts Sheet
Interview Guide
Recruitment Flyer
Reflexive Journal Template
Resources for Distressed Participant
Verbal Consent Script

The UTMB Institutional Review Board (IRB) reviewed the above-referenced research protocol via an expedited review procedure on **02-May-2023** in accordance with 45 CFR 46.110(a)-(b)(1). Having met all applicable requirements, the research protocol is approved. The approval for this research protocol begins on **02-May-2023.**

Continuing Review for this protocol is not required, as outlined in 45 CFR 46.109. A Status Report is required to be submitted to the IRB every three (3) years. A reminder will be sent approximately 90 days prior to its due

APPENDIX B: STUDY RECRUITMENT FLIER



APPENDIX C: EMAIL TO INTERESTED STUDY PARTICIPANT

Dear Colleague,

My name is Judson LaGrone, and I am a PhD Nursing Student at the University of Texas Medical Branch in Galveston, Texas. This email is a follow-up to your interest to participate in a research study. The interview is for my dissertation research which is a study of **Perceptions, Experiences, and Supportive Practices of Critical Care Nurses and Self-identified Traumatic Events.** Your participation would be to take part in a recorded interview lasting no more than 90 minutes. I believe your participation in the study and your previous experience(s) as a critical care nurse could provide valuable information on the types of self-identified traumatic events that you personally experienced in the clinical setting that have caused you distress.

As a critical care nurse since 2012, I know first-hand of the increased potential of experiencing a traumatic event that has caused distress in the clinical setting for the nurse. The purpose of this study is to examine self-identified traumatic events reported by critical care nurses in the clinical setting and how their work-place culture impacts the response. Also, the study aims to examine any formal and/or informal supportive interventions offered to the critical care nurse related to the work-related traumatic event. My hope is that by studying this topic, attention can be brought to this important subject, and with that, nurses may receive any needed support and intervention to improve their mental health and ability to continue safe patient care.

There are few criteria that each participant must meet prior to participate in the study:

- have worked in critical care areas for a minimum of one year (emergency department [ED] and intensive-care units [ICU])
- have experienced a self-identified traumatic event in the ED or ICU clinical setting causing distress to the nurse
- have access to a computer or tablet with internet
- are able to participate in online data collection and video conferencing
- are able to read, write, and speak English

You may find more in-depth information that you should know about this study in the attached document titled “Fast Facts Sheet.” Your participation is completely voluntary and all information you provide will remain confidential. Once you have read the attached information sheet and feel that you meet all the required participation criteria, please respond to this email with your willingness to participate. Also in your response, please provide several dates and times that you are available for a 90-minute interview using the video conferencing platform Zoom. You do not need a subscription to Zoom to participate. On the agreed upon date and time, I will provide you with an oral consent, collect confidential demographic data, and perform the interview. You may withdraw from the study at any time with no repercussions. If you do withdraw from the study before completing the interview, your information and any collected data will be destroyed and not used in the study.

Once again, I greatly appreciate your interest to participate. If you have questions or concerns about this study, please feel free to contact me at the email address provided below or within the attached Fast Facts Sheet.

The University of Texas Medical Branch (UTMB) committee that reviews research on human subjects, the Institutional Review Board (IRB) will answer any questions about your rights as a research subject and take any comments or complaints you may wish to offer. You may contact the IRB Office via email irb@utmb.edu.

Respectfully,

Judson LaGrone, MSN-Ed, RN, CVRN-BC
Doctoral Student
University of Texas Medical Branch at Galveston
Graduate School of Biomedical Sciences and School of Nursing
301 University Blvd.
Galveston, Texas 77555-1029

Primary Investigator Contact Information:
Judson LaGrone
Email: jplagron@utmb.edu

APPENDIX D: FAST FACT SHEET

utmb Health

FAST FACT SHEET **IRB#: 23-0100**

Study Name: Self-Identified Traumatic Events Among CCNs

Contact Information:
Principal Investigator: Judson LaGrone, Nursing PhD Student
Phone: (409) 659-2765
Email: jplagron@utmb.edu

Study Supervisor: Dr. J. Michael Leger, PhD, MBA, RN, CNL, NEA-BC, CNE
Office: (409) 772 - 8327
Email: jmleger@utmb.edu

What is the purpose of this research study?
The purpose of the study is to explore critical care nurses and the experiences of self-identified traumatic events in the work environment and the influence of work culture and the availability of supportive services to aid in coping.

What are the Research Procedures?
If you agree to take part, you will be asked to verbalize your consent to participate in the study and complete the following procedures. A ten-question demographic survey will be provided to you to be filled out completely prior to meeting with the principal investigator for a 60–90-minute video conferenced interview. The interview will be recorded and transcribed with the transcripts provided to you to review for accuracy. Each participant will be assigned a unique identifier for your privacy that will be on your demographic survey and stated at the beginning of your recorded interview to remove any personal data from the collected materials. The use of direct quotes may be used when reporting findings of the study with no identifiers. Interviews will be conducted through an encrypted link with recording and other documents stored on an encrypted and password protected hard drive. All study materials and documents will be stored in a lockbox when not in use. As a participant, you may be asked for a follow-up interview lasting no more than 30 minutes.

What are the Risks and Benefits?
Any time information is collected; there is a potential risk for loss of confidentiality. Every effort will be made to keep your information confidential; however, this cannot be guaranteed. During interviews, there is a risk of fatigue and/or emotional distress to occur for the participant when reflecting on past experiences. If at any time during your participation in the study you experience fatigue or distress, the principal investigator will offer opportunities to rest and continue the study per your preference. Also, you will be provided with resources of websites and hotlines to receive assistance if needed for experienced distress.

There are no direct benefits from participating in this study. We hope the information gained from this study will benefit other nurses who have experienced similar situations in the future.

Cost:
There is no cost to participate in this study.

How will my information be protected?
All results obtained in this study will be kept confidential and only available to the principal investigator. Your individual information will not be reported, only the results of all participants as a group. If a direct quote is included in the study results, your personal identification information will not be included in the report. Data collected in this research might be de-identified and used for future research or distributed to another investigator for future research without your consent.

How can I withdraw from the study?
Your participation in this study is completely voluntary. You may withdraw from the study before, during, or after the interview process. To completely withdraw from the study, you must notify the principal investigator at the contact information above. If you choose to withdraw from the study for any reason, any collected data will be destroyed and not used in the study.

Who can I contact with questions about this research study?
This study has been approved by the UTMB Institutional Review Board (IRB). If you have any complaints, concerns, input or questions regarding your rights as a subject participating in this research study or you would like more information about the protection of human subjects in research, you may contact the IRB Office via email irb@utmb.edu.

For questions about the study, contact Judson LaGrone or Dr. Martin at the numbers or emails listed above.

Before you agree to participate, make sure you have read the information provided above, your questions have been answered to your satisfaction, you have been informed that your participation is voluntary, and you have freely decided to participate in this research.

This form is yours to keep.

APPENDIX E: NARRATIVE FOR OBTAINING VERBAL CONSENT

Previously, we have discussed your desire and ability to participate in my research study exploring the perceptions and experiences of critical care nurses after a self-identified traumatic event causing distress to the nurse in the clinical setting. This research study is in conjunction with the course of study for my doctorate in philosophy of nursing at the University of Texas Medical Branch at Galveston.

You have stated that you are a critical care nurse who has or is currently working in the critical care setting and experienced one or more self-identified traumatic events in the clinical setting which has caused you a form of distress. As discussed, I want to explore critical care nurses' perceptions and experiences of self-identified traumatic events in the clinical setting and the availability of supportive resources. This study is expected to pose a very low risk to participants. Potential risks of participation include breach of confidentiality, emotional distress related to the discussion of the topic, and the participant or interview fatigue.

Any time information is collected, there is a potential risk of losing confidentiality. Every effort will be made to keep your information confidential; however, this cannot be guaranteed. Each participant will be assigned a unique identifier for your privacy that will be on your demographic survey and stated at the beginning of your recorded interview to remove any personal data from the collected materials. Your individual information will not be reported, only the results of all participants as a group. If a direct quote is included in the study results, your personal identification information will not be included in the report. Data collected in this research might be de-identified and used for future research or distributed to another investigator for future research without your consent.

During interviews, there is a risk of emotional distress occurring for the participant when reflecting on past experiences. Anytime during the data collection process that you may feel emotional distress, you can take a pause or break and determine if the interview is to proceed at a time of your choosing or to be terminated without any obligation.

A ten-question demographic survey will be provided to you at the beginning of the video-conferenced interview that will last no longer than 90 minutes. The interview will be recorded and transcribed for accuracy. The demographic questions and interview questions will be directly related to the research topic: perceptions and experiences of critical care nurses after a self-identified traumatic event which has caused distress to the nurse in the clinical setting. You will be asked if you are willing to participate in additional follow-up interviews to clarify information that you provided in response to the interview questions.

You will not directly benefit from your participation in this research project. The lived experiences shared through interviews will help the nursing profession for critical care nurses to further investigate lived experiences and perceptions of self-identified traumatic

events. The data will also provide insight into the availability or lack of supportive resources, such as debriefing, and perceived benefits and areas for improvement.

Your participation in this study is entirely voluntary. You may refuse to participate or stop your participation in this research study at any time without penalty or loss of benefits to which you are otherwise entitled. As a study participant, it is your right to refuse to answer any question during the data collection process. Your confidentiality, respect of your wishes, and integrity of the collected data are a top priority for me as the researcher of this study.

Are there any questions or need for clarity regarding the study overall or your participation? (Researcher will pause, answer any questions, and then proceed to the next question once all questions have been answered).

At this point, I would like to ask you to confirm you are still willing to participate in the study by acknowledging “yes” or “no.” If you acknowledge “yes,” you agree to participate and give me permission to turn on the recording devices and begin data collection. Do you wish to participate and continue?

APPENDIX F: BIO-DEMOGRAPHIC DATA SHEET

ID Code_____

Date Collected_____

Introduction and consent to record audio: "The recording has begun; can you please confirm again that you have consented to participate in this study, you have received answers to all your questions or areas needing clarity regarding the study? This will attest to you giving oral consent to participate in the described study."

The researcher will collect this data at the beginning of the first data collection session.

1. What critical care area do you currently work in or have worked in (select all that apply)?
    a. Emergency Department
    b. Cardiac ICU
    c. Medical ICU
    d. Neonatal ICU
    e. Neuro ICU
    f. Surgical ICU
    g. Trauma ICU
2. What is the size of the hospital in which you practiced in critical care?
    a. Small hospital (<100 beds)
    b. Medium hospital (100-499 beds)
    c. Large hospital (500 or more beds)
3. Which state(s) have you practiced in as a critical care nurse?
    _____
4. What is your age group?
    a. 20-30
    b. 31-40
    c. 41-50
    d. 51-60+
5. What is your identified gender?
    _____
6. What is your highest level of education in nursing?
    _____

7. How many years have you worked as a nurse?
    a. 1-5 years
    b. 6-10 years
    c. 11-15 years
    d. 16+ years

8. How many years have you worked in critical care?
    a. 1-5 years
    b. 6-10 years
    c. 11-15 years
    d. 16+ years

9. What is your current position as a nurse?
    a. Staff Nurse
    b. Charge Nurse
    c. Nurse Supervisor
    d. Nurse Manager/Director
    e. Other

APPENDIX G: SEMI-STRUCTURED INTERVIEW GUIDE

ID Code_____
Date Collected_____
Start Time_____
End Time_____
Collected via
Zoom Video Communications, Inc.
through encrypted link

Grand-tour Question:
As you know, I am interested in what happens to critical care nurses who have experienced a self-identified traumatic event in their nursing practice and what happens to them afterward. Would you please tell me about a self-identified traumatic event you experienced within the clinical setting that caused you distress as a critical care nurse?

The following are examples of Mini-tour Questions that may be asked to clarify or extend responses to the Grand-tour Question:

1. What effect did this event have on you?
2. What types of distress did this event cause for you?
3. What happened/what did you do immediately after the event?
4. How did you feel when you had to return to providing patient care immediately?
5. Did you feel that you could provide safe patient care immediately after the event? If not, when did you feel you could return to providing safe patient care?
6. How did your employer or manager support you?
7. What resources were made available by your employer to help you deal with the aftereffects of the event?
8. Was any sort of debriefing offered to you immediately after the event? If so, would you please describe it?
9. If you received any sort of support or resources, did it help you?
10. What resources did you seek yourself, if any, and how did it aid in your coping?
11. Did you do anything for yourself to cope with the event, and if so, what did you do?
12. Have you had any other self-identified traumatic clinical experiences you would like to tell me about?
13. Reflecting on your past experiences as a critical care nurse, how often do you believe you were exposed to events that could potentially cause you distress in the clinical setting?

Closing of interview:

Are there any other points or issues that you would like to discuss about your experience(s)?

If you remember something you forgot to mention today, please do not hesitate to email or call me. Here is the information: my email address is jplagron@utmb.edu, and my cell phone number is 409-659-2765.

Would it be okay if I contact you again if I have questions to clarify something you said?

Thank you again for taking the time today to speak with me about your experiences.

APPENDIX H: SUPPORTIVE RESOURCES

Resources for Participants Experiencing Distress

Emotional PPE Project for healthcare workers impacted by COVIS-19 Crisis: https://directory.emotionalppe.org/healthcare-workers-landing

National Alliance on Mental Illness helpline: Call 1-800-950-NAMI (6264), text "HelpLine" to 62640, https://www.nami.org/help

Substance Abuse and Mental Health Services Administration helpline for natural or human-caused disaster distress: Call 1-800-487-4889, https://www.samhsa.gov/find-help/national-helpline

Therapy Aid Coalition website for US healthcare professionals and first responders: https://www.therapyaid.org/

APPENDIX I: REFLEXIVE NOTES TEMPLATE

Reflexive Journal Entry

Participant ID Code_____
Date Collected_____
Circle one: Interview Session
Follow-up Interview Session
Reviewing of Collected Data

REFLEXIVE NOTES WILL GO HERE

APPENDIX J: Otter. ai™ CONFIDENTIALITY AGREEMENT

Lasted Updated October 2, 2023

[See also **Terms of Service**]

This privacy policy ("**Policy**") informs you of our practices when handling your Personal Information through the Services (both as defined below). In this Policy, "**Otter.ai**", "**we**" or "**us**" refers to Otter.ai, Inc., a company registered in Delaware with its registered address located at 800 W El Camino Real, Suite 170, Mountain View, CA 94040. We are the data controller under the applicable privacy laws.

Where we have an Otter Business or enterprise service agreement in place with an enterprise customer who is asking you to use our Services (for example your employer), we obtain and process your Personal Information on behalf of and at the instructions of that customer. In that context, such enterprise customers are the data controllers and their privacy policies will apply to the processing of your Information. We encourage you to read their privacy policies.

For the purpose of this Policy, "**Personal Information**" means any information relating to an identified or identifiable individual. This includes Personal Information you provide or generate when you use: (a) Our Otter meeting assistant app (the "**App**"); and (b), https://otter.ai, and any other dedicated Otter.ai websites (the "**Website**") (collectively, the "**Services**"). When you use the Services, you accept and understand that we collect, process, use, and store your Personal Information as described in this Policy.

If you are a California resident, our Privacy Notice for California Residents includes additional information about your rights and how we collect, use, and share information.

If you do not agree with this Policy, you must not use any of the Services. If you change your mind in the future you must stop using the Services and you may exercise your rights concerning your Personal Information as set out in this Policy.

1. INFORMATION WE COLLECT

We will collect and use the following Personal Information about you:

Information you provide to us

- **Registration Information**. When you create an account on our Services, you will be asked to provide your name, email, and a password, you may voluntarily add a profile picture. For Pro or Business plans which are paid Services, our

payment processing partner Stripe, Inc. may also collect your name, billing address, and payment information. Payment information is not shared with us and is maintained by Stripe.

- **App Information**. When you use the Services, you may provide us with your audio recordings ("Audio Recordings"), automatic OtterPilot™ screenshots and any text, images or videos that you upload or provide to us in the context of the Services. OtterPilot may take automatic screenshots which are available meeting transcripts to add value to the meetings by extracting useful visual information. The automatic screenshots will only take place in virtual meetings.
- **Communication Information**. When you contact us, you provide us with your phone number, email, and any other information you choose to provide over such communication, including information about your query.

Information you provide us about others

- If you choose to collaborate on a task with your co-workers or friends, or refer us to them, you provide us with the email address and contact information of your co-workers or friends.
- If you provide an Audio Recording, this may contain the Personal Information of third parties. Before you do so, please make sure you have the necessary permissions from your co-workers, friends or other third parties before sharing Personal Information or referring them to us.

Information we automatically collect or is generated about you when use the Services

- **Usage Information**: When you use the Services, you generate information pertaining to your use, including timestamps, such as access, record, share, edit and delete events, app use information, screenshots/screen captures taken during the meeting, interactions with our team, and transaction records.
- **Device Information**: We assign a unique user identifier ("**UUID**") to each mobile device that accesses the Services. When you use our Services, you provide information such as your IP address, UUIDs, device IDs, web beacons and other device information (such as carrier type, whether you access our Service from a desktop or mobile platform, device model, brand, web browser and operating system).
- **Cookies:** We use Cookies and other similar technologies ("**Cookies**") to enhance your experience when using the Service. For more information about our Cookies policy, see HOW WE USE COOKIES AND SIMILAR TECHNOLOGIES below.

Information received from third parties.

- **Information we receive from third party platforms**: When you connect third party platforms, apps or providers (such as Google Calendar, iCal or other calendar programs, Google Contacts or Zoom) to our Services, or when you register through a third party account (such as Google or Microsoft), we receive Personal Information that includes your username, profile picture, email address, time, location, calendar information, contact information from such

third parties and any information you choose to upload to such third party platforms ("**Platform Information**").
- **Information from platforms our Services relies on**: We receive transaction information from our payment processor Stripe.
- **Other third parties.** We may receive additional information about you, such as demographic or interest attributes from third parties such as data or marketing partners and combine it with other information we have about you.

We also collect, and use aggregated data such as statistical or demographic data for our purposes. Aggregated data may be derived from your Personal Information but is not Personal Information as this data will not directly or indirectly reveal your identity. However, if we combine or connect aggregated data with your Personal Information so that it can directly or indirectly identify you, we will treat the combined data as Personal Information which will be used in accordance with this Policy.

2. HOW WE USE YOUR PERSONAL INFORMATION

We use your Personal Information to:

- **Set up your account.** We use your registration information, device information and information received from third parties (such as your username, email address) in order to set up an account for you to use our Services. We do so in accordance with our contractual and precontractual obligations to you in order to provide you with an account to use the Services.
- **Provide you with the Services**. We use your audio recordings, usage information and platform information in order to provide you with the Services. In addition, we use your communication information to facilitate support (e.g. retrieval of a forgotten password). We do so in accordance with our contractual obligations to you in order to provide you with the Services.
- **Improve and monitor the Services**. We use information we automatically collect or generate about you when you use the Services, as well as information about your device such as device manufacturer, model and operating system, and the amount of free space on your device, to analyze the use of and improve our Services. We train our proprietary artificial intelligence technology on de-identified audio recordings. We also train our technology on transcriptions to provide more accurate services, which may contain Personal Information. We obtain explicit permission (e.g. when you rate the transcript quality and check the box to give Otter.ai and its third-party service provider(s) permission to access the conversation for training and product improvement purposes) for manual review of specific audio recordings to further refine our model training data.
- **Communicate with you**. If you contact us, we will use your contact information to communicate with you and, if applicable, your usage information to support your use of the Services.
- **Send you newsletters about product news or updates that may be of interest to you.** We will send you emails with news or updates pertaining to our Services. When doing so, we process your email address, name and may

process your usage information. Your consent can be withdrawn at any time by following the unsubscribe mechanism at the bottom of each communication.
- **Prevent fraud, defend Otter.ai against legal claims or disputes, enforce our terms and to comply with our legal obligations.** It is in our legitimate interest to protect our interests by (1) monitoring the use of the Services to detect fraud or any other user behavior which prejudices the integrity of our Services, (2) taking steps to remedy aforementioned fraud and behavior, (3) defending ourselves against legal claims or disputes, and (4) enforcing our terms and policies. When doing so, we will process the Personal Information relevant in such a case, including information you provide us, information we automatically collect about you, and information which is provided to us by third parties.

3. HOW WE USE COOKIES AND SIMILAR TECHNOLOGIES

We and our third party partners use Cookies, pixel tags, and similar technologies to collect information about your browsing activities and to distinguish you from other users of our Services in order to aid your experience and measure and improve our advertising effectiveness.

Cookies are small files of letters and numbers that we store on your browser or on your device. They contain information that is transferred to your device.

We use Cookies to collect information about your browsing activities and to distinguish you from other users of our Services in order to aid your experience.

We use the following types of Cookies and similar technologies:

- **Strictly necessary Cookies:** Some Cookies are strictly necessary to make our Services available to you; for example, to provide login functionality, user authentication and security. We cannot provide you with the Services without this type of Cookie.
- **Functional Cookies**: These are used to recognize you when you return to our Website. This enables us to personalize our content for you and remember your preferences (for example, your choice of language).
- **Analytical, performance, or advertising Cookies:** We also use Cookies and similar technologies for analytics purposes in order to operate, maintain, and improve our Services and measure and improve our advertising effectiveness. We use third party analytics providers, including Google Analytics and Amplitude, to help us understand how users engage with us. We also use third party advertising partners, including Facebook, to deliver ads to you on other sites. Google Analytics uses first-party Cookies to track user interactions which helps show how users use our Service and Website. This information is used to compile reports and to help us improve our Service and Website. Such reports disclose Website trends without identifying individual visitors. You can opt out of Google Analytics by going to https://tools.google.com/dlpage/gaoptout or via Google's Ads settings.

You can block Cookies by setting your internet browser to block some or all or Cookies. However, if you use your browser settings to block all Cookies (including strictly necessary Cookies) you may not be able to use our Services.

4. WITH WHOM WE SHARE YOUR PERSONAL INFORMATION

Third party services are not owned or controlled by Otter.ai and third parties may have their own policies and practices for collection, use and sharing of information. Please refer to third party privacy and security policies for more information before using such services. Third parties include vendors and service providers we rely on the provision of the Services. We share your Personal Information with selected third parties, including:

- **Other users** who see your Personal Information (such as your username and email) and any other information you choose to share with them through the Services.
- **Cloud service providers** who we rely on for compute and data storage, including Amazon Web Services, based in the United States.
- **Platform support providers** who help us manage and monitor the Services, including Amplitude, which is based in the U.S. and provides user event data for our Services.
- **Data labeling service providers** who provide annotation services and use the data we share to create training and evaluation data for Otter's product features.
- **Artificial intelligence service providers** that provide backend support for certain Otter product features.
- **Mobile advertising tracking providers** who help us measure our advertising effectiveness, including AppsFlyer which is based in Israel.
- **Analytics providers** who provide analytics, segmentation and mobile measurement services and help us understand our user base. We work with a number of analytics providers, including Google LLC, which is based in the U.S. You can learn about Google's practices by going to https://www.google.com/policies/privacy/partners/, and opt-out of them by downloading the Google Analytics opt-out browser add-on, available at https://tools.google.com/dlpage/gaoptout.
- **Advertising Partners**: We work with third party advertising partners to show you ads that we think may interest you. Some of our advertising partners are members of the Network Advertising Initiative (http://optout.networkadvertising.org/) or the Digital Advertising Alliance (http://optout.aboutads.info/). If you do not wish to receive personalized ads, please visit their opt-out pages to learn about how you may opt out of receiving web-based personalized ads from member companies. You can access any settings offered by your mobile operating system to limit ad tracking, or you can install the AppChoices mobile app to learn more about how you may opt out of personalized ads in mobile apps.

- **Providers of integrated third-party programs, apps or platforms**, such as Google Calendar and Apple iCal. When you connect third party platforms to our Services, you authorize us to share designated information and data created and/or uploaded by you to our servers with these third-party programs on your behalf.
- **Payment processors**, such as Stripe. These payment processors are responsible for the processing of your Personal Information, and may use your Personal Information for their own purposes in accordance with their privacy policies. More information is available here: https://stripe.com/gb/privacy.
- **Law enforcement agencies, public authorities or other judicial bodies and organizations.** We disclose Personal Information if we are legally required to do so, or if we have a good faith belief that such use is reasonably necessary to comply with a legal obligation, process or request; enforce our terms of service and other agreements, policies, and standards, including investigation of any potential violation thereof; detect, prevent or otherwise address security, fraud or technical issues; or protect the rights, property or safety of us, our users, a third party or the public as required or permitted by law (including exchanging information with other companies and organizations for the purposes of fraud protection). For more information, please see Otter's Data Request Policy.
- **Change of corporate ownership.** If we are involved in a merger, acquisition, bankruptcy, reorganization, partnership, asset sale or other transaction, we may disclose your Personal Information as part of that transaction.

5. HOW LONG WE STORE YOUR INFORMATION

Otter.ai stores all Personal Information for as long as necessary to fulfill the purposes set out in this Policy, or for as long as we are required to do so by law or in order to comply with a regulatory obligation. When deleting Personal Information, we will take measures to render such Personal Information irrecoverable or irreproducible, and the electronic files which contain Personal Information will be permanently deleted.

6. YOUR RIGHTS

In certain circumstances you have the following rights in relation to your Personal Information that we hold.

- **Access**. You have the right to access the Personal Information we hold about you, and to receive an explanation of how we use it and who we share it with.
- **Correction**. You have the right to correct any Personal Information we hold about you that is inaccurate or incomplete.
- **Erasure**. You have the right to request for your Personal Information to be erased or deleted.
- **Object to processing**. You have the right to object to our processing of your Personal Information where we are relying on a legitimate interest or if we are processing your Personal Information for direct marketing purposes.
- **Restrict processing**. You have a right in certain circumstances to stop us from processing your Personal Information other than for storage purposes.

- **Portability**. You have the right to receive, in a structured, commonly used and machine-readable format, Personal Information that you have provided to us if we process it on the basis of our contract with you, or with your consent, or to request that we transfer such Personal Information to a third party.
- **Withdraw consent**. You have the right to withdraw any consent you previously applied to us. We will apply your preferences going forward, and this will not affect the lawfulness of processing before your consent was given.

Please note that, prior to any response to the exercise of such rights, we will require you to verify your identity. In addition, we may require additional information (for example, why you believe the information we hold about you is inaccurate or incomplete) and may have valid legal reasons to refuse your request. We will inform you if that is the case. For more information on how to exercise your rights, or to exercise your rights, please email support@otter.ai.

If you are a California resident, California law affords you certain rights regarding our collection and use of your personal information. To learn more about your California privacy rights, please visit our Privacy Notice for California Residents.

7. Data Privacy Framework Principles

Otter.ai complies with the EU-U.S. Data Privacy Framework (EU-U.S. DPF), the UK Extension to the EU-U.S. DPF, and the Swiss-U.S. Data Privacy Framework ("Swiss-U.S. DPF") as set forth by the U.S. Department of Commerce. Otter.ai has certified to the U.S. Department of Commerce that it adheres to the EU-U.S. DPF Principles with respect to the processing of personal data received from the European Union in reliance on the EU-U.S. DPF and from the United Kingdom (and Gibraltar) in reliance on the UK Extension to the EU-U.S. DPF. Otter.ai has certified to the U.S. Department of Commerce that it adheres to the Swiss-U.S. DPF Principles with respect to the processing of personal data received from Switzerland in reliance on the Swiss-U.S. DPF. If there is any conflict between the terms in this privacy policy and the EU-U.S. DPF Principles and/or the Swiss-U.S. DPF Principles, the Principles shall govern. To learn more about the Data Privacy Framework program, and to view our certification, please visit https://www.dataprivacyframework.gov/.

For more information on how we comply with the DPF Principles, please see **APPENDIX: Otter.ai Data Privacy Framework Principles Notice**.

8. CHILDREN

The Service and Website are not targeted at children, and we do not knowingly collect Personal Information from children under the age of 13. If you learn that a child has provided us with Personal Information in violation of this Policy, please contact us as indicated below.

9. CONTACT & COMPLAINTS

For inquiries or complaints regarding this Policy, please first contact us at support@otter.ai and we will endeavor to deal with your complaint as soon as possible. This is without prejudice to your right to launch a claim with a data protection authority.

If you are based in the EEA or the UK, you may also make a complaint to either the Irish Data Protection Commission (on +353 578 684 800 or via https://forms.dataprotection.ie/contact) or the UK's ICO (on +44 303 123 1113 or via https://ico.org.uk/make-a-complaint/), or to the supervisory authority where you are located.

10. DATA SECURITY

Otter.ai maintains and implements physical, administrative, and technical safeguards to protect the confidentiality, integrity, and availability of personal information. However, the transfer of Personal Information through the internet will carry its own inherent risks and we do not guarantee the security of your data transmitted through the internet. You make any such transfer at your own risk.

The Website and Service may provide features or links to websites and services provided by third parties. Any information you provide on Apps, third-party websites or services is provided directly to the operators of such websites or services and is subject to their policies governing privacy and security, even if accessed via our Website or in connection with our Service.

11. CROSS-BORDER DATA TRANSFERS

To facilitate our global operations, Otter.ai may transfer, store and process your operations with our partners and service providers based outside of the country in which you are based. Laws in those countries may differ from the laws applicable to your country of residence. Where we transfer, store and process your Personal Information outside of the EEA or the UK we will ensure that the appropriate safeguards are in place to ensure an adequate level of protection such as through acceding to the Standard Contractual Clauses. Further details regarding the relevant safeguards can be obtained from us on request.

12. CHANGES

Where required, we will update this Policy from time to time. When we do so, we will make it available on this page and indicate the date of the latest revision. Please check this page frequently to see any updates or changes to this Policy.

13. ABOUT US

If you have any questions, comments or concerns about our Privacy Policy, you may contact us by email at support@otter.ai attn: Privacy Officer or by mail to:

Otter.ai, Inc.
Attn: Privacy Officer
800 W El Camino Real,
Suite 170,
Mountain View, CA 94040

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VITA

Judson LaGrone, MSN, RN, CVRN-BC

Assistant Professor
Lamar University, JoAnne Gay Dishman School of Nursing
P.O. Box 10081, Beaumont, TX 77710
May 2024-current

EDUCATION:

May 2017 Master of Science in Nursing (MSN - Education concentration).
Texas A&M University, College Station, TX

May 2012 Bachelor of Science in Nursing (BSN).
East Texas Baptist University, Marshall, TX

BOARD CERTIFICATION:

Cardiovascular Registered Nurse (CVRN-BC I)- American Board of Cardiovascular Medicine (exp. August 2025)

LICENSURE INFORMATION:

State	Status (active, inactive)	Type of Licensure	Expiration Date
Texas	Active	Registered Nurse - Compact	February 28, 2025

PROFESSIONAL WORK HISTORY:

May 2023-present **Assistant Professor (JoAnne Gay Dishman School of Nursing)- Lamar University, Beaumont, TX**

- Design and deliver course instruction through the development of instructional plans to meet course outcomes and the development of activities that support lesson objectives
- Serve as an instructor or course lead in didactic, clinical practicum, clinical simulation, or hybrid courses for all-level AND to BSN students and BSN students
- Deliver learning-centered instruction by establishing a classroom environment conducive to learning and student involvement aimed at student success

- Demonstrate flexibility in style and work schedule, as well as exhibit a passion for teaching while engaging students in the learning process
- Communicate consistently and effectively with administration, faculty, and students
- Contribute to a learning culture by participating in the school, college, and university committees, support local campus events, and participate in continuous professional development
- Mentor students and faculty in leadership and professionalism
- Develop and implement a mentoring program for male nursing students
- Provide ongoing formative and summative evaluations to students related to their strengths and weaknesses in the performance of skills
- Provide a welcoming and safe learning and work environment while supporting the diversity of faculty and students

September 2022-August 2023 **Instructor (Transitional Registered Nursing Program)-**

Lamar State College Orange, Orange, TX

- Develop curriculum and instruct all-level ADN nursing students through didactic, clinical practicum, and clinical simulation
- Develop, assessed, and implemented simulations
- Contribute to a learning culture by participating on curriculum and system task forces, support local campus events, and participate in continuous professional development
- Assist in the preparation of accreditation documentation and visits, ADN program development and application documentation, and program reports
- Chair and develop LSCO Inaugural Disaster Day
- Participate in on-site high school student and community outreach and campus guests when requested
- Provide individual and small group tutoring

February 2020-June 2022 **Nurse Manager (Cardiac Catheterization and Electrophysiology Lab)-**

Baylor Scott & White Health, Temple, TX

- Manage operation and staff of the Cardiac Catheterization and Electrophysiology Lab
    - 6 procedural suites, 15-bed pre/post-op area, 28-member team
    - $21.1 million annual expense budget
    - Chest Pain Receiving Center with 24-hour call team
- Maintain nursing staff by recruiting, hiring, and orientating nurses and auxiliary staff
    - Assisting in the development of a nurse fellowship

- Implement and maintain institution/department policy and guidelines to support and enforce evidence-based practice, State Board of Nursing Practice Act, and governing agency regulations
- Maintain nursing staff by coaching, counseling, and disciplining when appropriate and appraising job performance with opportunities of improvement
- Assist in the resolution of patient and staff needs by utilizing the multidisciplinary team approach
- Manage, implement, and evaluate financial objectives of the institution and department by participating in annual budget, analyzing variances, and scheduling expenditures
- Maintain professional relationships among healthcare teams and business partners
- Serve as an educational resource for the Department of Cardiology and the nursing fellowship program
- Manage during COVID-19 Pandemic
    - Develop, implement, and evaluate reduction plans during pandemic and for "Snap Back"
        - FTE Flex Plan
            - Decrease weekly FTEs by 4% with a goal to continue to increase productivity to 120% pre-pandemic
        - 10% Expense Reduction Plan
            - Decrease in expenditure for procedural area with a goal to continue to increase productivity to 120% pre-pandemic
            - Mitigate unforeseen financial loss and reduction in procedural area personnel
        - 25% Expense Reduction Plan
            - Decrease in expenditure for procedural area with a goal to continue to increase productivity to 120% pre-pandemic
            - Mitigate unforeseen financial losses and reduction in procedural area personnel
    - Develop, implement, and evaluate policy/procedure for STEMI patients who are presumptively positive or positive with COVID-19 arriving and departing from the procedural area with procedural staff and other departments involved in patient care
    - Design and implement simulation with all levels of staff within the department for receiving and handing off a presumptively positive or positive COVID-19 patient
    - Provide education to Cardiac Division regarding change in practices with infection control and serve as a champion with infection control for cardiovascular procedural and clinic areas

        - Maintained and requisitioned appropriate PPE to all levels of staff while monitoring par levels with limited supplies
        - Provided in-services on donning and doffing, PAPR, and N-95 Masks
    - Establish and provide a compassionate and empathetic environment to support staff in emotionally/psychologically while maintain a sense of community within the team
- BSWH EPIC/Cupid optimization build team
- Assist with COVID-19 vaccine hubs for administration to hospital staff and community members

November 2019-March 2020 **Staff Nurse (Electrophysiology Lab)-**
Baylor Scott & White Health, Temple, TX

- Practice as a Registered Nurse
    - Proficient in the care of patients within the cardiovascular population
    - Utilize effective management skills for three procedural suites and holding room
    - Demonstrate professionalism as a role model for other members of the nursing team
    - Develop self and team members while sharing organizational information
- Deliver patient care through the nursing process of assessment, planning, implementation and evaluation for complex tertiary cardiovascular procedures within the holding room and procedural suite
- Assist physician during electrophysiology studies and device implantation procedures
    - Prepare patients, procedural suite and equipment for pending cardiac procedures
    - Assist as scrub nurse for electrophysiology studies and device implantation
        - Serve as a preceptor for nurses learning to scrub implantation procedures
    - Administer procedural sedation while circulating and performing nursing interventions as appropriate during the procedure
    - Direct and guide patient/family teaching and activities of other nursing personnel while maintaining standards of professional nursing

June 2019-November 2019 **Staff Nurse (Cardiac Catheterization and Electrophysiology Lab)-**
Baylor Scott & White Health, Round Rock, TX

- Practice as a Registered Nurse

    - Proficient in the care of patients within the cardiovascular population
    - Utilize effective management skills for two procedural suites and holding room
    - Demonstrate professionalism as a role model for other members of the nursing team
    - Develop self and team members while sharing organizational information
- Deliver patient care through the nursing process of assessment, planning, implementation and evaluation for complex tertiary cardiovascular procedures within the holding room and procedural suite
- Assist physician during cardiac catheterization, angioplasty and/or stenting and device implantation procedures
    - Prepare patients, procedural suite and equipment for pending cardiac procedures
    - Assist as scrub nurse for cardiac catheterization, angioplasty, stenting, and device implantation
    - Administer procedural sedation while circulating and performing nursing interventions as appropriate during the procedure
- Direct and guide patient/family teaching and activities of other nursing personnel while maintaining standards of professional nursing

February 2018-May 2019 **Adjunct Faculty (Vocational Nursing Simulation Lab)- Chaffey College School of Health Sciences, Chino, CA**

- Develop, implement, and evaluate evidenced-based activities in the Learning/Simulation Lab in coordination with course faculty
- Design and implement simulation curriculum with a focus on skills assessment, accountability, and critical reasoning skills with use of continuous performance evaluation and final evaluation of a repeated simulation
- Participate in simulation activities as primary instructor
- Demonstrate nursing skills and techniques to students
- Utilize information technologies skillfully to support teaching-learning process including the use of high-fidelity human simulators
- Utilize critical reasoning skills to effectively communicate information, observations and/or activities to students
- Provide opportunities for students to demonstrate clinical reasoning, knowledge, and evidence-based decision-making skills in the Learning/Simulation Lab
- Provide individual and small group tutoring in the Learning/Simulations Lab
- Provide ongoing feedback to students related to their strengths and weaknesses in the performance of skills

- Demonstrate professionalism and sensitivity when interacting with students/peers

November 2016-May 2019 **Staff Nurse (Cardiac Catheterization Lab)-**
Pomona Valley Hospital Medical Center, Pomona, CA

- Practice as a Clinical Level III Registered Nurse
    - Proficient in the care of patients within the cardiovascular population
    - Utilize effective management skills for three procedural suites and holding room
    - Serve as a relief charge nurse for a twenty-five-member team
        - Assist with staffing, supply management, and workflow
    - Demonstrate professionalism as a role model for other members of the nursing team
    - Develop self and team members while sharing organizational information
- Deliver patient care through the nursing process of assessment, planning, implementation, and evaluation for complex tertiary cardiovascular procedures for an annual average of 1800 patients within the holding room and procedural suite
- Assist physician during cardiac catheterization, angioplasty and/or stenting, device implantation, endovascular aneurysm repair, transcatheter aortic valve replacement, and electrophysiology study procedures
    - Prepare patients, procedural suite and equipment for pending cardiac procedures
    - Assist as scrub nurse for cardiac catheterization, angioplasty, stenting, and device implantation
    - Administer procedural sedation while circulating and performing nursing interventions as appropriate during the procedure
    - Marked proficiency in diagnostic pacing techniques and ability to troubleshoot technical connections for electrophysiology procedures
- Direct and guide patient/family teaching and activities of other nursing personnel while maintaining standards of professional nursing
- Serve on the ST-elevation myocardial infarction (STEMI) four man call team with a thirty-minute response time
- Master multiple software programs including but not limited to Philips XPER Hemodynamics and St. Jude Claris System
- Serve on the STEMI Task Force and STEMI Receiving Hospital Committee to assist in forming and implementing policy and procedures for the hospital in regard to STEMI patients

        - Assisted with obtaining the American College of Cardiology national recognition as a Chest Pain Receiving Center
    - Apply evidence-based practice to clinical setting
        - Established and implemented Chest Pain and Cardiac Alert policy and protocols for the Emergency Department
        - Established and implemented Anesthesia Medication Tray policy and protocol for the Cardiac Cath Lab
        - Established and implemented Skin Integrity policy and protocol for patients receiving procedures with the anticipation of greater than three hours
        - Established and implemented Cardiac Alert Responder Roles policy, procedure, and simulation
        - Established and implemented Cardiac Alert Box policy, procedure, and simulation
    - Serve as a preceptor and mentor to nursing students, new hires, and rotating hospital staff
        - Established an orientation resource for new hires and compiled education resources for both new hires and students

December 2015-November 2016 **Staff Nurse (Emergency Department)-**
Pomona Valley Hospital Medical Center, Pomona, CA

- Deliver patient care for a Level II Trauma Center through the nursing process of assessment, planning, implementation, and evaluation for traumatic and emergency medical situations for over 100,000 patients annually
- Initiate patient triage and assessment in a fast-paced environment of the Emergency Department
- Maintain a safe environment and care for psychiatric and mental health patients as well as assist with 5150 placement and facility placement
- Determine the standards of care needed to develop care plan
- Perform nursing interventions as required
- Document patient progress and procedures
- Serve as a preceptor to nursing students and graduate nurses

August 2014-December 2015 **Travel Nurse (Emergency Department)-**
Aya Healthcare, California

- Initiate patient triage and assessment in a fast-paced environment
- Maintain a safe environment and care for psychiatric and mental health patients as well as assist with 5150 placement and facility placement
- Determine the standards of care needed to develop care plan
- Perform nursing interventions as appropriate
- Document patient progress and procedures
- Serve as a preceptor to nursing students and graduate nurses

January 2014-July 2014 **Clinical Teaching Assistant-**

Texas A&M University School of Nursing, College Station, TX

- Serve as a resource to the student for specific learning activities
- Provide the level of supervision or direct instruction as negotiated with the course instructor in the clinical setting
- Notify the instructor immediately with any concerns regarding student or client safety and well being
- Work with clients, staff, and other members of the agency community to understand the role, capabilities and learning needs of the student
- Organize and evaluate simulation and skills lab throughout the semester including final competency check for the semester
- Assist in clinical teaching within the skills lab, simulation lab, and clinical setting

August 2013-July 2014 **Charge Nurse–**

Grimes St. Joseph Health Center, Navasota, TX

- Coordinate clinical activities within a specific unit for an assigned shift in the Emergency Department
- Maintain a safe environment and care for psychiatric and mental health patients as well as conduct 5150 placement and facility placement
- Delegate patient care assignments based on nursing needs of each patient, the medical regimen and the qualifications and experience of nursing staff members
- Counsel staff personnel and resolve problems with House Supervisor and Director
- Identify and confront issues that affect the quality of patient care
- Communicate concerns through incident reports and through the chain of command in the Emergency Department
- Serve as a preceptor to nursing students and graduate nurses

August 2013-July 2014 **Endoscopy Team Leader–**

Grimes St. Joseph Health Center, Navasota, TX

- Perform duties of a circulating nurse in patient care
- Oversee the operating room during procedures
- Maintain a safe and functional environment for patients and staff
- Identify physical symptoms and changes in patients and take appropriate action
- Provide the necessary professional and clinical practice support for the team and peers
- Assist physician during endoscopic procedures
- Manage and operate equipment safely and correctly
- Maintain endoscopic equipment according to guidelines, regulations, laws and manufacturer's instructions

June2012-July 2014 **Staff Nurse-**

St. Joseph Regional Health Center, Bryan, TX

- Initiate patient triage and assessment in a fast-paced environment of a Level II Trauma Center
- Maintain a safe environment and care for psychiatric and mental health patients as well as conduct 5150 placement and facility placement
- Determine the standards of care needed to develop care plan
- Document patient progress and procedures
- Perform nursing interventions as appropriate
- Serve as a preceptor to nursing students and graduate nurses

I. RESEARCH and SCHOLARSHIP

Research and Scholarship focus: Qualitative methods examining the perceptions and experiences of critical care nurses with self-identified traumatic events that have caused them distress in the clinical setting

II. LECTURES/PRESENTATIONS AT SYMPOSIA AND CONFERENCES

LaGrone, J. (2024). *Normalizing the abnormal: Effects of critical care nursing culture & self-identified traumatic events*. Southern Nursing Research Society 38th Annual Conference, Charlotte, North Carolina.

LaGrone, J. (2023). *Dealing with the difficult patient*. Texas Podiatric Medical Association Annual Conference: Assistance Program, Irving, Texas.

LaGrone, J. (2023). *In-office emergencies*. Texas Podiatric Medical Association Annual Conference: Assistance Program, Irving, Texas.

LaGrone, J. (2022). *Emergencies, disasters, threats, and patient satisfaction in the ambulatory setting*. Texas Podiatric Medical Association Annual Conference: Assistance Program, Irving, Texas.

LaGrone, J. (2021). *Simulation-based education debriefing models: An integrative review*. Abstract published in the proceedings for the 46th Biennial Convention for Sigma Theta Tau International, Indianapolis, Indiana.

III. HONORS/AWARDS:

The Ralph and Mary John Spence Centennial Scholarship SON [2024]

- Recognizes an outstanding student from one of the five schools at the University of Texas Medical Branch

Student Leadership Award- UTMB School of Nursing Alumni Association [2023]

- Recognizes extraordinary students who have been engaged with the school and have fostered that relationship through the Alumni Association

Professional Excellence Award Nominee- Lamar State College Orange [2023]

- Focuses on involvement in activities that promote professional growth and assertion

Teaching Excellence Award Nominee- Lamar State College Orange [2023]

- Focuses on preparation, teaching methods, teaching performance, class assignments, and interaction with students

John P. McGovern Chair in Nursing Award- University of Texas Medical Branch [2022]

- Selected by the School of Nursing faculty

Michael Tacheeni Scott Endowed Scholarship Award- University of Texas Medical Branch [2022]

- Selected for outstanding student in the Graduate School of Biomedical Sciences

University Federal Credit Union Award- University of Texas Medical Branch [2022]

- Selected for demonstration of outstanding performance in all areas of academic life at UTMB

Daisy Nurse Leader Award Nominee- Baylor Scott and White Health [2021]

- Nominated by peers and staff for creating an environment where compassionate care can thrive

Jonas Philanthropy Scholar Nominee- University of Texas Medical Branch [2021]

- Nominated by School of Nursing faculty for graduate research foci specifically addressing the nation's most pressing healthcare needs

Interprofessional Scholar- Disaster Day Incident Commander- University of Texas Medical Branch [2022]

- Participate in a prestigious organization for students focused on interprofessional development and interaction
- Serve as a leader for the university's Disaster Day to organize, disseminate knowledge on disasters and medical care, and conduct simulation with the student body and local community

John P. McGovern Chair in Nursing Award- University of Texas Medical Branch [2020]

- Selected by the School of Nursing faculty

Pomona Valley Hospital Medical Center- Star Safety Award [2017, 2018]

- Awarded the Star Safety Award in recognition of policy and procedure changes within the institution to improve the quality of care and safety while providing care to STEMI patients

Sigma Theta Tau International Inductee- Iota Nu Chapter [2017]

- Inducted for nurse leader excellence for the improvement of patient care through the development of evidence-based practice for STEMI patients and the reduction of "door to balloon time"

Pomona Valley Hospital Medical Center- Clinical Level III Registered Nurse [2017]

- Awarded recognition by hospital management as a "proficient" nurse in accordance with the Clinical Levels Professional Model within the Pomona Valley Hospital system

Good Sheppard Medical Center- Longview Hospital Hero Award [2012]

- Awarded the Hero Award for efforts during a clinical rotation in the Emergency Department
  - Initiated hospital policy and protocol for possible child abuse
  - Used critical thinking and leadership to identify child had been kidnapped from the father
  - Family attempted an abduction of a child from the hospital; initiated protocol and personally prevented him and the client from leaving the hospital

East Texas Baptist University- Community Service Scholar [2012]

- Awarded the Community Service Scholar Award for continued community enrichment throughout college career
- Completed over 450 community service hours while maintaining full-time student status that aided in the growth of youth through Boy Scouts of America and youth group at church as well as free healthcare clinics for the less fortunate and homeless

Boy Scouts of America [1997-present]

- Eagle Scout with 3 palms and 52 merit badges
- Vigil Honor member of the Order of the Arrow: honor society of scouting's highest honor
- Founder's Award Honoree of the Order of the Arrow
- Served two terms as Lodge Chief leading the youth of Three Rivers Council Order of the Arrow
- Served Section Conclave Vice Chief: planned, promoted, and delivered on a program event for the southern half of Texas that broke previous attendance records
- Currently give back to the organization as an adult volunteer

IV. MEMBERSHIP IN SCIENTIFIC SOCIETIES/PROFESSIONAL ORGANIZATIONS:

American College of Cardiology, Member [2020-Present]

American Nurses Association, Member [2021-Present]

Heart Rhythm Society, Member [2019-Present]

Sigma Theta Tau International, Member [2017-Present]

Southern Nurse Research Society, Member [2020-Present]

Texas Nurses Association, Member [2021-Present]

V. ADDITIONAL SERVICE INFORMATION:

Young Professional Organization Steering Committee- Beaumont Chamber of Commerce-[2023-present]

- Serve as a member on the steering committee for the Chamber to organize professional events and seminars for the young professionals of Beaumont, Texas and the surrounding area

School of Nursing Faculty Committee- Course Evaluation, Student Representative- University of Texas Medical Branch [2021-present]

- Serve as a representative for the School of Nursing PhD cohorts to engage with faculty for course evaluations

Graduate School of Biomedical Sciences Student Ambassador for School of Nursing- University of Texas Medical Branch [2021-present]

- Serve as a representative for the graduate cohorts of the School of Nursing to the Graduate School of Biomedical Sciences to increase the ability to understand and present perspectives of students' challenges and needs
- Formulate and recommend actions to aid the graduate students to the Graduate School of Biomedical Science leadership