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Discovering the Living Experience of Feeling Overwhelmed by the Rapid Response Team Member

Rhonda Wayne Mann

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Discovering the Living Experience of Feeling Overwhelmed by the Rapid Response
Team Member

by

Rhonda Wayne Mann

A thesis submitted to the faculty of
Gardner-Webb University Hunt School of Nursing
in partial fulfillment of the requirements for the
Master of Science in Nursing Degree

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Submitted by:

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Abstract

Rapid response teams were implemented in efforts to combat mounting safety concerns among hospitalized patients. Numerous differing team compositions exist across the nation, however, most teams are led by a critical care nurse. Responsibilities of the rapid response team, in addition to unit based responsibilities, can lead to the feeling of being overwhelmed. Literature focusing exclusively on the feelings of the rapid response team member is obsolete. A qualitative study using the Parse research method was used to answer the research question: What is the structure of the critical care nurse's living experience of feeling overwhelmed during rapid response calls? Seven participants, representing day shift and night shift, that serve in a dual role of an intensive care clinical supervisor and rapid response team member were used as the purposive sample population. Dialogical engagement, extraction-synthesis, and heuristic interpretation were used for participant language collection and data analysis. The central finding of this study was: feeling overwhelmed is profound responsibility along with a lack of resources/support that creates self-reliance. Structurally transposed as: feeling overwhelmed is obligatoriness coupled with persistent struggle rendering sovereignty. These feelings left unaddressed could progress to compassion fatigue.

Keywords: rapid response teams, experiences, feelings, lived experience, overwhelmed, nurse, and Parse

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CHAPTER I

Introduction

Critical care members of any rapid response team (RRT) have a tremendous amount of responsibility placed on their shoulders. Responding to emergent calls, quick assessments of the situation at hand, supporting the patient and their family, mentoring the medical/surgical staff members, in addition to responsibilities on their home unit often times lead to feelings of being overwhelmed. However, these feelings are repressed due to the lack of time for expression, in combination with responsibilities of the work day and attempts for work/life balance. Exploration of feeling overwhelmed can identify common themes among the RRT responder group and creative solutions to provide support for the critical care RRT member.

Significance

After the publication of the landmark report *To Err is Human: Building a Safer Health System* in 1999 by the Institute of Medicine (IOM), the medical community and health care consumers became acutely aware that hospitals were not as safe as once perceived. It was estimated that at least 44,000 and as many as 98,000 deaths per year occurred secondary to preventable medical errors (Institute of Medicine, 1999). In addition, the costs of errors came in many forms, such as the financial burden of longer hospitalizations and modalities required to treat the medical error, diminished trust from the patient and families perspective toward the health care system, and loss of job satisfaction for health care workers (Institute of Medicine, 1999). It was paramount that strategies be identified and implemented to create safe environments for the patient population.

In 2004, the Institute for Healthcare Improvement (IHI) launched a quality improvement plan called the 100,000 Lives Campaign. This initiative aimed at saving a minimum of 100,000 hospitalized patient's lives through direct and targeted safety improvement efforts. The creation and deployment of RRT was one of the six interventions deemed prudent by the campaign. RRTs would bring critical care expertise to the bedside of the medical/surgical patient (Berwick, Calkins, McCannon, & Hackbarth, 2006). The IHI did not mandate the composition of individual RRTs; therefore, many differing functional models exist. Many studies regarding RRTs refer to the perceptions of the staff members that activate the call, however limited information is available related to the living experience of the RRT member. Due to the individuality of the composition of RRT across the country, in addition to the acute care facilities stance on the usefulness of the RRT, the responding member of the team will have a unique living experience (Mitchell, Schatz, & Francis, 2014). Identifying those experiences can reveal important information that can help hospitals improve staff relationships and patient outcomes.

Purpose

The purpose of this Masters in the Science of Nursing Thesis was to discover the living experience of feeling overwhelmed by the critical care nurse member of the RRT in a 457 bed, acute care facility in the Piedmont region of North Carolina.

Theoretical or Conceptual Framework

The Theory of Humanbecoming, developed by Rosemarie Rizzo Parse, is a grand theory rooted in phenomenology (Grove, Burns, & Gray, 2013; Hickman, 1995; Parse, 2007, 2015; Pilkington, 1999, 2005). Parse (2015) divides nursing into both a discipline

and a profession. “The goal of the discipline is to expand knowledge about human experiences through creative conceptualization and research” and “the goal of the profession is to provide service to humankind through living the art of the science” (Parse, 2015, p. 264). Within the discipline of nursing Parse identifies three paradigms – the Totality paradigm, the Simultaneity paradigm, and the Humanbecoming paradigm (Parse, 2015).

Originally, Parse (1981, 1995, 2015) developed the man-living-health human science theory. In her effort to remove gender identity, she renamed her theory the human becoming theory (Hickman, 1995; Parse, 1995, 2015). Parse’s ideas have become a school of thought amongst the community of nursing scholars (Parse, 2015). The evolution of her theory led to the merging of human becoming to humanbecoming to create more explicit concept of indivisible cocreation (Parse, 2007).

Parse (1999) delineates the ontology of the Humanbecoming Theory through a framework of assumptions and principles as follows:

1. The human is coexisting while coconstituting rhythmical patterns with the universe.
2. The human is an open being, freely choosing meaning in situation, bearing responsibility for decisions.
3. The human is unitary, continuously coconstructing patterns of relating.
4. The human is transcending multidimensionally with the possibles.
5. Becoming is unitary human-universe-health.
6. Becoming is a rhythmically coconstituting human universe process.
7. Becoming is the human’s pattern of relating value priorities.

8. Becoming is an intersubjective process of transcending with the possibles.
9. Becoming is unitary human's emerging. (p. 2-3)

Parse (1999) continues on to create assumptions as related to human becoming.

1. Human becoming is freely choosing personal meaning in situation in the intersubjective process of living value priorities.
2. Human becoming is cocreating rhythmical patterns of relating in mutual process with the universe.
3. Human becoming is cotranscending multidimensionally with the emerging possibles. (p. 3)

Further defining human becoming, Parse (1999) provides three principles.

1. Structuring meaning multidimensionally is cocreating reality through the languaging of valuing and imaging.
2. Cocreating rhythmical patterns of relating is living the paradoxical unity of revealing-concealing and enabling-limiting, while connecting-seperating.
3. Cotranscending with the possibles is powering unique ways of originating in the process of transforming. (p. 3)

The Humanbecoming school of thought desires to understand the relationship of the lived experiences of health and various phenomena (Parse, 2007; Smith, 2012; Maillard-Strüby, 2012). Parse developed three modes of inquiry for the purpose of exploring theoretical concepts and developing nursing research surrounding the humanbecoming worldview. The two basic methods are the Parse method and the humanbecoming hermeneutic method designed to expand knowledge on humanly lived experiences, while the applied research method seeks to discover the relationship when humanbecoming is

used as the framework for practice (Parse, 2005). For the purpose of this study, the researcher has opted to utilize the Parse method of research to expand the knowledge base of the living experience of feeling overwhelmed by the critical care nurse RRT member.

The Parse method contains three phases – dialogical engagement, extraction-synthesis, and heuristic interpretation. During dialogical engagement the researcher centers themselves to gain a true presence during their time together. The researcher poses a question for the participant to express their lived experiences with the phenomenon being researched. The dialogues are audio taped or videotaped for transcription (Parse, 2005). “Extraction-synthesis is all-at-once dwelling with and inventing” (Parse, 2005, p. 298). The researcher spends time dwelling on the dialogue obtained from the participants, listening to the stories, thus gaining insight on the lived experience of the phenomenon of study from their eyes, then extrapolating to abstraction. Finally, “heuristic interpretation is weaving the structure with the principles of humanbecoming and beyond to enhance knowledge and create ideas for further research (Parse, 2005, p. 298). The researcher creates an interpretation of the study in language of humanbecoming, assigns descriptive poetic phrases, and portrays the study findings through a chosen piece of literature, poetry, sculpture, music, or other artistic expression (Parse, 2005). In 2010, Parse added metaphorical emergings to the process of heuristic interpretation. The spoken words of the participants were found to be saturated with metaphors that express meaning of the phenomenon in question (Parse, 2011). “This expansion enhances depth and clarity of understanding and sheds new light on the meaning of humanly lived experiences” (Parse, 2011, p. 13). (Figure 1)

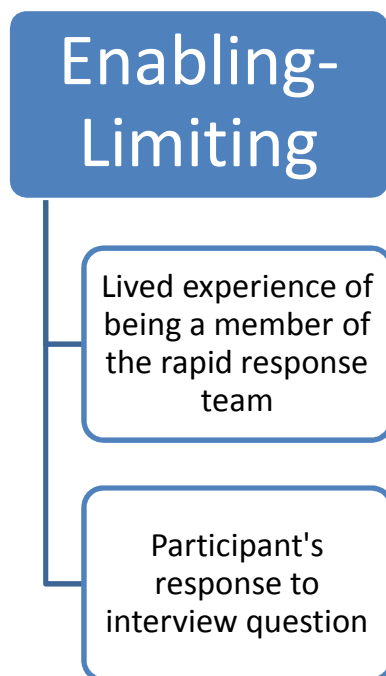


Figure 1: Conceptual-Theoretical-Empirical (CTE) Diagram

Thesis Question

What is the structure of the critical care nurse's living experience of feeling overwhelmed during rapid response calls?

Definition of Terms

Rapid Response Team's (RRT) are defined as "teams designed to intervene during the care process in order to reduce or eliminate preventable cardiac arrests in hospital settings" (Spaulding & Ohsfeldt, 2014, p. 195).

Rapid Response Team Users are the team members that initiate RRT calls.

Rapid Response Team Member is the critical care clinical supervisor for the purpose of this study.

Non-Technical Skills as defined by Chalwin, Flabouris, Kapitola, and Dewick (2016) are leadership, communication, team working, and decision making skills.

Summary

Patient safety is paramount and many initiatives were implemented after the exposure of fragmented health care systems that compromised safe patient environments came to light in the 1999 publication of *To Err is Human: Building a Safer Health System*. The deployment of rapid response teams to detect, provide early intervention, and decrease out of intensive care cardiac arrest was one of six initiatives chosen to improve patient safety. Each participating facility constructed their respective team in a manner that best suited their need and resources available. As a result, unique challenges face each RRT member.

Using the Parse method of qualitative research from the Humanbecoming perspective, themes can emerge through the discovery of the living experience of feeling overwhelmed by the critical care nurse RRT member: the purpose of this study. Analyzing themes can identify feelings that may have gone submerged leading to continued frustrations or lack of celebration. Pioneering this manner of inquiry, where no researcher has chosen to explore, opens up a frontier of new knowledge. Understanding individual interpretations of feeling overwhelmed can unearth elements that need to be examined to build a better team.

CHAPTER II

Literature Review

Rapid Response Teams (RRTs) have been implemented across the country in response to the Institute for Healthcare Improvement's (IHI) 100,000 Lives Campaign. Studies have revealed that patients show evidence of deterioration approximately six to eight hours prior to cardiac arrest (Kapu, Wheeler, & Lee, 2014; Mitchell et al., 2014). The ability for the medical/surgical nurse to summon critical care experts to review the patient's chart or to deliver immediate critical care interventions improves patient outcomes (Evans, 2013). Many articles have been dedicated to the medical/surgical staff feelings or perceptions in relation to the existence of or interactions with the RRT. Some secondary feelings or perceptions from the RRT member have filtered into the research; however, no evidence exists focusing exclusively on the RRT member. The purpose of this research study was to discover the living experiences from the critical care nurse RRT member during RRT calls in an acute care facility.

Review of the Literature Related to RRTs

A literature review was performed utilizing articles obtained from the Cumulative Index to Nursing and Allied Health Literature (CINAHL), Area Health Education Center (AHEC), PubMed, and the Google search engine. Key terms were "rapid response teams," "experiences," "feelings," and "lived experience," which produced seven articles articulating the perceptions and/or experiences of the medical/surgical nurse calling the RRT ranging from 2009 to 2016. One study was conducted in Australia and the remaining six conducted in the United States. No articles were found that described the

lived experience from the critical care RRT member or the use of Dr. Rosemarie Parse's Theory of Human Becoming.

Perceptions of RRT Users

Hart, Spiva, Dolly, Lang-Coleman, and Prince-Williams (2016) undertook a descriptive, qualitative study to explore and understand the experiences of medical-surgical nurses as first responders during clinical deterioration events. The study took place in an integrated healthcare system in the United States comprised of five hospitals. A demographic questionnaire and an interview guide were used to conduct 28 semi-structured interviews. Participants were selected with a purposive sampling method from medical/surgical nurses who activated RRT calls, in addition to those who were amenable to the audio taped interviews that took place from October 2014 to February 2016. Hart et al. (2016) identified three patterns with associated themes during the data analysis phase. The first pattern described the nurse's ability to recognize and respond to the situation at hand. The themes identified were the detecting subtle changes in vital signs, continuity in patient care assignments, and having a gut feeling something is not right with the patient. The second pattern identified was managing the event, describing themes of knowledge and experience of the nurse, ability to initiate emergency techniques, and delegation of tasks and acting as an informational support to the RRT. The third pattern mentioned spoke of challenges encountered during an event. The features of the room design presented barriers to patient care. The room size proved too small for emergency personnel, furniture, computer, and necessary equipment. The interviews were conducted in an integrated healthcare system in the southeast United

States and lacks diversity. This was considered a limitation, as well as a predominantly female sample.

A qualitative study was performed by Jenkins, Astroth, and Woith (2015) to explore the potential benefits to nurses who activate RRT calls. Social judgement theory as illustrated by the Lens Model of Cognition served as the theoretical framework and an exploratory design was used to guide the study. The site was a not-for-profit, community hospital situated in an urban area of the Midwestern United States. A convenience sample of 50 non-critical care nurses was recruited via email invitations and informational flyers. The survey instrument was distributed by email using a secure online system called SelectSurvey.NET. The study found that unit culture played a huge role in the activating RRT calls and newer nurses and more experienced nurses were likely to activate calls rather than one group more than the other. RRT users valued the RRT concept; however some non-critical care nurse were fearful of condescending attitudes from the RRT members. Feelings of having to justify the reason for the call and unrealistic expectations of the RRT user by the RRT member were expressed. It was felt that further education on effective professional communication for RRT members would be beneficial. Lastly, RRT users felt that RRT education was lacking. In the participating facility, RRT education was given as a new hire with sporadic follow up. Limitations identified were the methods of recruitment, data collection performed at only one facility, and use of a new data collection instrument.

Shapiro, Donaldson, and Scott (2010) used a qualitative method and modified thematic analysis to explore the impact of RRTs from the perspective of the nurses who use them. A sample group of 56 staff nurses representing 18 hospitals from 13 different

states was used. Various work settings were included – medical/surgical, step-down, and outpatient procedural area from nine teaching and nine non-teaching facilities. Focus groups were used to allow for full expression of feelings regarding the subject matter. The researchers found that the RRT users felt relief for an extra set of eyes, hands, minds, and bodies that were available to meet the patients’ needs in the setting of deteriorating vital signs, a “gut feeling” that something was not right, or not receiving needed help from the physician. One statement was made from the RRT member perspective regarding a feeling of concern for leaving their intensive care unit (ICU) patient to respond to a RRT call. A small sample size of 56 staff nurses was felt to be a limitation; however those 56 were from 18 different hospitals from 13 different states thus making the findings somewhat generalizable and suggested as strength.

Donaldson, Shapiro, Scott, Foley, and Spetz (2009) developed a mixed methods study to explore the impact of RRT implementation from the RRT user perspective. The quantitative portion consisted of collecting common characteristics of the RRT in various participating hospitals. The qualitative piece used a convenience sample of 56 nurses from 18 selected sites with an average bed size of 305. Thematic analysis was used to categorize the interview information. Three primary reasons surfaced for the nurse to activate a call – changes in vital signs or mental status, a “gut feeling” something was wrong, or the physician was not responsive. Four themes of assistance required from the RRT emerged from the interviews – extra eyes and hands, one call acquired assistance with any type of urgent need, the reputation of the ICU nurse carried more authority when communicating with physicians, and expedited transfers to higher levels of care. An obvious difference was felt during the interviews by the RRT users from the hospitals

that were more supportive of the RRT implementation versus those hospitals that were not supportive. Robust adopters used language such as there was never a bad call, while the hospitals that were not as supported felt they should have consulted with other staff members prior to calling the RRT. Not being supported created feelings of defeat among the RRT users. Limitations were identified in the variability in data submission and small sample size of 18. However, the 18 hospitals spanned 13 states representing urban, rural, teaching, and non-teaching facilities. This diversity was considered a strength.

Perceptions of RRT Users and Members

Chalwin et al. (2016) developed a mixed methods study to investigate experiences of staff interactions and non-technical skills (NTS) at RRT calls and their associations with repeat RRT calls. The study took place in 300 bed university-affiliated tertiary metropolitan in South Australia. A survey comprised of questions related to NTS performance during RRT calls was administered over a six week interval, advertised via email and staff meetings, and given in paper form or by Survey Monkey. Some answers were based on a five point Likert scale; others were ranking, and a comment section. For the quantitative data, the Likert items were expressed in frequencies and percentages and analyzed using Pearson's Chi-square test. The Friedman test was employed to analyze the ranked items. For the qualitative data, coding was used to place responses into one of four domains – leadership, communication, cooperation, or planning. The significant findings were lack of RRT member identification, communication, and handoff information. Both users and members alike expressed some uncomfortable interactions at some point during an RRT call. RRT users felt that they were unimportant during a call, stating feeling of distance and not being involved. Conversely, the RRT member

felt the user was uninterested. Overall, a lack of collaboration and communication of a plan of care for the patient were reasons for additional RRT activations. Low response rates led to the inability to generalize results, respondents with extreme opinions could have biased the results, and leading question format could have lowered validity were felt to be weakness of the study. Although, having a free text section and delivering the same questions to the RRT users and RRT members were believed to be strengths.

Perceptions of RRT Users, Members, and Leaders

Stolldorf (2016) conducted a qualitative study, with the use of purposive and snowball sampling, to assess the perceived benefits of RRTs from the perspective of nurse leaders, RRT members, and RRT users. A semi-structured interview guide was used to gain information from 50 participants from the three target groups. The use of email and distribution list, personal presentations at meetings, direct personal contact, and flyers were methods used to illicit participation, in addition to a small incentive for participants. The study sites were four community hospitals that had a bed size of 200 to 300 beds and had an active RRT for a minimum of four years. Data reduction, data display, and conclusion drawing or verification using ATLAS software was used to analyze the interview information received. Various themes were identified by all three groups polled. Organizational benefits were perceived to be positive patient and organizational outcomes, increasing community perceptions as patients and families were allowed to initiate RRT calls in the study facilities, reduced cost, and improved satisfaction for staff, patients, and families. RRT users felt supported in the availability of experts and used these calls as opportunities to learn from said experts. Increased patient safety through early recognition and intervention provided the provision of better

care for the patient. Only a few RRT members chose to participate therefore their views were underrepresented and considered a limitation. The authors considered the reduced risk of bias through the neutral nature of study questioning and neutral voice maintained during transcription maintaining confidentiality.

Leach, Mayo, and O'Rourke (2010) implemented a qualitative approach to understand the decision making prior to initiate a RRT call and the roles the nurses had in that process. A grounded theory approach with axial coding was utilized for data analysis. Fifty semi-structured interviews were performed from six acute care facilities in northern California. The following types of organizations were represented: non-profit community, magnet designated, public, academic, for-profit community, and integrated delivery system hospitals. Purposeful sampling was used to glean information from key staff members, which included 14 bedside registered nurses (RNs) who called RRTs, 16 RRT staff RNs, two respiratory therapists who responded to RRT calls, and 18 nurse supervisors who observed RRT calls. The RRT user felt affirmed to call the team for support or extra resources by consulting with other RNs, the unit manager, or the clinical nurse specialist (CNS). The RRT member felt empowered by nursing leaders to make the correct decisions to prevent adverse events. However, the RRT member occasionally felt some push back from physicians regarding the transfer of patients to a higher level of care. Both categories of RNs felt role synergy. The primary nurse believed he/she was the expert informational resource about the patient and the RRT member understood he/she had the autonomy to escalate needed treatments for the patient. Some of the challenges identified revealed that not all RRT interventions went smoothly and were attributed to differing decision making styles.

Literature Review Related to the Phenomena

A literature review was performed utilizing articles obtained from the Cumulative Index to Nursing and Allied Health Literature (CINAHL), Area Health Education Center (AHEC), and the Google search engine. Key terms were “overwhelmed,” “feeling overwhelmed,” “nurse overwhelmed,” and “Parse”. The CINAHL search for the keyword “overwhelmed” revealed 140,844 results. Narrowing the search to “feeling overwhelmed” revealed 4,534 results.

The phenomenon of being overwhelmed can relate to animate and inanimate objects. Rivers and tributary can be overwhelmed with water, power grids being overwhelmed by surges of energy, and humans feeling overwhelmed by stressful situations or life commitments. Many diverse types of literature speak of feeling overwhelmed, including the Holy Bible as mentioned by Drummond (2012). However, only two studies were found that utilized the Parse research method in investigating the phenomena of feeling overwhelmed. Another dissertation was found that used elements of the Parse research method.

Drummond (2012) conducted a qualitative study, employing the Parse method. A volunteer convenience sample of 10 mothers of children with type I diabetes was used.

The inclusion criteria were:

1. Mothers (natural or adoptive) caring for children with a diabetes mellitus Type I.
2. Capable of participating in a dialogical engagement which requires verbal communication, and ability to sit comfortably, and commitment of one hour.
3. Willing to participate and sign informed consent.

4. Eighteen years of age or older. (Drummond, 2012, p. 65)

“The central finding of the study of the lived experience of feeling overwhelmed is engulfing duress with unassuredness while endeavoring with cherished alliances” (Drummond, 2012, p. v).

The other study found utilizing the Parse research method and feeling overwhelmed in the general population was conducted by Condon (2014). The sample consisted of nine females and one male. Inclusion criteria were the ability to speak and read the English language. Recruitment was by word of mouth. “The major finding of the study is the structure: Feeling overwhelmed is burdening disconcertedness surfacing with divergent engagements as optimistic anticipation arises while structuring endeavors” (Condon, 2014, p. 216).

England (2008) conducted a study employing a hermeneutic phenomenological approach and elements of the Parse research method to study feeling overwhelmed in nurse managers. The purposive sample consisted of six female nurse managers using the snowball method. Inclusion criteria were males or females over the age of 21 that currently held a position as a nurse manager in a hospital setting. Exclusion criteria were currently in psychological counseling, suffered a recent life altering event such as a divorce or death of spouse, and other criteria deemed significant by the researcher. “Four essential themes were identified: there is nobody there, caught in the middle, feeling that you are a failure, and the inability to do” (England, 2008, p. 2).

Gaps in Literature

The majority of the research articles found focused on the perceptions of the RRT user. One article did contain some RRT member's perceptions of the role of individual nurses during an active RRT call (Leach et al., 2010). No information was located that portrayed the lived experiences of feeling overwhelmed in the RRT member during RRT calls. Additional research could identify if highly functioning RRT increases nurse recruitment and/or retention.

Only two articles were found that utilized the Parse research method (Condon, 2014; Drummond, 2012) and one that utilized modified elements of the Parse research method (England, 2008). Only one article pertained to nursing (England, 2008). No information was found in relation to the phenomenon of feeling overwhelmed for the critical care nurse RRT member. Further investigation could open a frontier of information to support this unique population of nurses.

Limitations of the Literature

The literature reviewed revealed minimal information regarding the perceptions of RRT members (Chalwin et al., 2016; Leach et al., 2010; Shapiro et al., 2010; Stollendorf, 2016) and no evidence of RRT members feeling overwhelmed. Using larger sample sizes with a qualitative research design can be difficult, as saturation may be reached with a small group. However, smaller sample sizes make the results difficult to create generalizability (Donaldson et al., 2009; Jenkins et al., 2015; Shapiro et al., 2010). Another limitation revolved around the recruitment method. Using email, distribution list, and survey flyers creates a convenience sample of those who read survey related information and those who choose to participate (Chalwin et al., 2016; Donaldson et al.,

2009; Jenkins et al., 2015; Stolldorf, 2016). In addition, the majority of the respondents were Caucasian and of the female gender (Hart et al., 2016). These gaps substantiate the need for further research related to RRTs.

The literature found using the Parse method to discover the phenomenon of feeling overwhelmed is scarce and even more limited in respect to the nursing profession. In all three studies found, the samples used were predominately female (Condon, 2014; Drummond, 2012; England, 2008). In the study performed by Drummond (2012) mothers of diabetic children was the target participant group; however Condon (2014) and Drummond (2012) only had one male between the two samples. The inclusion of more males could contribute information that could alter study outcomes. In addition, the methods of obtaining the sample groups by a volunteer convenience (Drummond, 2012), word of mouth (Condon, 2014), and snowball (England, 2008) could limit a diverse sample that could affect study outcomes. These factors alone authenticate the need for further research dedicated to the phenomenon of feeling overwhelmed.

CHAPTER III

Methodology

The publication of *To Err is Human: Building a Safer Health System* in 1999 brought increased attention to patient safety and the fragmentation of healthcare. At that time, an estimated 44,000 to 98,000 deaths occurred annually secondary to preventable medical errors (Institute of Medicine, 1999). The creation and deployment of rapid response teams (RRTs) was one of six initiatives deemed prudent by the campaign. Each participating facility constructed their RRT based upon their individual needs and resources available to bring critical care expertise to the bedside of the medical/surgical patient (Berwick et al., 2006). Studies have shown patients exhibit signs of deterioration approximately six to eight hours prior to cardiac arrest (Kapu et al., 2014; Mitchell et al., 2014) and the ability of the medical/surgical nurse to summons critical care experts to review the patient's chart or to deliver immediate critical care interventions has improved patient outcomes (Evans, 2013).

A knowledge gap exists of literature viewed exclusively from the perspective from the critical care RRT member. Critical care members of any rapid response team (RRT) have a tremendous amount of responsibility placed on their shoulders. Responding to emergent calls, quick assessments of the situation at hand, supporting the patient and their family, mentoring the medical/surgical staff members, in addition to responsibilities on their home unit often times lead to repressed feelings due to the lack of time for expression, in combination with responsibilities of the work day and attempts for work/life balance. Exploration of perspectives from the critical care nurse member can

identify common themes among the RRT responder group and promote creative solutions to provide support for the critical care RRT member.

Study Design

A qualitative, descriptive design utilizing the Parse method was employed to obtain the structure of the living experiences among the critical care member of the RRT. The Parse method includes three processes – dialogical engagement, extraction-synthesis, and heuristic interpretation (Parse, 2001, 2005). The researcher took time to center themselves to be truly present with the participant during their dialogue regarding the human phenomenon under query. “The researcher enters the rhythmical flow of the moment with each participant as the participant describes the experience under study” (Parse, 2005, p. 298). While maintaining true presence the researcher asked leading questions to engage the participant in disclosing more feelings related to their experience of the human phenomenon.

Setting and Sample

The setting for the digitally recorded dialogical engagement was one of two conference rooms within the acute care facility to maintain true presence with the participant based on the availability of the room. A purposive sample was used. The participants maintain a dual function serving in the clinical supervisor role and the critical care RRT member. They possess a unique perspective of the living experience of combining the RRT member role and home unit responsibilities. The participants range from six to 35 years in the nursing profession and nine months to 13 years in the clinical supervisor and RRT member dual role. Day shift (7a-7p) and night shift (7p-7a) was represented.

Design for Data Collection

Following approval from the Nursing Scientific Advisory Council (NSAC), the facility's Investigational Review Board (IRB), and the University's Institutional Review Board, the researcher individually spoke with each of the study participants. An explanation and purpose of the study was delivered, along with obtaining informed consent. (Appendix A) Once agreeable, the study participant was offered the option to have the dialogical engagement session while on duty or on non-duty hours. A session was scheduled to meet with the researcher convenient to the participant, one of two conference rooms was utilized for each session based on room availability.

Prior to each session, the researcher centered herself in order to maintain a true presence during dialogical engagement. As with the Parse method, the researcher requested each participant to describe their experience of being the critical care member of the RRT. The researcher did not interrupt them, but moved the dialogue forward with statements such as, "Go on", "Please say more about your experience", "Can you think of anything else that would help me understand your experience", or "Please relate what you are saying with your experience" (Parse, 2001, p. 170). Dialogical engagement could have lasted for 30 minutes with each participant unless the participant felt saturation had been reached. Sessions with participants took place between September 25th, 2017 to October 5th, 2017.

Measurement Methods

After transcription, dwelling with the written language of the participants will render the stories and experiences as they are perceived by the participants. The participant language was transposed into the language of science to portray the essence of

their experiences into one statement. Heuristic interpretation revealed the findings of the study. Structural transposition moved the perceptions into abstraction and conceptual integration connected the findings to one of three concepts that Parse identifies: revealing-concealing, enabling-limiting, or connecting-separating (Parse, 2005). Finally, an artistic expression, chosen by the researcher, which visually portrays the study findings, was adopted.

Protection of Human Subjects

Prior to conducting this study, an application was submitted to the Nursing Scientific Nursing Council (NSAC), the Investigational Review Board at the host facility, and the University's Institutional Review Board. Approval was received from each group respectively. This research study will be anonymous and confidential. No personal or demographic identifiers will be utilized. An alias was assigned to each participant's language for reporting purposes. Transcriptions of the participant's language was completed by the researcher, maintained on a password protected device, and deleted upon study completion. Benefits for the participants would be the reflection of feelings as performing in the critical care nurse responder of the RRT. This may lead to the sharing of ideas/concepts to provide support to this unique role.

Data Analysis

After dialogical engagement, the researcher dwelt with the written transcriptions for theme identification. The thesis advisor served in transcript review and transposition of language. The course advisor served as the Parse expert to maintain rigor and validation of findings.

CHAPTER IV

Results

The purpose of this research study was to explore the phenomenon of feeling overwhelmed by the critical care nurse nursing rapid response team calls. The study results will be utilized to optimize the structure of the rapid response team at the host facility and act as a catalyst for medical-surgical nurse education. Drilling down into the roots of the living experience of feeling overwhelmed in relation to the rapid response nurse team (RRT) member can shed insight into innovative solutions.

Sample Characteristics

The purposive sample consisted of seven clinical supervisors from the medical-surgical intensive care unit at a 457 bed acute care hospital in the Piedmont region of North Carolina. Each participant maintains a dual role of clinical supervisor and RRT member. The participants range from six to 35 years in the nursing profession and nine months to 13 years in the clinical supervisor and RRT member dual role. Day shift (7a-7p) and night shift (7p-7a) were represented; three day shift and four night shift. All seven clinical supervisors agreed to participate and signed the informed consent. Dialogical engagements sessions were performed at the convenience of the participant in one of two conference rooms within the intensive care unit at the host facility, based on room availability. Each session was audio recorded, transcribed by the researcher, and member checked by the participant. After the member checking process, an alias was assigned to maintain anonymity.

Major Findings

The researcher asked each participant to, “Describe the structure of feeling overwhelmed during rapid response team calls.” Each participant began to describe their interpretation of the living experience of feeling overwhelmed during these calls. Three major concepts and two minor concepts emerged after dwelling with each participant’s language. The major concepts revealed were profound responsibility, lack of resources/support, and self-reliance. The minor concepts were aloneness and need for dedication. Table 1 illustrates the essences of the participant’s language along with the researcher’s transposition to abstraction. Table 2 illustrates the Core Concepts across Levels of Abstraction.

Table 1

Language Art across Levels of Abstraction

Participant	Language - Art
Ann	<p><u>Ann’s language</u></p> <ul style="list-style-type: none"> • Feeling overwhelmed is being responsible for the whole house without support. • Feeling overwhelmed is a heavy burden of liability for all among diverse situations. <p><u>Researcher’s language</u></p> <ul style="list-style-type: none"> • Feeling overwhelmed is transcendence without sanction. • Feeling overwhelmed is self-reliance amid disequilibrium.
Bea	<p><u>Bea’s language</u></p> <ul style="list-style-type: none"> • Feeling overwhelmed is knowing nothing about the patient situation without the primary nurse’s help and not receiving return phone calls from the doctor while managing home unit patients, staffing needs, and codes. Dedicated RRT needed. • Feeling overwhelmed is lack of knowledge without and sufficient support while needing to handle home unit responsibilities. Dedicated resources increase satisfaction. <p><u>Researcher’s language</u></p> <ul style="list-style-type: none"> • Feeling overwhelmed is unknowing and deficiency while negotiating chaos.

- Feeling overwhelmed is disconcertedness but dedication creates tranquility.

Lou

Lou's language

- Feeling overwhelmed is dealing with nurses that don't know what is going on and not having needed resources or needed support while having divided devotion.
- Feeling overwhelmed is unassuredness without support with divided devotion.

Researcher's language

- Feeling overwhelmed is disconcertedness arising from disequilibrium.
- Feeling overwhelmed is self-reliance surfacing through negotiating chaos.

Sara

Sara's language

- Feeling overwhelmed is lots of responsibility in many places and responding to mandatory RRT calls, especially if the doctor is in the room. Dedicated RRT needed. I am spread too thin.
- Feeling overwhelmed is lack of knowledge, along with mis-use of resources, and needing to handle home unit responsibilities. Dedicated RRT resources increase satisfaction.

Researcher's language

- Disconcertedness arises from disequilibrium.
- Self-reliance surfaces through negotiating chaos. Dedication creates tranquility.

Rachel

Rachel's language

- Feeling overwhelmed is getting pulled away from unit responsibilities, feeling of being spread too thin, not getting what is needed from the doctor's, and calls inducing stress. Availability of support is helpful and a relief.
- Feeling overwhelmed is lack of knowledge without sufficient support and needing to handle home unit responsibilities. Availability of the likeminded increases satisfaction.

Researcher's language

- Feeling overwhelmed is disconcertedness arises from disequilibrium and unknowing. Resolute aloneness among alliances.
- Feeling overwhelmed creates self-reliance through negotiating chaos. Presence of the likeminded creates peace.

Diane

Diane's language

- Feeling overwhelmed is fear of the unknown situation, lack of knowledge or presence of the primary nurse, unnecessary use of RRT, pulled away from home unit responsibilities for long periods of time, lack of support, and feeling alone.
- Feeling overwhelmed is lack of knowledge without sufficient support while needing to handle home unit responsibilities. Dedicated resources increase satisfaction.

Researcher's language

- Feeling overwhelmed is disconcertedness arising from disequilibrium.
- Feeling overwhelmed is self-reliance surfacing through negotiating chaos. Dedication creates tranquility.

Josie

Josie's language

- Feeling overwhelmed is lack of resources (staff and supplies), lack of support from doctors, and fear of making the wrong decision.
- Feeling overwhelmed is fear without sufficient support.

Researcher's language

- Feeling overwhelmed is disconcertedness arising from disequilibrium and unassuredness.
 - Feeling overwhelmed is revealing self-reliance through negotiating chaos.
-

Table 2

Core Concepts across Levels of Abstraction

Core Concept	Structural Transposition	Conceptual Integration
Profound responsibility	Obligatoriness	Powering
Lack of resources/support	Persistent Struggle	Imaging
Self-reliance	Sovereignty	Originating, Enabling-limiting
Structure	Feeling overwhelmed is profound responsibility along with a lack of resources/support that creates self-reliance.	
Structural Transposition	Feeling overwhelmed is obligatoriness coupled with persistent struggle rendering sovereignty.	
Metaphorical Emergings	Making chicken salad	
Artistic Expression	Self-Made Man by Bobbie Carlyle	

Major Concepts

Profound responsibility. Each participant revealed some element of an extreme sense of responsibility for their home unit, the patients they see on RRT calls, and the entire hospital. This is particularly evident with the night shift participants; given that night shift have fewer resources in general. Experts from the participant's language that embody this concept are:

- I think the feeling, and it's probably a little different on days than on nights, but on nights probably being responsible for the whole house.
- You're thinking about what you need to do over here but you're also thinking about what needs to be done on the floor.

- We're responsible for so many things just on our unit...I feel torn.
- A lot of people depend on you.
- That's a lot on your shoulders.
- I am the resource for the entire hospital.

This participant group has many responsibilities and expectations. Each shift has issues that need to be addressed. Table 3 illustrates the responsibilities exclusive to the clinical supervisor role and Table 4 denotes the responsibilities of the RRT.

Table 3

Responsibilities of the Intensive Care Unit Clinical Supervisor

Responsibilities of the Intensive Care Unit Clinical Supervisor
<ul style="list-style-type: none"> • ICU patient triage • Ensuring adequate staffing for oncoming shift • Make calls to staff members and house supervisors for staffing issues • Facilitate staff pulling up patients from the ED in a timely manner • Intercepting new ICU admissions at the ambulance bay requiring endovascular procedures and providing escort to the CT scanner or VIR suite • Round on ICU staff • Leader rounding – new patient admissions with two hours and daily • Ensure daily quality controls are completed • Conflict resolution – staff, patients, and visitors • Staff evaluations – preparation and delivery • Presentation of staff disciplinary actions • Leading daily multidisciplinary rounds at ten am • Leadership of a unit based shared governance council • Maintenance of basic life support (BLS), advanced cardiac life support (ACLS), and specialty certifications • Attend monthly leadership meetings • Complete a weekly hand hygiene audit • Any other responsibilities as delegated

Table 4

Responsibilities of the Rapid Response Team Member

Responsibilities of the Rapid Response Team Member
<ul style="list-style-type: none"> • Respond to RRT calls with three minutes – assess the situation and activate a code sepsis, code stroke, code STEMI, or code blue as necessary • Complete corresponding documentation for each call – either paper documents or Care Event Report • Respond to code sepsis call in the ED within thirty minutes • Respond to code sepsis alerts throughout the house within thirty minutes • House resource for medical/surgical nurses when they are not confident whether they should activate a RRT call

In combination, the participants feel overwhelmed when multiple, lengthy RRT calls have pulled them off the unit for prolonged periods of time during their shift.

Profound responsibility is conceptualized as obligatoriness at the structural transposition level. Obligatoriness is conceptually integrated with the humanbecoming concept of powering. “Powering is the pushing-resisting rhythm in all human-human and human-universe interrelationships” (Parse, 1992, p. 38). The RRT member’s language describes the feeling of being pushed into profound responsibility and the reactive resisting from the participants in reluctance to accept. These descriptive rhythms coincide with the third principle of the humanbecoming theory of cotranscending with the possibles in order to create new ways of viewing the familiar (Parse, 1992).

Lack of resources/support. Each participant brought out feeling the lack of resources/support. A range of ideas were shared that formed this finding, from the lack of basic supplies needed in the moment to care for the rapid response patient, the lack of

knowledge on the medical/surgical staff to assist with critical events, the lack of response from the physicians, or the type of responses received from the physicians. Experts from their language:

- You don't always feel support from the physicians. They expect you to make all the decisions and it's gotta be the right one.
- Going out to see a patient you know nothing about, trying to fix them. Especially when you don't have that nurse (the primary nurse) there.
- It's overwhelming sometimes when you get there because either the nurse don't know what's going on with that patient cause they have so many other patients....but you don't have a physician there to back you up.
- The doctors that you deal with and that may or may not appreciate your efforts
- The doctors especially on nights, they rely heavily rely on us. Once the critical care nurse gets there it's okay, well y'all have it under control then, you don't need me (the physician).
- It can be overwhelming to need multiple different things – whether it's a blood draw, supplies to check a manual blood pressure or give fluids and you're wanting to stay with the patient at all times and you're looking for a nurse or a care partner or someone to go and get these things so that you can stay with the patient.

This RRT at the host facility has an approved set of standing orders that can be used to treat the rapid response patient. However, often times the RRT nurse has utilized the standing order to the fullest extent possible in the respective situation and needs further guidance from a physician. Comments from each participant's language reveals a

consistent theme related to the perceived lack of support needed from the physician group creating a feeling of practicing in a silo.

Lack of resources/support is conceptualized as a persistent struggle. Persistent struggle is integrated into the Parse concept of imaging. “Imaging refers to knowing; knowing exists at the explicit and tacit realms. Personal knowing is shaped through pre-reflective-reflective imaging, explicitly and tacitly all at once. Explicit knowing is reflected upon critically; tacit knowing is pre-articulate and acritical” (Parse, 1992, p. 38). All participants describe numerous accounts of insufficient support from physicians which directly reflect the explicit knowing as described by Parse.

Self-reliance. The concept of self-reliance was not directly stated by the participants, but strongly inferred from each dialogical engagement. The framework for the RRT calls is in place. The call is activated, a page goes out over an audible pager to the team, the team responds, and has a defined set of standing order for their utilization. Each call is different. The RRT nurse is charged with the trajectory of events. The available orders are somewhat helpful, but ultimately the RRT nurse has to figure out what is best for the patient. In combination with a profound sense of responsibility coupled with minimal support, these participants just figure it out and make the best decisions for all involved.

Self-reliance is structurally transposed as sovereignty. Sovereignty is conceptually integrated into originating and enabling-limiting. Parse states that “originating means creating anew, generating unique ways of living which surface through interconnections with people and projects” (Parse, 1992, p. 38).

In addition, Parse (1992) defines:

enabling-limiting is a rhythmical pattern of relating. In choosing, there are an infinite number of opportunities and an infinite number of limitations. Moving in one direction limits movement in another. Within the chosen direction, there are inherent opportunities and limitations all at once, thus one is enabled-limited by all choices. (p. 38)

As each RRT call is unique, the blending of these two concepts captures the essence of the RRT members thought processes. Each call generates new issues-solutions which enables-limits the flow of creativity by the individual nurses being which cocreates rhythmical patterns of living of the humanbecoming model.

Minor Concepts

Aloneness. Several of the participants revealed that they feel alone. The medical/surgical staff and the physician are looking to the RRT nurse to take care of the problem at hand. Experts from their language supporting this finding are:

- You're the only one out there able to do things and you're the only one (clinical supervisor) here somedays.
- You get out there and there's nobody, which that's one of the scariest feelings for me.
- You're on your own, girl.

The angst of knowing there is no one else that can do the things that you need to do and deliver the expected outcomes creates a lonely place for these participants.

Aloneness is structurally transposed as forsakenness. Forsakenness is conceptually integrated to imaging. Forsakenness is multidimensionally cocreating reality as evidenced by the statements made by the RRT members.

Needed dedication. In light of the changing dynamics of the RRT role and the clinical supervisor role, many participants yearn for the segregation of the two. The following statements are evidence of this finding:

- Helps me out a huge amount, every day she (a dedicated RRT member) is here. Make's me smile cause that's gonna make my day a lot easier.
- We desperately need a dedicated critical care team other than just the clinical supervisor on a 35 bed ICU.
- Wish there was more time that you could follow up with these patients. When we actually have a dedicated team maybe that can happen more readily.

The participant's suggest that better patient care could be delivered if a dedicated RRT was available.

Needed dedication is structurally transposed to devoted allegiance which is conceptually transposed to transforming. Parse (1992) states, "Transforming is the shifting of views of the familiar as different light is shed on what is known. Increasing diversity is rhythmically lived as experience melts into experience into experience and different priorities arise" (p. 39). With years of change added to each role, discovering new ways to care for the patients and RRT members must be given attention. Long term exposure to feeling overwhelmed can lead to burn out, moral fatigue, and becoming insensitive to others needs. The participants long for relief.

Metaphorical Emergings

In 2010, Parse believed it necessary to make an addition to the heuristic interpretation process. “After examination of the dialogical engagement of the many Parse research method studies made it clear that the linguistic descriptions of universal lived experiences by participants were rife with metaphors that creatively expressed the meaning of their lived experience” (Parse, 2011, p. 13). Over the years, this participant group has developed their own, unique metaphor for their daily work. It states, “We make chicken salad out of chicken s**t.” This metaphor directly expresses the essence of self-reliance that is found from deep within each participant. They mold the profound responsibility placed on them from various sources, make the best out of the resources/support they do have, and work through their aloneness to create safe and harmonious outcomes.

Artistic Expression

Finally, an artistic expression is chosen by the researcher that visually depicts the study findings. This may be poetry, a sculpture, drawings, photographs, paintings, or any other form chosen by the researcher (Parse, 2005; Parse, 2011). The sculpture of the “Self-Made Man” was chosen by the researcher as the visual depiction of the study findings. (Figure 2) The depiction of a man chiseling himself out of a block of solid rock embodies the essence of using one’s own ideas to better their situation and for those around them. “The essence of the sculpture is captured in the words bold strength and provocative intelligence. Indeed, it is a work that carries a strong psychological appeal: dealing with the full spectrum, complexity of emotion, struggles and triumphs of life” (Crosby, 2004). As the RRT members make every effort to use their self-reliance to

create better surroundings for all despite profound responsibility, lack of support/resources, and aloneness.



Figure 2: Self-Made Man (Bobbie Carlyle Studios, 2015)

Summary

Dialogical engagement with the seven participants revealed several themes. All expressed a deep rooted feeling of responsibility and a lack of support particularly from the physician group. Some of the participants verbalized feeling of being alone. They were not physically alone but they were solely looked to in these situations to quickly assess, develop a plan, and execute that plan. In the critical care unit, other personnel are present that possess the same skill set but on the medical/surgical units the RRT member is the only person with the critical care mindset leading to feeling alone. All of the RRT

calls require the critical care nurse to pull from their critical care experience and create solutions. Some decisions are black and white, but others are grey which forces them to figure it out. Self-reliance emerges. Several participants mentioned the need for a dedicated RRT. This concept would separate the role of the RRT member from the clinical supervisor. As the expectations have increased over the years, the prospect of this division is needed.

CHAPTER V

Discussion

Following the IOM investigation of safety concerns in the healthcare arena in 1999, the Institute for Healthcare Improvement (IHI) developed six targeted initiatives aimed at saving hospitalized patients lives. The addition of rapid response teams was one of the initiatives chosen to bring expert critical care thinkers to the medical/surgical patient's bedside. Hospitals were allowed to develop teams based upon their unique circumstances and resources available. Many differing models exist across the country as a result. Due to the individuality of the composition of these teams, the RRT members have different responsibilities leading to various perceptions and feelings. Nurses that serve in a dual role as a clinical supervisor and the RRT critical care nurse member may feel overwhelmed. Discovering the structure of feeling overwhelmed among this defined group was the aim of the study.

Implications of Findings

Upon the literature review related to RRTs, the perceptions of the team members were mentioned as an incidental finding, if mentioned at all. Upon review of the phenomenon of feeling overwhelmed, minimal work has been focused on nursing and none has been done directly focused on the RRT nurse member. These nurses have been left silent. The findings of this study revealed penetrating concerns among this particular group. Diverse feelings were exchanged through dialogical engagement exposing unearthed pockets of unexplored areas of concern. The entire group felt a deep seeded feeling of responsibility amid lack of resources/support from collegial alliances fostering a feeling of being alone. Increasing desire for the two roles to be segregated surfaced.

Application to Theoretical/Conceptual Framework

The Parse research method was chosen for the framework of this study. Due to the lack of research conducted focused solely on this group, a qualitative study would open this unexplored crevasse. The Parse method allowed the participants to express their thoughts and feelings related to the chosen phenomenon of feeling overwhelmed in the setting of serving in the dual roles of a clinical supervisor and the critical care nurse for the RRT at the host facility. “The structure of the phenomena emerging through this method is the paradoxical living of the remembered, the now-moment, and the not-yet, all-at-once” (Parse, 1999, p. 5). After dwelling with the verbatim transcriptions, themes were identified revealing that many of the participants share many of the same feelings. This study opens the window for an expanse of research opportunities.

Limitations

A limitation noted by the researcher during dialogical engagement was the presence of the audio recording device. Each participant was made aware of the presence of a recording device during the informed consent process. However, during the actual session, the participant seemed to develop stage fright. In addition, if the participant had been asked to write down their thoughts prior to dialogical engagement, this might have changed their perception of being recorded.

Another limitation noted was the timing of the sessions in comparison to her last worked shift. Emotions tend to be more acute immediately following an incident. Would the information received change if all the sessions were held immediately after a worked shift? Would the intensity of the shift change worked prior to the session change the information received? In this study, the dialogical engagement was held at the

convenience of the participant as follows - two participants were off duty, three participants were at the beginning of their shift, one participant mid-shift, and one after working night shift. Standardization of dialogical engagement within the participant group may prove beneficial for future research.

Implications for Nursing

Based upon the study findings, the dynamics of the RRT structure at the host facility require attention. With the continued weight of profound responsibility, feelings of aloneness coupled with the lack of resources/support, the RRT members, if left unattended by leadership, may progress to compassion fatigue. Compassion fatigue can create multitudes of problems for the person experiencing it, the patient, and the institution if not recognized and properly dealt with. Compassion fatigue was identified in the early nineties by Carla Joinson (1992), a nurse, who described it as a unique form of burnout that affects those in care giving roles from experiencing stress and traumatic patient care events. Coetzee & Klopper as cited in Rosa (2014) defined “compassion fatigue is the self-destructible culmination of frustrations and unprocessed moral obstacles when energy expenditure outstrips restorative process” (p. 18). Hinderer et al. (2014, p.161) defined compassion fatigue as “a loss of a nurses’ ability to nurture patients.” No matter what definition is chosen to describe this phenomenon, it is a real and growing problem that affects many physically and emotionally.

Anyone who serves in a care giving role may display symptoms of compassion fatigue; however, it is more readily identified by those who experience recurrent acute and traumatic injuries and frequent occurrence of death (Burtson & Stichler, 2010; Elkonin & van der Vyver, 2011; Hinderer et al., 2014; Holst, Lundgren, Olsen, & Ishoy,

2009; Hunsaker, Chen, Maughan, & Heaston, 2015; Lombardo & Eyre 2011; Rosa, 2014). Healthcare workers may exhibit physical symptoms that many include but are not limited to headaches, gastrointestinal issues, and trouble sleeping to emotional symptoms of mood swings, irritability, poor concentration, and substance abuse (Lombardo & Eyre, 2011). Employees suffering from compassion fatigue will not be as productive or as effective in their role leading to changes in their work ethic, attendance, and potentially resulting in leaving their position or the healthcare profession (Hunsaker et al., 2015). Once compassion fatigue has been identified, restorative measures can be implemented to retain the invaluable resource of an experienced healthcare provider.

Recommendations

Based upon the study findings, the participants recommended the segregation of the clinical supervisor role and the RRT member role. Over the years of role evolution, the combination of the two has become very difficult to balance. The acuity of the hospitalized patient population has increased and will continue to rise with the trend toward population health. This shift will attempt to keep patients healthy and out of primary care facilities, thus leaving the sickest of the sick to be cared for. Nursing must be able to meet the needs of the higher acuity throughout the facility. A roving RRT nurse could preemptively round on medical/surgical units querying the nurses regarding patients of concern. This could allow for earlier critical care intervention preventing a complete failure to rescue. In addition, the dedicated RRT nurse could round on all transfers off the critical care units in attempts to prevent a transfer back to a higher level of care. These extra responsibilities are simply unrealistic for a dual role RRT member.

Segregation has already been shown to increase job satisfaction and decrease the incidence of compassion fatigue amongst the dual role RRT member.

Prevention of compassion fatigue maintains the efficacy of the RRT members. Being astute to patient presentation, lab trends, hemodynamics, and critical care experience creates an environment to catch early triggers of decompensation. If the team members are consistently overwhelmed, their judgement may become clouded. Critical thinking could become impaired and the patients they are summoned to care for could suffer.

Team members suffering from compassion fatigue could begin to have attendance issues. Tardiness could slowly begin to occur, followed by absenteeism. If the RRT members are not present, this service has no affect. If this symptom is not recognized, the nurse could find another avenue to escape the responsibilities and demands placed upon them. An experienced critical care nurse leaving the nursing profession would be a loss for the patients and facility they serve, but for the nursing profession as a whole.

With the increasing complexity of hospitalized patients and decreasing reimbursement, it is imperative to prevent untoward patient events. The presence of an experienced RRT can prevent patient decompensation and out of ICU cardiac arrest. According to the AVP of the critical care division at the host facility, the RRT calls have progressively increased since inception but the out of ICU cardiac arrests have remained down. This prevents transfers back to the ICU, which cost approximately \$3000.00 in accommodation charges a day. Our RRT has been an invaluable resource for this facility (R.B Wright, personal communication, November 14, 2017). This point alone demonstrates the need to prevent compassion fatigue among the RRT members.

Conclusion

Literature solely focused on the RRT nurse is obsolete. This study attempted to give this unique population a voice. The participant group of nurses, who serve in a dual role as a clinical supervisor and the critical care nurse RRT member, was asked to describe the structure of the living experience of feeling overwhelmed during rapid response team calls. After dialogical engagement the participant's language was transcribed verbatim per the researcher. The major core concepts of profound responsibility, lack of resources/support, and self-reliance were identified. The minor core concepts of aloneness and need for dedication were identified. The central findings of this study was feeling overwhelmed is profound responsibility along with a lack of resources/support that creates self-reliance. These feelings, in conjunction with the minor findings, could represent the catalyst for change regarding the framework of the rapid response team in the host facility and across America.

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Appendix A

Informed Consent

8/22/2017

Expires 8/16/2018

Discovering the Living Experience of Feeling Overwhelmed by the Critical Care Nurse Rapid Response Team Member – Informed Consent

Rhonda Mann is a graduate student in Gardner-Webb University's Hunt School of Nursing MSN program and is conducting research on the living experience of feeling overwhelmed by the critical care rapid response team member.

Purpose: This is a qualitative study seeking to understand the living experience of feeling overwhelmed by the critical care rapid response team member in the language of the participant. The participant's language will then be abstracted into language of the researcher and finally transposed into the language of science according to the Parse research method. There are no direct benefits to survey participation; however, the information may provide insight related to the feelings and perceptions of responding to rapid response calls, in addition to home unit responsibilities.

Procedure: Participants will agree to a thirty minute, audio recorded dialogue session with the researcher and review of respective theme interpretation for trustworthiness. To participate, you must be currently working the dual function as a clinical supervisor and rapid response team member. The sessions will be conducted in a private conference room, convenient for the participant.

Confidentiality: This research study is anonymous and confidentiality will be maintained throughout the study. No personal or demographic identifiers will be collected. An alias will be assigned to each participant for reporting purposes. Participant language transcriptions will be kept in the possession of the researcher on a password-protected device. Transcriptions will be shared with the researcher's Gardner-Webb University thesis advisor for transposition of language and analysis support. After completion of this research, the audio recordings will be erased, but the transcriptions will remain secure at Gardner-Webb University's Hunt School of Nursing for three years, after which it will be destroyed. The Carolinas HealthCare System Nursing Scientific Advisory Council and the Gardner-Webb University Institutional Review Board have approved the research study.

The records of this study will be kept private. In any sort of report, we might publish, we will not include any information that will make it possible to identify a patient. Your record for this study may, however, be reviewed and/or photocopied by Carolinas HealthCare System, or by representatives of the Food and Drug Administration or other government agencies. To that extent confidentiality is not absolute.

Voluntary Participation: Your completion of the research study is voluntary and you are under no obligation to participate. At any time during the survey, if you choose that you do not wish

to continue participation, you may withdraw participation without consequences. There are no costs or incentives associated with participation in this study. The dialogical engagement session will take approximately 30 minutes.

Risks and Benefits: There are minimal risks to participating in the research study; however if you experience distress from participating in this study, please contact the Employee Assistance Program at Carolinas HealthCare System at 704-355-5021. There are no risk of job employment based upon the information given for study purposes. There are no direct benefits associated with participating in this study; however, it is hoped that your input will help nursing and organizational leaders understand the rapid response team member's living experience of feeling overwhelmed.

Questions: If you have any further questions, feel free to contact Rhonda Mann at rmann1@gardner-webb.edu, Dr. Abby Garlock at agarlock@gardner-webb.edu, or the Carolinas HealthCare System Investigational Review Board at 704-355-3158. Thank you for your time and willingness to participate in the research study.

Research Participant Statement and Consent:

I understand that my participation in this research study is entirely voluntary. I may refuse to participate without penalty or loss of benefits. This study has been explained and I have read this document. I have had the opportunity to ask questions and have them answered completely. By completing this survey, I give the researcher permission to use the data obtained from the sessions for the research study and voluntarily agree to participate in this study.

Signature: _____
Date: _____